PART ONE: AN RCGP POSITION STATEMENT

THE FUTURE OF GP OUT OF HOURS CARE
EXECUTIVE SUMMARY

General practice has a vital role to play in the delivery of effective patient care at all times of day, including outside normal working hours. Those seeking help from the NHS at this time are often at their most vulnerable, and for many of these patients general practice is best placed to provide the care they need.

Pressures facing the UK’s urgent and emergency care services continue to be the subject of significant public debate. Although much of this debate has focused on A&E, there is a strong case for the skills of the expert medical generalist working in the community to be placed at the heart of our response to the challenges of meeting the needs of patients out of hours.

GPs already make a crucial contribution to the delivery of urgent and emergency care, making up a major part of the out of hours NHS workforce, with GP services of some form available 24 hours a day in most parts of the UK. Evidence indicates that patient satisfaction with the out of hours services GPs provide is relatively high and that the performance of these services is improving. However, too many patients are not aware that they can access these services, and the overall fragmentation of the out of hours care system can leave patients unsure as to where to seek help.

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The RCGP believes that to safeguard care for patients, future models of out of hours care provision should be based on the following principles:

- Patients should be able to gain timely access to the skills of an expert medical generalist when they need it, including outside core surgery hours.
- Services must be developed from a patient perspective, delivering integrated, whole person care to individuals interacting with different parts of the health and social care system.
- Personalisation and continuity of care are key, with systems and processes put in place to facilitate the appropriate sharing of patient information and ensure smooth and timely handover of care.
- The quality and safety of care are paramount and all service delivery models must ensure that working patterns are safe and sustainable.
- Providers and commissioners should be responsive to their local context, tailoring services to the needs and priorities of their populations.
- Out of hours services must be adequately resourced. Proposals to enhance out of hours services should not be pursued to the detriment of the ability of general practice to provide patient access in hours.

To deliver on these principles and support general practice to provide high quality patient care outside of contracted working hours in future, political willpower and action from policy makers throughout the NHS will be needed. The RCGP recommends that decision makers:

- Remove barriers that prevent providers of out of hours services from developing more integrated services, such as current restrictions on patient record sharing.
- Make it easier for GPs who wish to ‘opt in’ to deliver out of hours care directly to do so.
- Ensure that proposals to enhance the provision of extended hours GP services are adequately funded, and that in England commissioning processes for out of hours services are made more transparent.
- Take steps to ensure the general practice workforce has the capacity to deal with demand for out of hours care — including implementing four year training for all GPs, improving the assessment system for GP out of hours competencies, boosting training and support in out of hours GP care and undertaking long-term workforce planning.
THE ROLE OF GENERAL PRACTICE IN THE PROVISION OF OUT OF HOURS CARE

The provision of general practice outside its core contractual hours (8am to 6.30pm Monday to Friday) is fundamental to the effective operation of the NHS. Many patients who present during this ‘out of hours’ period are best dealt with in primary care and GPs play a vital role in responding to their needs. This includes both the provision of planned care (commonly known as extended services) and urgent and emergency care.

GPs bring not only generalist skills that are essential to the treatment of patients in the out of hours period but also a unique knowledge of the health needs of their patients and local populations. As such, they have an important role to play in leading efforts to enhance the quality of out of hours care, for example by ensuring continuity and enabling a more proactive approach to the management of complex patients.

At the same time, it is not realistic to expect that patients will be able to see the GP of their choice out of hours, nor that every practice will be in a position to deliver out of hours care. Instead, the focus must be on encouraging and enabling GPs to lead in the planning and provision of out of hours GP care, working in collaboration with other professionals across the whole of the health and social care system.

WHAT GENERAL PRACTICE CURRENTLY PROVIDES

In April 2004, GP practices were given the opportunity to transfer responsibility for the provision of out of hours care to Primary Care Organisations, and this is an option which the vast majority of practices have taken up. However, this does not mean that GPs no longer provide out of hours care. GPs make up a major part of the workforce that staffs the organisations contracted to provide out of hours GP services, and also work in a variety of other settings such as urgent care centres.

According to a 2014 report by the National Audit Office, in 2013-14 out of hours GP services in England handled around 5.8 million cases, 3.3 million of which were face to face consultations, including 800,000 home visits. In addition, other out of hours services in England which regularly employ GPs (such as urgent care centres, walk-in centres and minor injury units) see 7 million patients every year. This is in comparison to 14.8 million attendances at A&E each year both in and out of hours.

As well as providing urgent and emergency care, many GPs also offer planned care in the evenings or over the weekend. Analysis of data from the NHS Choices website suggests that the majority of GP surgeries in England (60%) currently provide some form of extended opening (outside 8am - 6.30pm), with 17% open over the weekend, and 53% providing extended opening hours during the week.
In England, 74% of respondents to the July 2014 GP Patient Survey said they felt it was easy to get through to their out of hours service, and 77% were happy with their GP opening hours. In Scotland, the closest equivalent figures were 71% and 78%; and in Northern Ireland, 75% and 86% (figures are not available for Wales).

The Department of Health has commissioned the Primary Care Foundation to develop a benchmarking tool of out of hours GP services in England to support quality improvement. The latest summary benchmark report found that, although there are still some unexplained differences between services, the overall performance of out of hours care is improving. In particular, access to out of hours services is good, with a definitive (final) clinical assessment taking place within 20 minutes in more than 80% of potentially urgent cases, compared to just over 60% when the previous benchmarking exercise took place. In addition, in a recent report on GP out of hours services the National Audit Office concluded that overall GP services are performing well against the standards set.

There are three main ways in which out of hours GP care can be organised and delivered:

- **Practice based provision.** Practices provide out of hours care for their patients ‘in house’ utilising their own resources. Due to the pressure it puts on GPs, this form of provision has become increasingly rare, with only around 10% of all GP practices currently ‘opted in’ to this system.

- **Collaborative models of provision.** Under this approach, groups of GPs or GP practices in a particular area come together to offer general practice services through a rota system. This may, for example, be achieved through the formation of a GP cooperative or a GP federation.

- **Outsourcing.** This involves contracting out responsibility for the provision of out of hours GP services to a separate organisation, which may be a private provider, a social enterprise, or an NHS body.

According to the April 2014 Market Analysis carried out by Urgent Health UK, social enterprises (which are generally either GP led or run) account for 56.1% of the out of hours market in England, measured by population served (up from 49% in April 2013), and GP practice providers 2.4%. Commercial services accounted for 22.6% and NHS run services accounted for 20.2%.
OUT OF HOURS GP SERVICES AND THE WIDER HEALTHCARE SYSTEM

The provision of out of hours GP services is just one part of a wider system that includes walk-in centres, urgent care centres, GP led health centres, A&E, as well as other services such as social care.

There has been much discussion of whether a lack of access to GP out of hours services is driving increased pressure on A&E departments. A recent large scale study by Imperial College London\(^4\) found that the percentage of a practice’s registered population able to see their GP within two weekdays – a measure of access to GP services – was associated with a lower rate of self-referred discharged emergency department visits per registered patient. However, this did not look specifically at the out of hours period, and it is important to note that there is much stronger evidence of a correlation between A&E attendance and both deprivation and location.

At the same time, evidence suggests that the rise in the number of patients going to A&E is not as sharp as it has been reported to be in some sections of the media. For example, much of the increase in A&E activity in England 2003-04 was due to a change in the data series to collect previously unrecorded attendances at walk-in centres and minor injury units.\(^5\) RCGP analysis shows that attendances at major A&E units (type 1) in 2003-04 in England totalled 12,665,482\(^6\), while in 2011-12 there were 14,013,922 attendances at major A&E departments.\(^7\) This equates to a 10.6% increase over the 8 year period, or on average 1.3% per year. Over the same period England’s population grew by around 6%, or 0.8% on average per year.\(^8\) This would suggest that between 2003-04 and 2011-12 attendances at major A&E units increased at only 0.5% per year above the rate of population change. In contrast, the average number of GP consultations per patient in England increased by 41% over a 13 year period, from 3.9 per patient in 1995 to 5.5 in 2008 – a rate of 2.7% per year.\(^9\) Over the same period England’s population grew by 4.5% or at a rate of 0.34% per year. Indicating that GP workload has increased at a much higher rate than A&E workload in recent years.
Much of the public debate about out of hours care has focused on the pressures on A&E. Whilst this is not to be dismissed, too little attention has been given to the fact that huge pressures are being felt across the urgent and emergency care system and are not confined to A&E. One of the drivers behind this is the rising number of frail elderly and people with multimorbidity. This means that people are more likely to need to attend A&E, more likely to be admitted, and more likely to stay for longer once admitted. For example, a survey of hospital chief executives undertaken by the HSJ in July 2013 cited an increase in the severity of illness as one of the key causes of A&E pressures.

Problems with the discharge of patients from hospital at weekends are also perceived to be a factor behind pressures across the urgent and emergency care system. The National Audit Office’s recent report on managing emergency hospital admissions notes that the number of delayed discharges to social care is decreasing, while the number to other parts of the NHS are increasing – although it cautions that there are concerns that the data reported may not accurately reflect the scale of the problem.

It is likely that levels of patient awareness of GP out of hours services are also an important factor. According to the GP Patient Survey, 44% of people in England do not know how to contact their GP out of hours service. In addition, patients may be confused by the varied nature and nomenclature of the community services on offer, whilst in contrast A&E has a high ‘brand awareness’ amongst the public. A survey undertaken by the National Audit Office found a correlation between lack of awareness of out of hours services (including NHS 111) and A&E attendance in England. In addition in 2011, the Primary Care Foundation found that the proportion of A&E cases that could be classified as ‘primary care’ was between 10 and 30%. A similar report by the College of Emergency Medicine from 2014 found that over a 24 hour period around 15% of attendees at A&E could be seen by a GP without the need for an Emergency Department assessment, with the largest sub group of these being young children.
MODELS OF GOOD OUT OF HOURS PROVISION

There is no ‘one size fits all’ model for the design and delivery of out of hours GP services. However, in deciding what approach to adopt, there are certain common principles which the College believes should be applied:

- Patients should be able to gain timely access to the skills of an expert medical generalist when they need it, including outside core surgery hours.
- Services must be developed from a patient perspective, delivering integrated whole person care to individuals interacting with different parts of the health and social care system.
- Personalisation and continuity of care are key, with systems and processes put in place to facilitate the appropriate sharing of patient information and ensure smooth and timely handover of care.
- The quality and safety of care are paramount and all service delivery models must ensure that working patterns are safe and sustainable.
- Providers and commissioners should be responsive to their local context, tailoring services to the needs and priorities of their populations.
- Out of hours services must be adequately resourced. Proposals to enhance out of hours services must not come at the detriment of the ability of general practice to provide patient access in hours.

POLICY RECOMMENDATIONS

To support GPs in providing high quality services out of hours, it is essential that the right policy levers and incentives are put in place. Set out on the next pages are four key areas in which policy change is needed.
INTEGRATED CARE

The development of an integrated approach to the provision of out of hours care is vital to ensure that patients receive care from the right health professional, at the right time and in the right place, supported by the patient information necessary to provide the best possible treatment.

A single point of access for patients requiring urgent care during the out of hours period, such as NHS 111 is intended to provide, could offer significant benefits by simplifying access for patients and encouraging them to access services in ways that are most appropriate. However, the introduction of NHS 111 has not always been adequately aligned with the way in which GP out of hours services operate, generating incompatible processes and poor patient experience. For example, in some areas of the country where NHS 111 is not directly run by the out of hours service, a double layer of phone triage has emerged, with the time to clinical assessment being measured separately by the NHS 111 and the out of hours care provider. Similarly, there are discrepancies between the time to face to face consultations set out in the National Quality Requirements for the out of hours period, and the standards set out for NHS 111.26

In addition, the limitations which exist on the ability of different providers involved in out of hours care to share patient information continues to act as a significant barrier to continuity of care. In many cases, providers of out of hours GP services still routinely have to operate without access to patient notes. According to a survey undertaken in England by the Health and Social Care Information Centre, only 37% of urgent care centres were able to transfer data electronically to local A&E departments; only 20% of A&Es were able to receive electronic data from ambulance services; and only 30% of these services reported that all local GPs were able to receive summary information electronically about patients seen in their unit.27

Policy recommendations:

- Make integration between different parts of the health service a key consideration when developing new out of hours services.
- Remove barriers that prevent providers of out of hours services from accessing patient records.
- Review national standards and specifications for out of hours GP services and NHS 111 to ensure integration.
- Ensure that responsibility for promoting awareness of out of hours services rests with one body, so that a lack of understanding of the various forms of provision available can be adequately addressed.
ENCOURAGING GP LED MODELS OF OUT OF HOURS CARE

GP practices are uniquely positioned to lead the delivery of integrated, patient centred care out of hours, given the knowledge that they have of the patients registered at the practice, and the ongoing nature of the GP patient relationship. Given this, practices wishing to develop GP led models of out of hours care provision should be encouraged to do so. At present, however, legal and financial barriers can mean that the opposite can often be the case.

In England, there are concerns that the rules on commissioning may have the effect of preventing GPs who wish to opt back into the provision of out of hours services from doing so. For example, legal advice was given in December 2013 to a group of local GPs in Hackney, London, who wished to take back the provision of out of hours services within their area. In addition, small scale, locally based providers may struggle to compete for contracts against large scale commercial enterprises with greater experience of tendering and greater scope to undercut on price.

In addition, there can also be a financial disincentive for GPs to take back direct responsibility for out of hours care. GPs who remain opted in to out of hours care provision receive an extra 5.6% of their global sum entitlement. However, this is viewed by many as being inadequate and may not reflect the full range of factors that can drive the costs of provision, for instance the degree of rurality.

Policy recommendations:

- The Department of Health should clarify the legal position of GPs seeking to opt back into the provision of out of hours care, and make legislative changes if necessary to ensure that they are able to do so without the requirement to go through a competitive tendering process.

- Government in England, Wales, Scotland and Northern Ireland should work to review the payments received by practices that are opted into responsibility for the provision of out of hours services, to ensure that this does not act as a disincentive.
WORKFORCE

The GP workforce is one of the major enablers of out of hours care. While the majority of out of hours services are fully staffed, there have been some high profile examples of out of hours services failing to recruit and retain enough GPs to provide adequate care; for example, Serco in Cornwall which was subject to a National Audit Office report due in part to concerns over the level of staffing.28

The GP workforce as a whole is already struggling to meet demand and the profile of those GPs engaged in out of hours work is ageing. Any increase in out of hours GP provision is therefore likely to require a significant increase in GP numbers over and above the current workforce.

If GPs are engaged in providing additional evening and weekend care, this will mean that they have reduced availability during weekdays, due to the need for rest breaks. This poses real practical challenges, especially for single handed practices. Although the number of these has fallen to 921 since 2002, 11.4% of practices in England still fall into this category.29 Smaller group practices (e.g. 2-4 GPs) will also face significant logistical difficulties managing with fewer GPs available during the in hours period, especially rural and remote practices that need adequate numbers of GPs on duty to provide home visit and nursing home visit cover across a large geographical area.

A 2013 Scottish Workforce survey identified that older GPs were undertaking the majority of out of hours work in Scotland, with over 45s contributing 50% of the total hours input during the out of hours period in Scotland over the survey year.30 Given this, it will be important to attract sufficient numbers of younger GPs to participate in the provision of out of hours care, although this may be challenging given the growing number of GPs balancing work and family commitments.
In addition, GPs may be discouraged from undertaking out of hours work by the high cost of medical indemnity (medical insurance purchased in advance of undertaking out of hours work). A marked increase in the cost to GPs of buying indemnity insurance has been identified by out of hours providers as a barrier to the recruitment of GP staff in a 2014 report by the National Audit Office.\textsuperscript{31}

It is also important that newly qualified GPs are equipped with the skills they need to deliver out of hours care in an urgent care environment, including to patients not registered with their own practice. The RCGP believes that the current three year training programme for GPs does not include sufficient training in the skills required to provide the high quality out of hours services needed and rightly expected by today’s more diverse and ageing population. Out of hours work (especially where it involves urgent and emergency care through a designated out of hours service) involves a key set of clinical, risk assessment and decision making skills. Urgent and emergency care in the out of hours period can involve providing care to more patients with immediate and severe conditions than are encountered in the in hours period, with reduced access to medical records, and a greater use of telephone consultations. It can also mean working in relative isolation, without the ability to liaise fully with secondary care, meaning that a GP in the out of hours period can find themselves with more responsibility to assess and manage medical risk while having access to less support and fewer resources.

There are many environments in which a GP trainee can develop competencies relevant to out of hours work. However, the current training system does not provide sufficient opportunity for the necessary training in an out of hours setting to integrate, further develop and assess these competencies in context. The current COGPEd guidelines specify that GP trainees should do at least twelve sessions of between 4 and 6 hours in an out of hours service in their final year.\textsuperscript{32} However, the interpretation of this has been left up to the local level, with many deaneries/Local Education and Training Boards, taking this to mean that GP trainees have to do a minimum of only 48 hours of out of hours training in total.\textsuperscript{33} In addition, there are persistent problems around out of hours providers supplying sufficient sessions for GP trainees to allow them to develop their professional skills.
A properly skilled out of hours GP workforce is one of the outcomes that the College’s proposal for an extended and enhanced four year GP training programme is intended to deliver. The introduction of a four year training programme for all GPs means that, for the first time, all GP trainees would receive specialist led clinical training in child health and mental health, plus enhanced training in drug and alcohol misuse, and the rehabilitation and care of older people, all of which include specific competencies needed for work in primary care services out of hours. All GP trainees would receive emergency care training during their primary care placements.

As a result of extending the training time to include a minimum of 24 months of general practice based training over the four years, GP trainees would gain a 33-50% increase in out of hours experience by working regular sessions with out of hours providers. In addition, as part of a four year training programme, GP trainees would have an opportunity to undertake innovative placements in unscheduled, urgent and out of hours care settings.

**Policy recommendations:**

- Implement four year training for all GPs as a means to produce a workforce with the correct competencies to provide good quality out of hours care.

- Improve the assessment system for GP out of hours competencies, by clarifying core competencies and enhancing elements of formative and summative assessment.

- Introduce a requirement to consider the ability of services to provide training sessions and supervision as part of the clinical commissioning process in England and according to other arrangements in the devolved nations.

- Plan to ensure that the capacity of the future GP workforce is adequate to meet future out of hours as well as in hours needs.

- Consider what appropriate financial support could be given to individual GPs where the cost of indemnity insurance has reached unsustainable levels.
Cost per case and per head of population of out of hours GP services is affected by a number of factors, including population age, levels of demand, and geography. In general, higher cost out of hours services are more likely to be rated by patients as good or very good.

Urgent Health UK’s April 2014 Market Analysis of the out of hours market records a drop in average spend per head of the population, from around £9.00 per head in 2012 to £7.98 per head. The report notes that this reflects the fact that commissioners have been squeezing suppliers hard on price and have taken money from out of hours contracts to help pay for NHS 111.

In addition, the National Audit Office has estimated that the cost of delivering out of hours GP services in 2013-14 was around £400 million. This is real terms reduction from previous years, in part due to the introduction of NHS 111, and the consequent loss of call handling related income from individual GP services.

This loss of income combined with an ongoing lack of investment in general practice services has led to many providers facing financial difficulties, which in turn can lead to a lack of faith in the ability of the service to provide safe care, thereby driving GPs away from the service. This situation may be one of the underlying causes behind recent rises in the cost of medical indemnity.

Concerns have also been expressed that in some cases contracts for out of hours services may be awarded on the basis on price over and above quality. However, this is difficult to verify, due to the extremely limited nature of the data publicly available.
Alongside the funding of out of hours services for urgent care, there is also a need for adequate resourcing for extended hours services. Currently, there is considerable variation in the level of funding available between local areas and the four nations of the UK, and additional investment is needed if general practice is to be in a position to meet national policy aspirations in this area. In 2013, the Coalition Government announced a £50 million Challenge Fund to encourage longer opening hours for GP practices in England, and the Scottish Government has announced £4 million to support the health service to test innovative approaches to providing seven day care, with a further £1.5 million specifically for rural GP practices, including provision for extended opening hours. However, whilst schemes such as these are welcome, the nature of the funding that they provide is one-off rather than recurrent.

**Policy recommendations:**

- Ensure that proposals to enhance the provision of extended hours GP services are adequately costed and funded.
- Improve transparency regarding the basis on which out of hours services are awarded, and work with commissioners to ensure that cost is not prioritised over quality.
The concept of the ‘Expert Medical Generalist’ is defined in The GP 2022: A Vision for General Practice produced by the RCGP: “As career-long professional learners, GPs will use their self-directed learning skills to undertake structured, needs-based continuing professional development programmes that will enable them to develop from proficiency towards generalist expertise. Such expertise will be manifested, for example, through an enhanced ability to structure care plans that consider both individual conditions and multimorbidity, while also supporting self-care and enabling shared decision-making alongside delivering evidence-based interventions and managing limited resources.”

Currently Clinical Commissioning Groups in England, NHS Boards in Scotland, Local Health Boards in Wales and Health and Social Services Boards in Northern Ireland.


2013/14 Scottish Health and Care Experience Survey: 71% overall positive rating for out of hours care and 78% happy with GP opening hours.

NI GP patient survey 2010/11: 75% of respondents said they felt that they had received care quickly from the out of hours service and 86% were happy with their surgery’s opening hours.

Primary Care Foundation, (2012). Benchmark of out of hours: an overview across the services. London: Primary Care Foundation.

A cooperative is a non-profit organisation which is entirely owned and staffed by GPs from within the area in which it operates. GP federations are associations of GP practices that come together with the goal of sharing responsibility for developing high quality, patient focussed services for their local communities.


REFERENCES


24 Primary Care Foundation and NHS Alliance, (2011). Breaking the mould without breaking the system. London: Primary Care Foundation and NHS Alliance.


In the case of rural areas for example, where the number of patients seen in any given session could be quite small, this might mean that the trainee satisfies the requirement to undertake a certain amount of out of hours activity but nevertheless, in that time, has little direct patient contact and is less likely to adequately develop the required competencies.

34 Primary Care Foundation, (2010). Improving out of hours care: what lessons can be learned from a national benchmark of services. London: Primary Care Foundation.

35 Primary Care Foundation, (2012). Benchmark of out of hours – an overview across the services. London: Primary Care Foundation.


