

Our new approach to the inspection of NHS GP out-of-hours services: Findings from the first comprehensive inspections

October 2014

The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England.

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

We also have a statutory duty to oversee the safe management arrangements for controlled drugs in England.

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Foreword

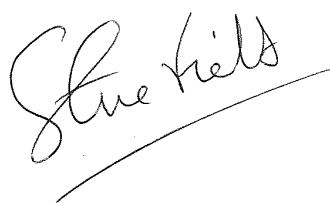
When I started my role as Chief Inspector of General Practice in September 2013, I committed to inspecting NHS GP out-of-hours services in England, which provide important services to people who need urgent access to care when their GP practice is closed. Since then, we have been developing a more comprehensive, and GP-led approach to inspecting these services. We began testing this new approach in January 2014. This report gives an overview of the findings from these first inspections.

Out-of-hours services are often considered to be higher risk than those provided during the day time by GP surgeries and there have been some notable failures in the past associated with out-of-hours care. In 2010, David Colin-Thomé and I carried out a review commissioned by the Minister of State for Health, which found an unacceptable variation in the quality of care across NHS GP out-of-hours services; so, when we started our inspections I did not have high hopes about the quality of out-of-hours care. However, as I reviewed each inspection report, I was pleased to see many examples of good and outstanding practice. We found that many of the doctors, nurses, and managers were passionate about delivering quality care and about putting patients' needs at the centre of what they do. They are also good at sharing this learning with others and we want to support this by highlighting some of their good work in this report.

We did see some problem areas, which we are following up, but overall, I am pleased with the improvements in the quality of the services we have inspected.

This report also provides some commentary and updates to the recommendations made following the 2010 review. Our recent inspections saw progress in these areas, although there is still room for improvement.

I hope, as we continue to inspect, we will see further improvements in the quality of care that patients receive at night and at weekends.

A handwritten signature in black ink that reads "Steve Field". The signature is written in a cursive style and is underlined with a single horizontal stroke.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of our findings

This report is a high-level overview of what CQC found in our first comprehensive inspections of NHS GP out-of-hours services. Between January and March 2014, we inspected 30 NHS GP out-of-hours services, run by 24 registered providers. Between them they had responsibility for the care of approximately 36% of the population in England. These services were selected as they had not been inspected by CQC under our previous approach.

Overall, we found that the majority of services were safe, effective, caring, responsive and well-led. We identified many examples of good practice, which we think should be shared so that others are able to learn from them, and some of these examples are included throughout this report.

We found that:

- Out-of-hours providers regularly monitored the quality of care they provided by auditing, putting routine monitoring systems in place and investigating incidents. The providers shared the lessons they had learned and the subsequent actions with all staff. There are some important lessons to learn from the good practice we saw, and GP services, including in-hours general practice, can learn from this.
- There were fewer locum GPs covering shifts than we expected in the services we inspected. Most of the GPs were sessional GPs from the local community. This meant people were receiving care from GPs who were familiar with the specific needs of the local population and the locally available care services.
- There were some good examples of GP out-of-hours services reaching out to the local community to raise awareness of services and to make contact with people who may have poor access to primary care. This was done using social media and working with support organisations.
- Providers had developed innovative and responsive care as a result of feedback from the local population in a number of services. For example, one service provided transport to enable patients to visit in response to feedback that a lack of transport was stopping some patients from attending appointments. Several services had systems in place to predict and manage high levels of activity, such as employing a 'clinical navigator' or 'patient flow co-ordinator' to ensure that patients were prioritised based on their condition and seen in a timely way.

However, we did find some variation in the quality and safety of care across the services and improvements are still needed.

We found that:

- Some providers did not have safe mechanisms for storing and checking the stocks of medicines they held, and for recording the use of controlled drugs.
- Some providers did not have appropriate recruitment processes in place.
- Some providers did not have adequate systems for checking and monitoring equipment, including oxygen and emergency medicines.
- Some providers did not inform patients how they could make complaints about the service.

We issued compliance actions to some services in these areas, but we found no serious concerns that required us to serve a warning or enforcement notice.

As well as outlining our general inspection findings and highlighting some examples of good practice, we have provided some commentary on how the recommendations from the 2010 review have been addressed. There has been progress in many of the areas where we made recommendations, although there is still some room for improvement.

1. Introduction

“Since our joint GP out-of-hours review in 2010, Steve Field and I have felt there is still unfinished business in how we can contribute to delivering a high-quality, high-value system of out-of-hours care. I readily accepted Steve’s invitation to be the independent GP chair of CQC’s review of NHS GP out-of-hours services, as I believe that CQC’s role goes beyond merely searching for poor care. We have been impressed by the good quality of most of the GP out-of-hours providers visited so far. As in all healthcare services, high quality is not uniform, and we have identified good and sometimes not so good performance. But one of the successful elements of CQC’s fresh approach to inspections has been the enhanced visiting teams, comprising experienced inspectors and specialist clinical and managerial advisers.”

Professor David Colin-Thomé

Former National Director for Primary Care, Department of Health

Independent GP chair of CQC’s review of NHS GP out-of-hours providers

CQC began registering providers of NHS GP out-of-hours services in 2012. Before this, there had been a number of high-profile failures in both the arrangements for how care was commissioned and how it was delivered to patients. Most notably, this involved the now disbanded GP out-of-hours provider, Take Care Now, and the actions of one of its locum doctors, Dr Ubani, in 2008. The case led to the review, commissioned by the Minister of State for Health, into out-of-hours providers in 2010, led by Professor Steve Field and Professor David Colin Thomé.

This report highlights where our inspections and other agencies found improvements based on those specific recommendations. We describe where we found good practice among the 30 services we have inspected so far, and where we have identified areas that need to improve.

These inspections were the first to use our new approach for this type of service, and we have evaluated how this has worked. We have used the learning from this to feed into our developing approach to inspecting and regulating GP out-of-hours services and GP practices. The new approach will be fully implemented in October 2014.

The history of NHS GP out-of-hours providers

GP out-of-hours services are primary medical services for patients with urgent needs that cannot wait until their GP practice is open again.

The out-of-hours period covers:

- Monday to Thursday, 6.30pm to 8am the following day.
- Weekends, starting at 6.30pm Friday through to 8am the following Monday.
- Good Friday, Christmas Day and other bank holidays.

GP out-of hours care changed substantially when a new General Medical Services (GMS) contract, introduced in April 2004, allowed GPs to opt out of responsibility for providing out-of-hours care to their patients, transferring responsibility to their local primary care trust (PCT). Some GPs chose to still be involved in out-of-hours care, these GPs are referred to as 'opted in'. Figures from the Primary Care Foundation showed that, in 2012, around 10% of GP practices were still responsible for organising their own out-of-hours services for patients. The GPs working in other out-of-hours services are usually sessional GPs from local GP practices (about 40% work for their local GP out-of-hours services), dedicated out-of-hours GPs and locum doctors.

In 2012, out-of-hours services changed again with the gradual introduction of the NHS 111 service, which now handles incoming calls from patients in all parts of the country. The impact of NHS 111 has been varied, but overall the number of cases being handled by NHS GP out-of-hours services has fallen, as NHS 111 now provides the telephone 'front end' of most out-of-hours GP services.¹ Some NHS GP out-of-hours services provide the NHS 111 service for their area and in other areas it is provided by different organisations.

The results of the annual GP patient survey² in July 2014 have shown that overall, patients are positive about their experience of GP out-of-hours care. Of the patient respondents sampled, 66% reported that their experience was 'fairly good' or 'very good.' However, it is worth noting that this had dropped from 70% in the previous year (June 2013).

NHS GP out-of-hours services are generally perceived to be inherently higher risk than daytime general practice for the following reasons:

- Out-of-hours providers deal with unfamiliar patients, and staff do not always have access to the patient's medical history or their medical records.
- Cases are often more complex than those found in daytime general practice, with a higher proportion of vulnerable patients with urgent care needs, including patients receiving palliative care.

¹ July 2014, National Audit Office: Out of hours GP services in England (www.nao.org.uk/report/hours-gp-services-england-2/).

² Source: GP patient survey – the sample size for GP out-of-hours services for July 2014 was 119,343 patients, for June 2013, this was 124,317 patients.

- The initial assessment is completed on the phone.
- Care is short and episodic, which does not lend itself to clinicians building a relationship with patients.
- Out-of-hours providers have a comparatively large workforce. The staff may not work regularly for the organisation so may not know each other well, and may also often be working in unfamiliar surroundings.

There have been a number of high-profile failures in out-of-hours care, including the tragic death of David Gray in 2008. In this case, treatment was provided by a German locum doctor, Dr Ubani, who was flown in to provide cover for an NHS out-of-hours GP provider, Take Care Now (TCN). The direct cause of death was the injection of 100mg of diamorphine, which the coroner deemed to be gross negligence manslaughter. The coroner acknowledged that mitigating factors (tiredness, lack of familiarity with local services, and less than adequate induction) contributed to Dr Ubani's poor judgement of treatment. CQC subsequently investigated TCN and we found that there were clear failings:

- TCN failed to act on a safety alert from the National Patient Safety Agency (NPSA) in May 2006, relating to risks associated with higher doses of morphine and diamorphine. There were two incidents involving overdoses of diamorphine in 2007. Both doses were administered by doctors flying in from Germany to work shifts in the out-of-hours service. Neither case was reported as a serious untoward incident or investigated in depth.
- There was a clear warning from a TCN doctor, which was documented in governance meeting minutes from 2008. He stated, "There is a systematic problem...if we do not address this, it is only a matter of time before a patient is killed by an overdose of morphine from one of our palliative care boxes."
- TCN did not make changes to the way diamorphine was used and stored until after David Gray's death in 2008.
- Five PCTs commissioned out-of-hours services from TCN. The PCTs did not sufficiently monitor or manage the performance of these services. TCN failed to provide accurate and robust performance information to the PCTs. There was no clear process in place to manage the local medical performers list, and there was no system to share concerns about a clinician from one area to another.

The death of David Gray led to the then Minister of State for Health, Mike O'Brien, asking Professor David Colin-Thomé and Professor Steve Field to lead a ministerial review into NHS GP out-of-hours care in October 2009, which was then published in January 2010. In 2009, Professor Steve Field was the Chairman of the Royal College of General Practitioners and Professor David Colin Thomé was the National Director for Primary Care at the Department of Health. The review concluded that the quality of GP out-of-hours services varied unacceptably³ and it made a number of recommendations to improve the quality of out-of-hours care.

3

http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_111892

We have not been able to gather evidence from our inspections to follow up on every recommendation made, because our role is to inspect **providers** and we have not looked in detail at the role of commissioners. Where we did not have enough evidence from our inspections to follow up a recommendation, we worked with the Department of Health, NHS England and the General Medical Council (GMC). We provide an update on the 2010 recommendations in [section 4](#) of this report. Full details of the recommendations are listed in the table in the [appendix](#).

The National Audit Office (NAO) has also recently published an important report on NHS GP out-of-hours services, which aimed to find out whether services are providing value for money. The NAO's report examined the performance of out-of-hours GP services, the oversight and assurance arrangements, and how out-of-hours GP services are integrated with other urgent care. The NAO's findings have provided a helpful update on the some of the recommendations made in 2010.

2. Our new approach to inspecting GP practices and GP out-of-hours services

How we inspect

The focus of our new inspection approach across all the services we regulate is on the quality and safety of services, based on the things that matter to people. This enables us to get to the heart of patients' experiences of care. There is more information on our new approach to inspecting primary care services on our website: www.cqc.org.uk/content/doctorsgps.

Our inspection teams set out to answer five key questions about the quality and safety of care:

- **Is it safe?** By safe, we mean that people are protected from abuse and avoidable harm.
- **Is it effective?** By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
- **Is it caring?** By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
- **Is it responsive?** By responsive, we mean that services are organised so that they meet people's needs.
- **Is it well-led?** By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

For GP out-of-hours services, our inspection teams use evidence from a variety of sources to answer these five key questions:

- Information from CQC's ongoing relationship with the GP out-of-hours service.
- Our analysis of data from a range of sources.
- Information we gather before the inspection, including information from:
 - People who use services.
 - Other stakeholders, such as clinical commissioning groups (CCGs) and NHS England Area Teams.
 - GP practices, as well as out-of-hours providers themselves.
- The inspection visit.

As part of our first inspections we sent letters to registered providers and commissioners asking for specific information about the services. To gather the views of people who use the service we held a series of public listening events and also asked the provider to display CQC comments cards to enable people to give us their comments about a service in writing.

Our new, more comprehensive approach includes ongoing Intelligent Monitoring of the risks that individual providers are not providing either safe or high quality care. We used our new inspection approach for GP out-of-hours services before we used it to inspect GP practices. At the time of the inspections, we were still developing our approach to Intelligent Monitoring for GP practices and GP out-of-hours services with expert stakeholders. This is why we did not use Intelligent Monitoring as part of this first wave.

Our inspection teams usually include a CQC lead inspector, a GP, practice manager or practice nurse and an Expert by Experience. Experts by Experience are people who have experience of using or caring for somebody who uses a type of service.

In developing our new approach to regulation and inspection, we consulted with a range of stakeholders and developed an expert NHS GP out-of-hours services reference group with key stakeholders. All inspection reports were discussed at a National Quality Panel, chaired by Professor Steve Field, to check for quality and consistency.

The services we inspected

We inspected 30 NHS GP out-of-hours services, which were run by 24 registered providers. These services serve a combined population of around 19 million people, this is 36% of England's population. Our inspections included larger commercial providers and a range of not-for-profit social enterprise organisations, as well as several GP co-operatives who had come together to deliver GP out-of-hours services to their local population.

These GP out-of-hours services were chosen for inspection as they had never been inspected before. We have previously inspected all other GP out-of-hours services in England under our old methodology.

Of the services we inspected, the population reach for the providers ranged from 88,000 to 1.5 million. The providers operated in inner city urban areas as well as very rural areas with low-density populations, covering vast geographical areas. There was a wide range in the levels of deprivation and ethnic diversity.

3. Key findings

Our inspection teams found many examples of very good care that providers and their staff should be proud of. We found the majority of services were safe, effective, caring, responsive to patients' needs and well-led. We did not find any examples of very poor care that required us to take enforcement action, although we did have some concerns, which resulted in issuing compliance actions to the providers. These were in areas of medicines management, recruitment and supporting workers. Our inspectors are following up these concerns. We have not been able to include all the examples of good care in this overview report, but we encourage you to read our inspection reports on our website if you would like to see more. The following findings are set out under the five key questions that we ask.

Safe

We found that most of the services we inspected were safe. We found some great examples of significant event analysis in most services. This was such a strong area in these services, and we feel that all GP services, including in-hours services, can learn from this.

However, there were some problems in a minority of services, relating to medicines management and staff recruitment. Where we identified concerns we used our regulatory powers to make sure the provider addressed them.

Recruitment and staffing

The majority of providers that we inspected had robust and rigorous recruitment procedures in place. The policies explicitly detailed the checks that needed to be made, including pre-employment background checks to make sure the people they employed had the appropriate qualifications, skills and knowledge. We also saw evidence of good induction processes for GPs and other staff.

We found low usage of locum GPs in the services we visited. Most used GPs who worked in local GP practices. This meant that patients would be seen by experienced GPs who were familiar with local health and social care services if they needed to refer patients promptly to other services. Where locums were used, appropriate safety checks were in place, such as using a preferred agency where locums were subject to the same recruitment interviews and checks as a permanent employee.

We used our regulatory powers and issued six services with compliance actions because they either did not have sufficient recruitment procedures in place or they were not being followed. For example, some of these services did not have evidence that appropriate Disclosure and Barring Services (DBS) checks were carried out.

There was also a lack of clarity from some providers around whether GPs working for out-of-hours services had the appropriate indemnity cover and whether this was sufficient for the number of hours they were working in the out-of-hours service.

Good practice example

BrisDoc Healthcare Services Limited

There was a clear recruitment and selection policy, which the provider kept under regular review to ensure it covered all of the standards set out in the NHS Employers safer recruitment guidelines. A standard operating procedure was created in November 2013 to recruit local sessional doctors to fill the clinical rota. This ensured that the recruitment processes were consistent, streamlined, quick and unambiguous. Recruiting sessional doctors from the local area meant that the appointed GPs understood the make-up of the population and its needs. It provided assurance that clinicians working for the GP out-of-hours service were suitably qualified and that all employment checks had been completed and were up to date.

Learning and improving

We found that there were good risk management systems in place. There was a commitment to learn from incidents. The majority of the services we visited had an open and transparent culture for reporting, recording, learning and sharing learning from these incidents. We saw services carrying out numerous significant events analysis and clinical audit cycles. The staff we interviewed were aware of these processes and could describe incident reporting and learning mechanisms for the service.

Good practice example

Cambridgeshire Doctors On Call Limited

The provider held a weekly complaints and incident management meeting. This was a sub-committee of the quality and patient safety committee. Any incidents or adverse events were reported to the board through this committee. The provider had experienced a serious adverse event in the previous year, involving a patient ending their own life. We saw that a thorough and rigorous internal investigation had been carried out. This had identified some key learning points, which were shared with staff appropriately. We also saw evidence that less serious significant adverse events were fully recorded before being investigated by the provider's medical director.

We saw that action and learning plans were shared with all relevant staff after the investigations were complete. The provider used a 'serious incident update' form to notify the local CCG of individual events. We saw a completed form for a recent event involving a consent issue. The form had been comprehensively filled in with details of the incident, an analysis of events leading up to it and the actions taken by the provider after the event. The local CCG monitored the provider's performance monthly in relation to the standard and timeliness of significant adverse event reporting. The CCG was satisfied with both measures in the last two quarters we looked at.

Medicines management

For medicines management, we mostly found good practice but we also found some areas that required improvement to ensure patients were protected from the risks associated with the unsafe use and management of medicines. In those providers, we found variations in the quality of the mechanisms for storing medicines, checking the stocks of medicines held and how the use of controlled drugs was recorded.

We saw that some services had robust mechanisms for handling medicines, backed up by a cycle of regular audits. Where issues were identified, lessons were learned and acted upon in a timely manner. Most of the providers who responded to our pre-inspection information request told us that their CCG monitored their prescribing patterns and carried out unannounced visits. Some also told us that, as part of their contract with the CCG, they have to regularly audit prescribing patterns. Our inspectors saw examples of prescribing audits and actions taken to address issues and improve practice. We found issues with medicines management in seven of the services we inspected, and we issued compliance actions to them. The services have action plans in place to address these concerns and we will be following up on their progress. There were inconsistencies in the way different services handled medicines. This was mainly due to a lack of clarity around the processes for checking stocks of medicines and ill-defined roles and responsibilities, which meant that checks were not happening consistently and not always recorded. Therefore, the services could not be assured of stock levels for medicines.

Some services were not following their own protocol on handling controlled drugs. For example, one service's standard operating procedure stated that the controlled drugs register must be completed by a doctor and countersigned by the duty manager when drugs are removed. However, since the controlled drugs register was first opened on 6 August 2013, there had never been two signatures when a controlled drug had been removed, nor did it include information relating to which patient the medicines had been administered to. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. It is therefore important to handle controlled drugs appropriately.

Good practice example

Cambridgeshire Doctors On Call Limited

One of the provider's directors was responsible for the medicines management for the service. There were up-to-date medicines management policies and staff we spoke with were familiar with them. Medicines in the primary care centre in the Chesterton Medical Centre were kept in a secure store that only clinical and pharmacy staff had access to. Medicines and equipment bags were ready for doctors to take on home visits. The bags were sealed with security tags so that it was clear if they had been opened and needed to be checked. We saw evidence that the bags were regularly checked to ensure that the contents were intact and in date.

We looked at how controlled drugs were managed. The records showed that the controlled drugs were stored, recorded and checked safely. When on home visits, doctors stored controlled drugs in a purpose-built safe fitted into the provider's own vehicles. Clear records were kept whenever any medicines were used. The records were checked by pharmacy staff who re-ordered supplies as required.

There was a monthly medicines management meeting, which was a sub-committee of the quality and patient safety committee. Any medicine-related issues were reported to the board through this committee. Any changes to the drugs that doctors carried were discussed at the medicines management meeting. These were communicated to clinical staff electronically and by attaching a note to drug boxes. There were standard operating procedures (SOPs) for using certain drugs and equipment. We looked at a SOP for the use of intravenous drugs. The SOP was in date and was clearly marked to ensure that staff knew it was the current version. Staff we spoke with were clear about the processes around medicines management.

Equipment and infection control

In the majority of services, clinical staff had access to the equipment they needed. As part of our inspection we also looked at the equipment carried in the vehicles that GPs used when visiting patients and we had no concerns with the equipment on board. In several services we saw that some GPs on home visits were using paper-based copies of the British National Formulary (BNF). The electronic version is more up-to-date and we have encouraged providers to consider enabling GPs to have electronic access when on home visits.

In a small number of the services we visited, we found inadequate systems for checking and monitoring equipment. Equipment such as oxygen and emergency medicines should be checked routinely to make sure they are in good working order and not out of date.

The standard of cleanliness was generally high. However, in some services it was not clear what actions had been taken following infection control audits.

Safeguarding

Most of the services we inspected had ensured that all clinical staff were trained in safeguarding children and adults.

There were policies in place for safeguarding children and vulnerable adults from the risk of abuse. Staff we spoke with demonstrated a good understanding of safeguarding patients from abuse and knew what they should do if they suspected anyone was at risk of harm. Information was available to support staff in recognising and reporting safeguarding concerns to the appropriate authorities for investigation. There were appropriate safeguarding leads for the services and staff were able to tell us who the lead was. This meant staff had access to information and support to enable them to act appropriately if they believed a patient may be at risk of harm.

Effective

Clinical audit

The vast majority of services we inspected had clinical audit systems in place. We saw many completed clinical audit cycles. We found that improvements had been made to services as a result of a wide range of quality assurance activities, including clinical audits. Quality assurance and audits took place at all levels within the services we inspected, from monitoring the performance of health support workers to clinical directors sampling 5% of care records. We felt that the GP out-of-hours services we inspected as a whole have been particularly strong in this area. All GP services, including in-hours, can learn from the many good examples we have seen in this area.

Good practice example

Cambridgeshire Doctors On Call Limited

The provider's audit committee oversaw the auditing and monitoring of the service. The committee had designed a cyclical programme of audits for the whole year. Areas to be audited included consultations, patient records, hand washing, information governance and medicines management. The human resources team also conducted audits of staff absence, staff turnover and appraisals. The results of audits were shared with all staff through a regular clinical bulletin.

We looked at the results of a recent audit of the appropriateness of home visits. Cambridgeshire Doctors on Call had identified that the number of home visits that it made was higher than average for out-of-hours providers and that they were increasing. The audit looked at the reasons why this might be. The feedback to doctors was to think carefully before agreeing to a home visit, but that ultimately doctors needed to make decisions using their own clinical judgement. We also saw the results of audits of consultation times and the

effective use of previous case histories, and how these were shared with all staff. We were told that the provider had not so far completed any full audit cycles from which they could demonstrate continuous service improvement. We saw evidence that the provider's audit committee was addressing this issue. The provider made effective use of the Royal College of General Practitioners clinical audit tool to assess the performance of its doctors. Newly recruited doctors were subjected to a higher rate of audit until the medical director was satisfied with their performance. All audit results were considered in detail by the patient safety and quality committee before being presented to the full board on a monthly basis.

Patient information

The majority of services we saw had appropriate systems to share and receive patient information. Most had systems that could send consultation information to a patient's GP by 8am the next day. We only had concerns with one provider who did not have sufficient systems in place to share patient information; we issued them with a compliance action.

There were some good examples of information sharing, such as services being able to access the same GP records through the same system and special patient notes (SPN) that flagged up vulnerable patients. However, to ensure a service that addresses the needs of the most vulnerable people, all services need to make sure that there are SPNs in place for patients with more complex ongoing needs and flag up patients that need end of life care.

Good practice example

SELDOC

SELDOC kept up-to-date electronic information in its system for patients from the GP practices it covered in the area who had long-term conditions, complex needs and those needing end of life care. This enabled the service to identify and quickly respond to these patients when needed. All calls from these patients or their carers are prioritised and they receive a call back from a duty doctor to assess their needs within 20 minutes. When required, a doctor will provide a home visit within two hours. The service also had close links with mental health teams who could provide additional specialist support as well as the emergency duty social work teams based at the same location.

Information relating to vulnerable patients is stored electronically and is automatically highlighted if the person calls the service. The medical director told us that they did occasionally receive calls from hospital pathology teams when blood tests were grossly abnormal and we were shown an example where it was necessary for SELDOC to respond and clinically assess the patient's medical condition.

Appropriate information was shared with all relevant care providers in a timely way.

Clinical triage

We saw effective clinical triage in place in all but one of the services we inspected. The staff who answered the phones were competent and trained in recognising patients that need urgent care. Receptionists were trained to assess the urgency of a patient's needs in a waiting room and escalate this to the appropriate clinicians. People using the services received a call back from a GP, and were seen by a GP when required, in a timely way. We saw one clinical triage system that was less effective because a separate organisation was providing the NHS 111 service. In this instance, there had been issues with the local NHS 111 where they had failed to correctly triage patients' symptoms and, in some cases, failed to pass on the correct information to the out-of-hours service. These events were well documented by the service. We spoke with staff and saw that the service had carried out appropriate investigations and taken action where necessary to prevent it happening again.

Good practice example

Partnership of East London Co-operatives Limited

GPs had clearly designated roles so that they were either triaging patients on the phone, seeing patients face-to-face (base doctors) or visiting patients at their home (visiting doctors). Base doctors were supported by reception staff, and visiting doctors had drivers. Base and visiting doctors also triaged telephone calls to assess and prioritise the order of the treatment of people when not seeing patients.

Caring

During our inspections, we received a good level of feedback from patients about the quality of their out-of-hours services. This included several hundred comments cards. Our Experts by Experience also spoke with people waiting to see clinicians. The feedback was mostly positive.

A common theme was that the staff, particularly the doctors, were very supportive. Patients told us that they thought the care they had received was good and they felt safe. For example, the parents of a young child told us the doctor was very understanding of their worries. We found this many times. People told us that staff were kind and caring, and that information was provided in a way they could understand. They felt that the GPs working for the out-of-hours service took time to listen to them and talk to them about their healthcare needs.

Most of the providers we inspected had policies in place about chaperoning and ensuring patients' dignity. Those we spoke with were aware of respecting patients' personal, cultural and religious needs.

Responsive

We saw some very positive examples of services being planned around the needs of the local population. We also saw evidence of staff engaging with the local community. There were translation services available in all the services we visited. We saw that some services closely monitored patient flow; they had systems in place to predict and manage high levels of activity. Patient flow data was also shared with CCGs on a regular basis.

We saw evidence of good rostering systems to forecast and schedule staffing levels. These were used by staff to indicate their availability and enabled managers to plan accordingly. However, we also saw a few services where staffing levels were not planned or managed well. This meant that the service would be unable to respond appropriately to an increase in demand.

Several of the services we inspected employed a 'clinical navigator' or 'patient flow coordinator'. Staff in these roles were responsible for ensuring that patients were seen in the mostly timely and effective way. They were often healthcare assistants who had received extra training to be able to recognise and prioritise the urgency of a patient's symptoms. In busy periods, the patient flow coordinator would also highlight the need for reserve staff to be brought in.

Many people who need out-of-hours services cannot readily get to a service as they may have mobility issues or feel vulnerable due to their condition. NHS GP out-of-hours services cover a larger area than GP practices so it is likely that the GP out-of-hours service will be further away and, as a result, less accessible than their usual GP practice. It may also be late at night, which will mean that public transport is less readily available. We saw many services respond to this and offer transport services or make home visits for certain patient groups, such as older people and people with long-term conditions.

Good practice example

NEMS Community Benefit Services Limited

NEMS Community Benefit Services Limited (NEMS) had an effective patient transport system that enabled patients who did not have access to private or public transport to attend a treatment centre for consultation. This enabled the provider to respond to the needs of patients from population groups that may otherwise have difficulty in accessing the service. We also learned from a patient (confirmed by staff) that on those occasions when the transport system was unavailable due to high demand, NEMS commissioned and paid for taxis for patients.

Responding to the needs of the community

We were very pleased to see many examples of close working relationships with local care services, which provided joined-up care for patients. Several of the providers we inspected

operated a 'professionals' telephone line. This enabled local healthcare professionals, such as nurses from local nursing homes, to seek medical advice without first having to call the out-of-hours service.

We saw services integrating into the local community and attending community events with minority groups to raise awareness for GP out-of-hours services.

Good practice example

GoToDoc

We saw that GoToDoc had attended community events to communicate with minority groups such as Eastern European and Somalian groups. They had also worked with faith groups and held workshops to raise awareness of the service.

GoToDoc also works closely with local healthwatch and voluntary providers to obtain public feedback and share information about the service. We saw that they had actively contributed to the Manchester homeless strategy and used social media to promote access and awareness to the service.

Several providers showed us how they worked alongside other health and social care services, such as district nurses, palliative care nurses, mental health crisis teams and the voluntary sector. This showed that the out-of-hours GP services were an integrated part of the local health economy.

Good practice example

M-Doc

The service covered two nearby military bases. The staff had identified the possibility of an increased demand from patients with mental health needs once military personnel returned from active service overseas. The doctors' handbook included a section on liaising with the military health service when treating these patients.

Information about patients receiving palliative care was shared between the patient's GP, M-Doc and a local coordination service run by the Sue Ryder charity. This ensured that doctors working for the service had all the information they needed to treat and support people receiving end-of-life care. M-Doc kept a separate supply of drugs intended for use with patients receiving palliative care. A safety chart was kept with the palliative care drugs to enable doctors to check the compatibility of patients' syringe drivers with the different drugs available.

Well-led

We found evidence of close working relationships between the services we inspected and local commissioners. There were regular meetings to discuss planning of the service. We also saw evidence of comprehensive forward planning, based on information that providers had gathered from monitoring their service and the needs of the local population.

Most of the services we visited had a thorough system for dealing with complaints in a timely way. The services carried out formal reviews of complaints, and there were procedures in place to prevent, respond to, and learn from complaints. Staff knew how to support patients to make a complaint or to raise a concern with managers. We saw evidence of complaints and concerns that had been followed up in the previous 12 months. We were told that concerns were treated seriously and were followed up by the appropriate person.

A number of services had very clear visions and values, which were made clear to staff at all levels. Staff told us that there was a culture of openness that encouraged the sharing of information. The services had a 'blame free culture' policy and a 'being open' policy. These policies were readily available to all staff.

However, we also saw services where many policies were in place but were not put into practice. Staff we spoke with were not aware of the policies. For example, one provider had an in-depth complaints policy but patients were not always made aware of it. We visited two primary care centres that had no information for patients about how to make a complaint.

Good practice example

BrisDoc Healthcare Services Limited

Clinical governance meetings took place each week to review cases and provide feedback and advice to individual clinicians. This process used a clinical governance performance and support management tool.

Each clinician had been colour-coded and rated in terms of their knowledge, skill and proven performance. Each score equated to the level of scrutiny overview. For example, new staff were rated as purple, which meant that the clinical governance team would review 100% of the people they had seen. Those rated as yellow, who were deemed to require less monitoring, would have 10% of their patient consultations reviewed. Alongside this the provider had an electronic clinical toolkit on their intranet, which clinicians could access for specific advice on areas such as prescribing, end of life care and mental health care. This showed that the provider took reasonable steps to ensure the safety of people at all times.

Training

Most of the services we visited had good training and support for staff, including nurses, GP trainees and GPs. The staff we spoke to told us they felt supported. Where good induction processes were in place, as a minimum, doctors newly recruited to the services had a comprehensive induction as well as face-to-face induction sessions with the service manager and medical director. They were also able to work several shifts alongside a more experienced out-of-hours doctor before working shifts on their own.

Several of the providers we inspected had close relationships with the local GP education deanery. This showed that the providers emphasised and supported continuous learning.

We saw five services where the induction process could be improved and we issued compliance actions to four of them because of insufficient systems to support staff.

In these services, an induction information pack was available for new staff but there were no formal induction programmes. Some new staff did not have formal performance reviews, which meant the service did not know the requirements needed for training new staff. Supervision meetings were also not taking place. This meant that there were no assurance mechanisms in place to assure the abilities of the new staff member, beyond initial recruitment. The lack of a formal induction also meant that, in some cases, staff were unfamiliar with the layout of the service and where drugs and equipment were kept, resulting in delays for patients.

Good practice example

Cambridgeshire Doctors On Call Limited

We saw a comprehensive training matrix for all staff employed in the organisation. It was colour coded to enable managers to see at a glance when staff training was due. The provider was required to meet training requirements identified using a training needs analysis agreed with the local CCG. Compliance with the training requirements was discussed at a monthly meeting with the CCG. At the most recent monthly meeting, the provider agreed to additional indicators to give the CCG a better overview of training requirements in the service.

The training matrix and the reporting from this ensured that both the service and the CCG were able to maintain an up-to-date view of training requirements, enabling them to adapt and make changes in a timely way.

Patient feedback

In most of the services we visited there were mechanisms in place to actively seek and follow up patients' feedback. We have seen services proactively gathering feedback from patient surveys, and groups of people who use services. We saw evidence that patient feedback, learning and actions taken were discussed routinely at leadership meetings; and for most services, patient feedback contributed to learning and improvement in the service. A small number of services did not have any processes for patients to be able to provide feedback; this meant that the service was not listening to its local population

Staff appraisal

We found a mixed picture when looking at staff appraisals. Some services had systems in place; we saw annual performance appraisals and GPs receiving reviews of their work, with regular training reviews. In others, some staff did not have records of appraisals that had taken place and there was a lack of a formal system for ongoing appraisals.

Training systems were in place in most of the services we visited, to ensure that GPs and nurses kept up to date with professional training. A number of services ran continuing professional development (CPD) programmes.

Good practice example

Urgent Care Centre Queen Mary's Hospital

The nurses and doctors told us they had their consultations audited shortly after they started work at the service and then every six months. This audit looked at how staff had recorded the reason for visits, history, diagnosis, management, prescribing, use of IT system and safety netting (advice for patients of what to do if symptoms get worse). These audits were then followed up at a performance management group and any action points fed back to staff where additional support was offered. Common themes were fed back to all staff using a 'bullet point' document as well as being used during routine appraisals. We saw that issues had included not recording or giving full safety netting advice.

4. Ministerial review into NHS GP out-of-hours services: progress on recommendations since 2010

In 2008, David Gray died after a locum out-of-hours GP, working for the provider Take Care Now, gave him an excessive dose of diamorphine. Following this, in October 2009 the then Minister of State for Health, Mike O'Brien, asked Professor David Colin-Thomé and Professor Steve Field to lead a ministerial review into NHS GP out-of-hours care. The report of the review '[General Practice Out-of-Hours Services: Project to consider and assess current arrangements](#)' was published in January 2010 and concluded that the quality of GP out-of-hours services varied unacceptably. That report made a number of recommendations to improve the quality of out-of-hours care. This report provides an update on where improvements and progress have been made since then.

Some of the evidence from our early inspections, described in the previous section, has informed our update on the progress against the recommendations from the ministerial review. But at CQC our role is to only inspect providers of services, so we have not looked in detail at the role of commissioners. Where our inspections have not found sufficient evidence to report back on the recommendations, we have asked for statements and evidence from other organisations responsible for taking forward the recommendations in the report to Ministers in 2010.

The National Audit Office (NAO) recently published an important report on NHS GP out-of-hours services, which aimed to find out whether they are providing value for money. The NAO report focuses on contract arrangements with clinical commissioning groups (CCGs) and performance management of the services. The NAO's findings have provided a helpful update on some of the recommendations made in 2010.

The ministerial review divided the recommendations into the following themes:

- Commissioning and performance management of GP out-of-hours providers
- Selection, induction, training and use of out-of-hours clinicians
- Management and operation of performers lists.

We have structured this report in line with those themes and we have also included a specific section on changes to the English language test, as we felt that this is an area that needed extra attention.

The appendix of this report contains a summary of progress against all the recommendations made in 2010.

Commissioning and performance management of GP out-of-hours providers

The 2010 ministerial review highlighted concerns about how GP out-of-hours services are commissioned and how their quality is checked. It concluded that commissioners were not always aware when the services were not providing adequate or safe care. The review made several recommendations to improve this.

Since the ministerial review, there have been changes to the NHS. These changes disbanded the primary care trusts (PCTs) and strategic health authorities (SHAs) and created NHS England, NHS England Area Teams and clinical commissioning groups (CCGs) in their place. Where the 2010 recommendations made reference to strategic health authorities, these responsibilities have now been passed to NHS England.

NHS England has delegated commissioning of out-of-hours services to CCGs, who commission for their own geographical area. The exception is for those GPs who opted in to maintain contractual responsibility for providing out-of-hours services.

Those GPs who opted in are able to either provide GP out-of-hours care directly to their patients or to sub-contract to other bodies. NHS England commissions these services (known as 'opted-in services') directly through the General Medical Services (GMS) contracts that it holds with GPs. Where the opted in service has been subcontracted, NHS England is still responsible for quality assuring these services. The recent report from the National Audit Office (NAO) found that NHS England has no information on how many opted-in services have sub-contracted their out-of-hours services, and to whom. NHS England told us it is taking steps to address this and strengthen processes for assuring the quality of opted-in services.

From April 2014, all GP practices that have opted out of providing out-of-hours services are required, through their GMS contract, to monitor the quality of the local out-of-hours services offered to their registered patients and report any concerns to their CCG. NHS England issued guidance to CCGs in March 2014, which outlined the expectations on CCGs in relation to this responsibility. These include:

- Involving local GP practices in monitoring the quality of out-of-hours services.
- Monitoring against the national quality requirements.
- Producing an annual return confirming that the CCG has appropriate arrangements in place to assure the quality of out-of-hours services.
- Reporting on significant issues or concerns.

Our inspections did not look in detail into the commissioning and performance arrangements within CCGs because our remit is to inspect the providers of out-of-hours services at the location. However, the NAO report has evidence to enable us to report on progress in response to the recommendations about commissioning and performance management arrangements.

The NAO found that the large majority of CCGs manage their contracts for out-of-hours GP services actively, including monitoring compliance with national quality requirements. The majority receive performance information from providers at least monthly, and use this information, as well as patient feedback, to challenge providers.

The NAO did find some room for improvement in the way some CCGs manage their contracts. There were instances where contract managers could not explain some aspects of the performance information and some CCGs, in their response to NAO's survey, did not provide data on compliance against some national quality requirements. They found that CCGs could be doing more to encourage providers to perform well. There was also wide variation in the level of information that CCGs received.

During our inspections and through speaking with CCGs, we have seen some evidence that locally-developed indicators for quality management have been used in regular discussions between services and the CCG to help assure the quality of out-of-hours care and identify resourcing issues.

In 2007, the Department of Health appointed the Primary Care Foundation, following a tendering process, to produce comparisons of performance across out-of-hours services in England. The work built on the established national quality requirements, measuring outcomes in addition to process. A set of benchmarks for out-of-hours services were developed in order to make accurate comparisons across different services so that providers and commissioners could better recognise poor care and take action to improve it.

The Primary Care Foundation is in the process of extending these benchmarks to cover the wider urgent care sector. Through its ongoing contact with commissioners and providers, the Primary Care Foundation has seen that the benchmarks for out-of-hours services have been carefully used to review systems and processes to minimise the chance of errors such as those of the Take Care Now case of 2008 being repeated.

"We feel that the service provided out of hours is far more responsive and better governed than in the past". Primary Care Foundation

However, the Primary Care Foundation feels that commissioners need to remain alert. Following the changes in responsibility associated with the move from PCTs to CCGs, many of those now involved in commissioning services were not involved in the detailed review of GP out-of-hours services and systems. New providers (some based on federations of GPs) are looking to take on responsibility for urgent care services, and such organisations need the same rigour in recruitment, systems, training and governance as the long-standing providers of out-of-hours care.

Selection, induction, training and use of out-of-hours clinicians

Care delivered in a GP out-of-hours service is very different to care delivered in a GP practice during normal working hours. The staff working for an out-of-hours service may not know the patients and they often have no access to their medical records. Their initial contact with, and assessment of, these patients is invariably on the telephone. They may work in an unfamiliar location and with colleagues who they have never worked with before. In addition, they may deal with a higher proportion of patients who are considered to be particularly vulnerable, for example, young people, older people, and those with chronic or terminal conditions.

The ministerial review therefore highlighted the importance of having staff that are selected, inducted and trained using rigorous and effective procedures. Failures in staff selection, induction and training have featured in many of the examples of poor out-of-hours care.

Checking how staff are recruited, how they are inducted and how they are trained is a key part of our new inspection approach. As this report on our findings from our early inspections demonstrates, most of the services we inspected had processes in place for recruitment and induction, but a few did not.

Because of the key differences in GP out-of-hours services compared with GP in-hours practices, the ministerial review recommended that all GP trainees should have extensive, bespoke out-of-hours training, and that providers should work with LETBs to achieve this. In response to this, in March 2010 the Committee of General Practice Education Directors (COGPED) published its [position paper](#)⁴ giving guidance on how GP trainees should be trained in out-of-hours working. Also, in September 2011, the Royal College of General Practitioners (RCGP) published a [review of out-of-hours training](#)⁵. CQC contacted RCGP and COGPED to comment on the progress made against this recommendation.

The RCGP issued a statement to CQC for this report on the effectiveness of the guidance from COGPED. It confirmed that the guidance was a useful resource to implement GP out-of-hours training in the UK, but suggested that the guidelines should be more targeted to make sure that there was consistency in the level of training a GP trainee would receive. COGPED guidelines state:

“GP trainees should do at least 12 sessions of between four and six hours in an out-of-hours service in their final year. However, many LETBs, have implemented this by requiring GP trainees to do a minimum of only 48 hours of out-of-hours training in total whilst others ask their trainees to do 72 hours. In a rural setting with a sparse population, 48 hours of OOH care may not provide an adequate number of face-to-face patient contacts to allow a GP trainee to gain the required competencies.”

⁴[http://www.cogped.org.uk/document_store/1286375694vGnm_out_of_hours_position_paper_\(revised_2010\).doc](http://www.cogped.org.uk/document_store/1286375694vGnm_out_of_hours_position_paper_(revised_2010).doc)

⁵<http://www.rcgp.org.uk/gp-training-and-exams/mrcgp-workplace-based-assessment-wpba/cpr-aed-and-out-of-hours-requirements.aspx>.

The RCGP feels that out-of-hours providers are not supplying sufficient sessions for GP trainees to allow them to develop their professional skills, and that the training provided in each out-of-hours service varies in both quantity and quality.

GP directors have recently agreed that this guidance will be revised during summer 2014. COGPED, in discussions with LETBs, has suggested that the guidance is well taken up and in active use. There is an active deanery out-of-hours leads (DOOHLs) group, which works collaboratively to monitor standards across services and advise COGPED on policy. The extent of implementation in each area has varied. We have also heard that in some areas the number of patients attending out-of-hours services has reduced and there are often insufficient numbers of patients attending these services to provide appropriate experience for GP trainees.

COGPED is confident that the quality of training, and perhaps the quality of the services as a consequence, have improved since the ministerial review. COGPED and the RCGP work closely together to ensure that GPs who complete their training programme are competent to provide out-of-hours services. Both organisations will continue to develop and monitor the quality of training for GP out-of-hours services.

Below is a case study from Croydon CCG where a redesign of services has seen a significant reduction in GP out-of-hours usage. However, this has resulted in difficulties for GP trainees in terms of gaining out-of-hours training.

Case study from Croydon CCG

NHS Croydon's urgent care strategy aims to ensure that patients are seen at the right time, in the right place, by the right professional and at the right cost. As part of this strategy, in March 2012, NHS Croydon CCG carried out a major re-design of its urgent and emergency care services.

In this re-design, the GP out-of-hours contract was changed to an NHS contract for urgent care, with one provider running the GP out-of-hours service and the urgent care centre, both of which were located at the front of the A&E department at Croydon University Hospital.

At the same time, NHS 111 was commissioned to be the front end of the GP out-of-hours service. This meant that when patients called the GP out-of-hours service they were assessed by NHS 111's trained health advisers using NHS Pathways and booked directly into the out-of-hours service for either GP telephone advice, an appointment at the centre, or a home visit, depending on the outcome of the assessment.

This service re-design has reduced visits to the GP out-of-hours service by nearly 50% and while the number of patients seen in the emergency department (ED) has remained constant, the number of patients seen in the urgent care centre has steadily declined by about 8-11% since the changes. The savings to the CCG have been significant due to a combination of fewer contacts with GP out-of-hours, urgent and emergency care services, and the fact that 40% of adults and 60% of children are now being seen in the

urgent care centre by a multidisciplinary workforce at a lower urgent care tariff. This is in keeping with the CCG's urgent care strategy and the changes have therefore proved to be a commissioning success.

However, the reduction in the number of contacts with the GP out-of-hours service and the lower number of calls for GP telephone advice caused by the success of NHS 111 has meant that the previously successful GP out-of-hours training scheme has had to be reviewed and re-designed to ensure that GP trainees have sufficient exposure and experience to enable them to attain the out-of-hours competencies.

Management and operation of performers lists

At the time of the ministerial review, the Performers List Regulations stated that all GPs must be included in a list held by a primary care trust (PCT) before they could practise as a GP. This was to protect patients from unsuitable or inefficient practitioners, and to enable PCTs to intervene at an early stage if there were any concerns. However, there were no systems in place to enable any concerns to be communicated between PCTs nationally. In the Take Care Now case, the locum, Dr Ubani, was denied entry onto the local performers list in Leeds. He then successfully applied in Cornwall, and, on the basis of this, was able to work in Cambridgeshire. In addition, Dr Ubani did not work as a GP in Germany but registered as a GP in Germany, enabling him to work in the UK as an EU worker, thereby obviating the need for GMC assessment.

The changes that have taken place since then should safeguard against this happening again. The NHS (Performers Lists) (England) Regulations 2013 have given NHS England the responsibility for holding and maintaining the England performers lists for primary medical, dental and ophthalmic performers. This means that NHS England has the power to manage performance for these professions and protect the public from any GP who is not suitable or falls below the required standards. NHS England has created a website to enable anyone to check that a GP is on the NHS performers list: <https://www.performer.england.nhs.uk/>.

If a performer is refused admission to the list, the NHS England Area Team must inform a range of people, including the NHS Litigation Authority (NHSLA).

At the moment NHS England's Area Teams cannot see information held by another Area Team about the potential unsuitability of a GP. But this is being addressed and will be rectified later in the year. In addition, NHS England Area Teams have access to a directory of performers that details any conditions on inclusion.

Changes to the English language test

The ministerial review expressed concern about the competency in the English language of doctors from outside the UK. There was confusion among PCTs about whether the General Medical Council (GMC) could conduct language tests for doctors from the European Union, which meant they were uncertain of when they could check the English language skills of applicants to their medical performers lists, and how this should be handled. Where PCTs did make checks of language knowledge, they took different approaches. The review recommended that, as a minimum, all doctors should be able to: converse with patients or their helpers; read and understand the British National Formulary (BNF); talk to pharmacists and other healthcare professionals; and arrange admissions to hospitals.

There was also some confusion over whether doctors could be added to a performers list if they needed to improve their knowledge of English. More guidance was needed. The review concluded that the approaches taken by different PCTs were too varied.

At the time of the review, doctors from the European Economic Area (EEA) were able to practise irrespective of their language abilities. Even where there were concerns, under EEA law, the GMC was unable to conduct language tests.

This has now been addressed. From June 2014, if the GMC has concerns about a doctor's ability to communicate effectively with their patients they must provide evidence of their English skills or undergo a language assessment. The score for International English Language Testing System (IELTS) test for doctors from overseas who want to practise in the UK has also been increased, from 7 to 7.5 out of 9.

Niall Dickson, Chief Executive of the General Medical Council has provided the following statement on this issue:

“The new system, which allows us to check when we have a doubt, is an important milestone in creating better, safer care for patients. Everyone has a right to expect to be treated by a doctor who can communicate effectively in English and this new system will help us achieve this. It is also important that everyone understands this does not in any way absolve those who employ doctors of their responsibilities – they must carry out thorough checks before taking a doctor on, and that includes making sure that the doctor is qualified and competent to carry out the duties they are being given.”

The table in the appendix of this report provides a detailed overview of progress against each of the recommendations made in the 2010 report.

5. Next steps

The results of our learning from this first wave of inspections will feed into our overall model of regulation. We will continue to test and evaluate our overall approach to inspecting out-of-hours care until the end of September 2014. During this time we will also analyse the feedback we received from the consultation on our provider handbook for NHS GP practices and GP out-of-hours services. We will use what the public and our stakeholders have told us, alongside our evaluation of the inspections carried out so far using the new approach, to refine our key lines of enquiry, descriptors of what 'good' looks like and our overall model.

In October 2014 we will publish a handbook for GP out-of-hours services and roll out our inspection methodology for GP practices, including GP out-of-hours services. We will also start to award ratings to GP out-of-hours services.

We will integrate these inspections alongside our inspections of GP practices into our six-monthly cycles of visits to CCG areas across England.

NHS 111 services were introduced in 2012 and are gradually handling all incoming calls from patients in England. The findings of our inspections of NHS GP out-of-hours services show that joined-up working between different services has a direct impact on whether patients experience timely, safe, appropriate and effective care. GP out-of-hours providers need to work with NHS 111 to ensure systems are in place to make sure that acutely ill patients in need of urgent primary care do not receive it significantly slower than they would have done with the old model of care.

Over the coming months we will be building on our inspections of NHS GP out-of hours inspections and developing and testing an approach to inspection of NHS 111 and urgent care services in a more joined-up way. We will signal our priorities for our overall approach to urgent care later in 2014.

We have also started to consider how urgent care is provided in local health economies. We will consider how we can look at how GP practices, GP out-of-hours services, urgent care centres, walk-in centres, NHS 111 and A&E departments work together to provide care for patients in need.

Appendix: Update on progress in response to the recommendations of the 2010 review

The following table lists the recommendations made as part of the 2010 ministerial review and provides an update on progress made against each recommendation published in the report *General practice out-of-hours services; project to consider and assess current arrangements*. Since 2010, there have been changes to the NHS. These changes included disbanding primary care trusts (PCTs) and strategic health authorities (SHAs) and creating NHS England, NHS England Area Teams and clinical commissioning groups (CCGs) in their place. Where the 2010 recommendations made reference to strategic health authorities, these responsibilities have now passed to NHS England. NHS England has delegated commissioning of out-of-hours services to CCGs, who commission for their own geographical area. The exception is for those GPs who opted in to maintain contractual responsibility for providing out-of-hours services.

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 1</p> <p>Commissioners should review the performance management arrangements in place for their out-of-hours services and ensure they are robust and fit for purpose. In particular, commissioners should involve local GPs in the process.</p>	<p>NHS England has delegated the responsibility for GP out-of-hours services to CCGs. However, responsibility of those GP practices that have opted to retain responsibility for their GP out-of-hours services (also referred to as being 'opted-in') remains with NHS England.</p> <p>Our inspections did not look in detail into the commissioning and performance arrangements within CCGs because our remit is to inspect the providers of out-of-hours services at the location. Our evidence for this recommendation draws heavily on the recent NAO report.</p> <p>The NAO found that the large majority of CCGs manage their contracts for out-of-hours GP services actively, including monitoring compliance with national quality requirements. Evidence from the NAO review indicates that CCGs have adequate resources to manage their contracts with out-of-hours providers. The review also identified evidence of CCGs assessing the 'riskiness' of services and meeting frequently with providers. CCGs received regular monitoring reports from the services about their performance against the national quality requirements⁶.</p> <p>The NAO's report says that the majority of CCGs receive performance information from providers at least monthly, and they use this information, as well as patient feedback, to challenge providers; but there is still room for improvement. The full report from NAO <i>Out of hours GP services in England</i> can be found here: www.nao.org.uk/report/hours-gp-services-england-2/#</p>	<p>Partially implemented</p> <p>This recommendation has been implemented by the large majority of CCGs that commission GP out-of-hours services and there are some examples of good practice. However, more work needs to be done to make sure that all CCGs are routinely reviewing the performance of out-of-hours services. In addition, NHS England needs to retain an overview of the quality of those GP practices that have opted to retain responsibility for their GP out-of-hours services.</p>

⁶ The Department of Health has set standards – national quality requirements – for all GP out-of-hours services to meet. The 13 requirements are designed to ensure that patients receive the same levels of high-quality and responsive care across the country

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p>NHS England issued guidance to CCGs in March 2014, which outlined the expectations on CCGs in relation to this responsibility. These include:</p> <ul style="list-style-type: none"> • Involving local GP practices in monitoring the quality of out-of-hours services. • Monitoring against the national quality requirements. • Producing an annual return confirming that the CCG has appropriate arrangements in place to assure the quality of out-of-hours services. • Reporting on significant issues or concerns. <p>This guidance can be found here: http://www.england.nhs.uk/wp-content/uploads/2014/03/pri-med-care-ccg-14.pdf</p> <p>In addition, from April 2014, all GP practices that have opted out of providing of out-of-hours services are required, through their contract, to monitor the quality of the local out-of-hours services offered to their registered patients and report any concerns to their CCG. Where the GP practice has opted to retain responsibility for providing out-of-hours services, the responsibility for monitoring quality falls to the local NHS England Area Team. The NAO interviewed some members of the Area Teams during its review and found no evidence that they were monitoring performance, for example against the national quality requirements, or challenging GPs where necessary. The seven local Area Teams interviewed were undertaking very little assurance work on out-of-hours services, and some appeared unaware of who provided the services in their area. This included one Area Team where all the GP practices remained opted-in and, as a result, the NAO commented that there was little assurance that GPs who opted in to retain responsibility for out-of-hours care are providing an acceptable service.</p>	

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p>NHS England informed its local Area Teams of the need to seek assurance about out-of-hours GP services in March 2013. However, it did not give guidance about how to gain such assurance until a year later in March 2014. NHS England has told us that it is strengthening its arrangements for the assurance of 'opted-in' services.</p>	
<p>Recommendation 2</p> <p>Commissioners should supplement the core national quality requirements with a suite of locally developed quality indicators (including requirements to monitor clinical outcomes trends, patient reported outcomes and more intensive patient and stakeholder feedback)</p>	<p>We identified that some CCGs had developed additional indicators to the national quality requirements.</p> <p>For example, one out-of-hours provider has to provide: patient feedback data, serious untoward incident and significant events data, and information about complaints. Another reported that the commissioner has recently made it a requirement for the provider to submit a monthly report detailing the delivery of operational hours.</p> <p>The NAO review identified that the level of information that CCGs receive varies. Some received information on all the national quality requirements, while others on only a subset; some received data that allowed them to compare current performance with previous months and years; some had access to supplementary information about contractual key performance indicators; and over 90% received regular details of serious incidents and complaints and the action taken to address them.</p> <p>Guidance issued by NHS England in March 2014, which describes CCGs' responsibilities in relation to commissioning out-of-hours services, only refers to ensuring that any contractor engaged in the provision of out-of-hours services meets the national quality requirements and not any additional indicators, as recommended by the ministerial review.</p>	<p>Partially implemented</p> <p>Not all CCGs have done this. More work needs to be done to ensure that the quality of GP out-of-hours services is routinely monitored by the commissioners.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 3</p> <p>In line with national quality requirement 5, commissioners and providers should review the current arrangements in place for receiving patient experience reports. They should also ensure that they are regularly sourcing feedback from other stakeholders such as local GPs, A&E departments and ambulance services, etc.</p>	<p>Evidence from CQC inspections demonstrated that out-of-hours providers regularly seek the views of patients. We also identified that CCGs request information about patient experience as well.</p> <p>Below are some of the examples we found.</p> <ul style="list-style-type: none"> • One provider routinely contacted 5% of patients each month to gain feedback on the service they or their family had received. • One provider carried out customer satisfaction surveys by calling a random sample of 50 people back over a six-day period. The methodology set out to assess patient satisfaction with the telephone advice service, waiting times, staff courtesy, understanding language and information, and ease of access to the service. They also assessed the outcome of the advice given over the phone and used this to identify any improvements that might be made to the service. Results showed that a large majority of people surveyed were very happy with the service they received. • A patient satisfaction summary from one provider for a three-month period from August to October 2013 detailed trends in the patient responses, the lessons learned and the action taken. Results were reviewed and discussed at quarterly meetings and were highlighted at quality management forum meetings. <p>The NAO found “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”.</p>	<p>Partially implemented</p> <p>Some CCGs and providers gather information about patient experience and local stakeholders. However, more needs to be done to build on this, particularly by those GP practices that have opted to retain responsibility for their GP out-of-hours services and NHS England as their commissioner.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p>In addition, the NAO also found that “NHS England was also not using data from the GP Patient Survey to identify services where patients were particularly satisfied or dissatisfied”.</p>	
<p>Recommendation 4</p> <p>Commissioners should support out-of-hours providers to become a valued and integral part of the local health economy, ensuring that they have a place on any local urgent care boards or networks. This includes ensuring the provider is able to develop integrated pathways with other parts of the system.</p>	<p>In 2013, NHS England directed CCGs and other local health bodies to create urgent care working groups to 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. (In 2014, NHS England has introduced Systems Resilient Groups to replace Urgent care Boards. SRGs have a wider remit than urgent care). Local commissioners and providers we interviewed were positive about the impact of these working groups, which, they told us, were encouraging collaboration and innovation.</p> <p>Evidence from the NAO review and the most recent GP patient survey indicates mixed awareness among the public about their out-of-hours service. The NAO identified some examples of campaigns to raise awareness of out-of-hours and other urgent care services. There are many examples from CQC inspections of out-of-hours providers having close relationships with local care providers offering joined up care for patients. This included close working relationships with mental health teams, social services, the local Healthwatch, dementia crisis and voluntary providers.</p> <p>Below are some of the good practice examples we found.</p> <ul style="list-style-type: none"> • One provider participated in a scheme known as ‘Right care’ for patients with long-term conditions and complex healthcare needs to ensure they received seamless patient care. All ‘Right care’ patients 	<p>Partially implemented</p> <p>We have found some examples of joined up urgent care, for example in Croydon (see p29). But more work needs to be done to develop further integrated urgent care in local areas.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p>have a care plan completed by their 'in-hours' GP, which can be accessed with the patients consent via the computer. This means NHS 111, the out-of-hours provider and the A&E department can see this care plan. These patients have their own special telephone number to access the out-of-hours service. Since the introduction of this service there has been a reduction in ambulance call outs and hospital admissions for these patients.</p> <ul style="list-style-type: none"> • One inspection found that an out-of-hours provider had good links with the local rapid response mental health team to provide support for patients with mental health needs out of normal hours. It was also possible for healthcare professionals to refer patients to the out-of-hours service without going through the NHS 111 service. The service also had an arrangement with the local hospital's paediatric department to ensure that out-of-hours doctors were aware of patients already under the care of the hospital's paediatric team. 	
<p>Recommendation 5</p> <p>Commissioners and providers should benchmark services to ensure the validity of their performance data. Benchmarking will enable PCTs [NHS England] to consider whether the resources allocated to the service are sufficient to ensure delivery of productive and high-quality services.</p>	<p>In 2009, the Department of Health put out for tender the contract for benchmarking GP out-of-hours services and selected the tender from the Primary Care Foundation. The most recent benchmarking took place in April 2012. This was voluntary and not all providers took part, with two thirds of commissioning PCTs in England participating. The Primary Care Foundation has told the NAO that it intends to collect up-to-date data from CCGs in 2014. The Primary Care Foundation has provided the following statement about progress against this recommendation:</p> <p><i>"The benchmark that we run (being extended to a wider urgent care benchmark) and our contact with commissioners and providers</i></p>	<p>Partially implemented</p> <p>We have seen examples of providers benchmarking their services, for example those signed up with the Primary Care Foundation and those organisations that are part of Urgent Health UK. However this has not been done by all providers and commissioners.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p><i>means that we saw how these were carefully used to review systems and processes to minimise the chance of errors identified in the review of Take Care Now in 2010 being repeated. We feel that out-of-hours services are far more responsive and better governed than before the change in contractual arrangements in 2004, and the recent inspection reports from the CQC on out-of-hours providers support this confidence.</i></p> <p><i>But commissioners need to remain alert. With the changes in responsibility associated with the move from PCTs to CCGs many of those now involved in commissioning such services were not involved in these reviews, and new providers (some based on federations of GPs) are looking to take on responsibility for urgent care services. Such organisations need the same rigour in recruitment, systems, training and governance as the long-standing providers of out of hours care."</i></p> <p>Our inspections saw examples of where providers have participated in benchmarking exercises. NHS England has stated that with effect from 1 April 2014, CCGs must participate in a scheme for the benchmarking of performance against the national quality requirements. CCGs must publish benchmarked data on provider performance annually.</p>	

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 6</p> <p>The Primary Care Foundation should continue to work with participating PCTs [NHS England], providers and the Department of Health to ensure that the recommendations of their recent benchmark review are implemented, whilst taking into account the findings of this, and the forthcoming CQC report.</p>	<p>The Primary Care Foundation has now completed four cycles of the national out-of-hours benchmark. In the most recent round, everyone, whether a commissioner, provider or service user, has been able to see how services are performing on a wide range of headline indicators. This has allowed services to make helpful comparisons and learn from each other, driving up the quality of care across the country.</p> <p>The Primary Care Foundation has provided the following recommendation:</p> <p><i>“We recommend that, particularly those that are new to this area of care, should be sure to learn from our benchmark that objectively compares the service received by patients but also to read the detail from the investigations into the deaths of both Penny Campbell and David Gray. Such reports provide a stark reminder of the importance of remaining alert.”</i></p>	<p>Partially implemented</p> <p>We support the continuing work of the Primary Care Foundation to benchmark services. Providers and their commissioners need to ensure that they understand their performance and how it compares to others.</p>
<p>Recommendation 7</p> <p>Strategic health authorities (SHAs) [NHS England] should monitor action taken by PCTs in response to this report and in carrying out appropriate performance management of out-of-hours providers. SHAs should monitor performance management of services</p>	<p>Following the disbanding of SHAs, NHS England took on the responsibilities of SHAs.</p> <p>NHS England published guidance for CCGs in March 2014, which outlined the expectations on CCGs in relation to this responsibility. CCGs are required to report to NHS England on all functions that NHS England has delegated to them. This includes commissioning of out-of-hours care. Details of this are provided in the guidance from NHS England: http://www.england.nhs.uk/wp-content/uploads/2014/03/pri-med-care-ccg-14.pdf</p>	<p>Partially implemented</p> <p>Evidence from the NAO report suggests more work needs to be done to improve the performance management of GP out-of-hours services.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p>The NAO report states:</p> <p><i>“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”</i></p>	
<p>Recommendation 8</p> <p>The Department of Health should strongly consider the development and introduction of an improvement programme for PCTs to support their commissioning and performance management of out-of-hours services.</p>	<p>In 2010, following the ministerial review, Sir David Nicholson, the former Chief Executive of NHS England wrote to PCTs asking them to read the ministerial review report and implement the recommendations.</p> <p>NHS England has delegated commissioning of out-of-hours services to CCGs for their area, except for those GPs who have maintained contractual responsibility for providing out-of-hours services. In March 2014, NHS England issued guidance to CCGs (that was tested with Area Teams and CCGs before publication), which included guidance about quality requirements and reporting. It included guidance about using patient survey results from GPs to monitor the reporting arrangements and performance of out-of-hours providers. NHS England told us there will be an additional opportunity to ‘triangulate’ information arising from the new contractual requirement for GPs to monitor the quality of out-of-hours services.</p>	<p>Not implemented</p> <p>Changes to commissioning arrangements have impacted on this recommendation being implemented. Consideration should be made to the development of an improvement programme to support the commissioning and performance of out-of-hours care to ensure consistency and improvement in the quality of GP out-of-hours services across England.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 9</p> <p>PCTs [NHS England] and providers should continue to work with postgraduate deaneries to ensure the provision of a comprehensive, consistent and well-structured training programme for GP Registrars⁷, which complies with COGPED guidance, and with the DH letter of 17 December 2009.</p>	<p>NHS England and Health Education England (HEE) issued a joint letter to CCGs and Area Teams outlining expectations about out-of-hours training opportunities in April 2014. http://www.england.nhs.uk/wp-content/uploads/2014/04/Out-of-Hours-Training-for-GP-Registrars.pdf</p> <p>We found evidence from our inspections that some providers have been working closely with LETBs⁸ of HEE to support training of GP trainees. Health Education East of England⁹ told CQC that it holds annual meetings between the GP school, the out-of-hours training providers and the commissioners for development. This is attended by one or two senior representatives from every out-of-hours service provider and commissioner. Health Education East of England also told us the local GP trainer groups are encouraged to invite the out-of-hours providers to share best practice and concerns annually to enhance the out-of-hours training for the GP trainees.</p> <p>The Committee of General Practice Education Directors (COGPED)¹⁰ recommends that GP trainees complete 72 hours, or 12 sessions, of out-of-hours work in their final year of GP training. Health Education England has a role in coordinating this training to make sure the recommendations are rolled out nationally.</p> <p>COGPED provided us with the following statement about GP out-of-hours training:</p>	<p>Partially implemented</p> <p>HEE should work closely with the RCGP to ensure an appropriate curriculum is implemented across England.</p>

⁷ GP Registrars are now known as GP Trainees.

⁸ Local Education and Training Boards (LETBs) are responsible for the training and education of NHS staff, both clinical and non-clinical, within their area.

⁹ Health Education England provides national leadership and coordination for the education and training within the health and public health workforce within England.

¹⁰ COGPED offers a forum for Postgraduate GP Directors to meet and share good practice. Its aim is to encourage and maintain a consistent approach to GP training across the UK.

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p><i>“Unscheduled care in the context of GP provision of out of hours care is an important part of the GP curriculum and out-of-hours placements are a rich learning environment. GP specialty trainees learning in out-of-hours settings present an opportunity for GP out-of-hours providers to develop and recruit their future workforce. It is in providers’ interest therefore to work with LETBs who undertake a governance role in terms of placement approval and clinical supervision for training. LETBs have used this role to advise on the quality of OOH provision and the quantity of training available. Although there are organisational difficulties for OOH providers to ensure adequate experience is provided for GP specialty trainees, current evidence suggests that this is occurring, with few reports of trainees not being able to find sufficient available OOH sessions to fulfil their training.</i></p> <p><i>Challenges include ensuring that training is included in OOH contracts at all stages; the current COGPED guidance is to be refreshed later this year.”</i></p> <p>We were told about some instances where the re-design of urgent care services has led to a reduction of call volume to the GP out-of-hours service by nearly 50%, but that this has also led to an insufficient number of patients attending these services to provide appropriate experience for GP trainees (see case study on page 29).</p>	

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 10</p> <p>The Royal College of General Practitioners (RCGP) should review the guidance concerning GP Trainees' training in out-of-hours and should update this as necessary. This work should involve engagement with the necessary stakeholders, including COGPED.</p>	<p>The RCGP provided the following comment to demonstrate progress against this recommendation:</p> <p><i>“The RCGP considers the COGPED guidance to have been a useful resource for the implementation of GP out-of-hours training in the UK. However, the RCGP has some concerns that the existing guidelines are too vague and, as interpretation of these guidelines has been left up to the local level, in practice there is wide variation in the level of practical experience each GP trainee will receive in an out-of-hours setting. We have concerns that the assessment process for GP trainees working in the out-of-hours period has not been formally codified as part of the COGPED guidelines. Finally, there are persistent problems around out-of-hours providers supplying sufficient sessions for GP trainees to allow them to develop their professional skills, with the training provided in each out-of-hours service varying in both quantity and quality. Therefore, the RCGP believes that the impact of the COGPED guidelines could be further strengthened by including standards around the requirement for LETBs to quality manage the provision of training by out-of-hours service providers, including the training and accreditation of their out-of-hours clinical supervisors.”</i></p>	<p>Partially implemented</p> <p>HEE should work closely with RCGP to ensure an appropriate curriculum is implemented across England.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 11</p> <p>Out-of-hours providers should consider the recruitment and selection processes in place for clinical staff to ensure they are robust and that they are following best practice in this area. This includes evidence of a detailed knowledge and skills outline for staff that sets out the generic qualifications and appropriate experience, skills (including telephone assessment) and knowledge required to work in the out-of-hours service, and should be applied to all locums as well as staff who regularly work for the provider.</p>	<p>Evidence from CQC inspections identifies that providers have robust recruitment and induction processes in place, although some are better than others. We had some concerns about the recruitment processes of a few out-of-hours providers in relation to staff records, but on the whole we were fairly satisfied.</p> <p>We found the following good practice examples during our inspections:</p> <ul style="list-style-type: none"> • One provider only recruited GPs from the practices covered by the out-of-hours service. All GPs were thoroughly checked to ensure their fitness to practise, including GMC registration, inclusion on the performers list, and suitable and verifiable references. GPs were also required to undertake competency testing before starting work, which included having satisfactory English language skills. • A GP at one provider told us that the recruitment process was very thorough and included clinical scenarios, which they had to successfully complete. 	<p>Implemented</p> <p>We found that the vast majority of services had a robust recruitment process in place. Those that still need to improve their recruitment processes should learn from the good practice we found in our inspections.</p>
<p>Recommendation 12</p> <p>Out-of-hours providers should consider the contents of their induction process to ensure that it is comprehensive and is completed before any staff work a first shift for the service.</p>	<p>Our inspections found many robust induction programmes for both clinical and non-clinical staff. We saw five services where we felt the induction processes could be improved. For example, one provider did not provide induction training for all its staff before they started to work for the service to ensure they were familiar with systems and processes. Another provider did not always appropriately complete and document induction processes for all staff.</p>	<p>Implemented</p> <p>The majority of the services we inspected had robust induction programmes. All GP out-of-hours services need to learn from the good practice we found in our inspections.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p>We found the following good practice examples during our inspections:</p> <ul style="list-style-type: none"> • A provider used comprehensive induction and initial training packs that were tailored for each role in the organisation. New clinical staff were mentored at first by a more experienced colleague, and they needed to be signed off as competent by the medical director before being able to see patients alone. Upon successful completion of the induction and initial training programme, staff were issued with a certificate of competency that was kept on their personal file. All staff that completed the induction programme were asked to complete an evaluation form to provide feedback about their experience. • A provider had an online learning system that all staff, including clinicians, used for induction training. Clinicians were able to access BMJ learning and were required to complete specific modules within a month of starting employment. All staff were also supported by regular supervision sessions, observation of practice and appraisal. All of these measures helped to ensure that staff were safe and competent in carrying out their specific roles. 	

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 13 PCTs [NHS England] should review whether recruitment, induction and mentoring requirements for the out-of-hours provider are set out adequately in their contract with the provider, and satisfy themselves that these are passed through to any sub-contractor or agency that the provider engages.</p>	<p>Our inspections saw no evidence to indicate that contracts reflect these requirements. However, our findings about providers' recruitment and induction requirements are described on page 28 of this report on. Our inspections provided evidence of robust induction programmes for both clinical and non-clinical staff. Urgent Health UK has seen better governance of recruitment of clinicians, with more effective controls on qualification, indemnity, training and performance management. Not surprisingly, this has had unintended consequences, with some patients apparently using the out-of-hours services in preference to their own GP practice. Recruitment of clinicians, a problem that occurred from the start, remains a significant issue that takes substantial resources to manage, especially when contract values are often shrinking.</p>	<p>Not implemented</p> <p>We have found no evidence that this is included in contracts. Despite this, we have seen many examples of providers implementing their own systems for this purpose.</p>
<p>Recommendation 14 Providers should co-operate with other local and regional providers (both in and out-of-hours) to share any concerns over staff working excessive hours for their respective services. PCTs [NHS England] and providers alike should also encourage clinical staff to share information about their working arrangements with all organisations that they work for, and providers should ideally put this requirement in their clinicians' contracts.</p>	<p>Some providers informed CQC that as part of contract monitoring arrangements they have to submit information about staff levels. CQC inspectors spoke with a number of staff who were all positive about their providers and did not report any concerns. Staff also told CQC they knew how to whistleblow and felt confident they could raise concerns with the provider.</p> <p>NHS England have told us they do not routinely review each APMS contract, this is a matter for CCGs. With regard to GP practices that have opted in, the GMS contract regulations 2004 and GMS contract amendment regulations 2014, do not make reference to monitoring staff working excessive hours.</p>	<p>Not implemented</p> <p>We have seen no evidence that this is monitored. More work needs to be done in this area. This will become increasingly important as the number of GPs available in some areas may be decreasing. This means that some local GPs may be working excessive hours. Providers and commissioners need to be aware of the extent to which this is happening, to ensure the safety of patients and the wellbeing of staff. We will continue looking at this as part of our future CQC inspections of GP out-of-hours services.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 15</p> <p>Out-of-hours providers should consider the adequacy of their clinical governance arrangements (including those for clinical audit) and should consider undertaking trend analysis of clinical performance for common and/or high-impact conditions as part of these audits.</p>	<p>Evidence from CQC inspections shows that providers have good clinical audit processes in place.</p> <p>We found the following good practice examples during our inspections:</p> <ul style="list-style-type: none"> • A provider carried out quarterly clinical audits of consultations. The audits reviewed the quality of triage calls, telephone consultations and face-to-face consultations at primary care centres and on home visits. Information from these clinical audits was actively used to drive up standards of care. We saw that there was a rolling programme of audits covering areas such as medicines management, clinical conditions and referral patterns. GPs told us that participation in these audits helped support their appraisals and re-validation. The provider was also a member of Urgent Health UK (UHUK) and participated in regular benchmarking audits with other out-of-hours providers. The UHUK gave the service positive overall assurance in March 2014 following audits in areas such as patient surveys and complaints. The audit findings did not highlight any major concerns. Participation in regular audits demonstrated the provider's commitment to continually improve its service. • A provider used an independent auditing body to carry out regular auditing. The provider was measured against a range of national and internal standards. The results of the audits and actions taken were reported in the quarterly reports to the board. 	<p>Implemented</p> <p>We have found some good examples of this during our inspections.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 16</p> <p>PCTs [NHS England] should regularly check that all the locum and sessional staff on their Medical Performers List have appropriate access to appraisal and continuing professional development (CPD).</p>	<p>NHS England is responsible for managing entry to the medical performers lists. This work is managed by the Area Teams of NHS England. NHS England has published a standard operating procedure for Area Teams to process applications to join the medical performers list. This can be found here: http://www.england.nhs.uk/wp-content/uploads/2014/08/sop-med-perf.pdf</p> <p>The GMC has stated in relation to checks locum and sessional staff:</p> <p><i>“The responsibility for supporting doctors in primary care through appraisal and revalidation rests with the Area Teams in NHS England. This responsibility extends to all doctors who are on the national GP performers list, regardless where they undertake their practice. The requirements the GMC has set for revalidation apply to all doctors, irrespective of where they work, and include consideration of the whole of a doctor’s practice and their CPD, at every appraisal, every year. The GMC has revised its guidance on appraisal and revalidation to remind all doctors and their responsible officers that a doctor’s whole practice, including locum work, needs to be reviewed in every appraisal.”</i></p>	<p>Implemented</p> <p>This is being addressed through the introduction of revalidation for all doctors in England. An annual appraisal is undertaken for all GPs by appraisers appointed by NHS England Area Teams. The GP appraisers are responsible to the designated responsible officer in the NHS England Area Team.</p>
<p>Recommendation 17</p> <p>Out-of-hours providers should consider the benefit of signing agreements with locum agencies for preferred provider status to ensure consistency in the quality of any locums required.</p>	<p>In our inspections, we saw that a number of GP out-of-hours providers did not use locum doctors. Instead they appeared to mostly use GPs working in local practices. This meant that patients would be seen by experienced GPs who were familiar with the local health and social care services if they needed to refer patients promptly to other services.</p> <p>Where locums were used, we saw evidence that they were from a reputable agency and that they went through the same employment checks as permanent employees.</p>	<p>Implemented</p> <p>We found evidence of this during our inspections</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 18</p> <p>The Department of Health and CQC should ensure that when registration of out-of-hours providers is introduced in 2012, that the requirement for organisations to source workers who are fit to practise should include those workers sourced by the provider from a locum agency.</p>	<p>CQC registration requirements involve checking that all staff, including locums, are fit to practise. In addition, our new approach to regulating GP practices and GP out-of-hours services includes routine checks on effective HR practices during our inspections. This includes making sure that the provider has robust recruitment checks and extensive and effective inductions.</p>	<p>Implemented</p> <p>This is reflected in our new approach to inspecting GP practices and GP out-of-hours services.</p>
<p>Recommendation 19</p> <p>The Department of Health should work closely with the GMC to consider to what extent PCTs [NHS England] could rely on the checks of identity and medical qualifications under the GMC's registration procedures. DH should consider streamlining the requirements in the Regulations for the checking of such documentation by PCTs.</p>	<p>NHS England gave us the following statement in regards to identity and medical qualifications checks in relation to the medical performers' list,</p> <p>“The DH considered the extent to which PCTs could rely on checks on identity and medical qualifications undertaken elsewhere when it was developing the Performers List Regulations 2013. It considered that the purpose of the medical register and the performers list is different. The performers list checks are more aligned with those undertaken by an employer than a regulator i.e. look more closely at fitness for purpose rather than fitness to practise. Consequently it decided no change was necessary to the Regulations. Appropriate checks on identity should always be carried out by organisations to satisfy themselves that a person has the appropriate skills and experience to undertake the duties they are being engaged for.”</p>	<p>Implemented</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
<p>Recommendation 20</p> <p>The Department of Health should, as a matter of urgency, issue guidance to PCTs [NHS England] to assist them in making decisions about whether or not a doctor has the necessary knowledge of English to be admitted to their Medical Performers Lists.</p>	<p>The Department of Health issued interim guidance for PCTs to ensure that they were confident of English language abilities of all GPs.</p> <p>The GMC has specified, as a requirement of gaining a licence to practise, that all doctors who practise medicine in the UK must have the necessary knowledge of English to communicate effectively so they do not put the safety of their patients at risk. Communicating includes speaking, reading, writing and listening. Further details on this can be found on the GMC website: www.gmc-uk.org/doctors/registration_applications/language_proficiency.asp.</p> <p>Changes to GMC powers in June 2014 require doctors from European Economic Area to provide evidence of their English skills or undergo a language assessment if there are concerns about their ability to communicate effectively with their patients. Doctors can demonstrate their knowledge of English in different ways – one of which is to provide a valid International English Language Testing System (IELTS) certificate which meets the GMC's requirements. Since June 2014, the GMC has required doctors taking IELTS to achieve an overall score of 7.5 out of 9 (up from 7.0). This requirement is the same for all doctors seeking to practise in the UK – including those from outside the EEA.</p> <p>Niall Dickson, Chief Executive of the General Medical Council has provided the following statement on this issue:</p> <p><i>“It was nonsense that we could do nothing to check on doctors whose English was not good enough. The new system, which allows us check when we have a doubt, is an important milestone in creating better, safer care for patients. Everyone has a right to expect to be treated by a doctor who can communicate effectively in English and this new</i></p>	<p>Implemented</p> <p>We support this change to UK law which allows the GMC to check concerns around the English language ability of doctors from within the EEA practising in the UK.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p><i>system will help us achieve this. European law does not yet allow us to routinely check every doctor, but persistent campaigning by the GMC and others means that that reform is on its way and the change to UK law is a vital first step.</i></p> <p><i>It is also important that everyone understands this does not in any way absolve those who employ doctors of their responsibilities – they must carry out thorough checks before taking a doctor on, and that includes making sure that the doctor is qualified and competent to carry out the duties they are being given. Failure to do this is a serious dereliction of duty and it is a requirement of every healthcare organisation in the UK."</i></p>	
<p>Recommendation 21</p> <p>The Department of Health should consider issuing guidance to PCTs [NHS England] about the circumstances in which they may wish to informally invite applicants to discuss in person their applications for inclusion in their Performers List</p>	<p>NHS England gave us the following comments about Performers Lists:</p> <p><i>"NHS England is responsible for managing entry to the medical performers lists. This work is managed by the Area Teams of NHS England. NHS England have published a standard operating procedure for Area Teams for processing applications to join the medical performers list"</i></p> <p>This standard states that Area Teams will need to meet with all applicants when their application is submitted (see http://www.england.nhs.uk/wp-content/uploads/2014/08/sop-med-perf.pdf).</p> <p>NHS England also provided the following statement:</p> <p><i>"If a performer is refused admission to the list the Area Teams (AT) have to inform a range of people, including the NHS Litigation Authority (NHSLA). This is under regulation of the performers list</i></p>	<p>Implemented</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p>regulation 18 http://www.legislation.gov.uk/uksi/2013/335/made. When making an application to join the list, the performer has to inform the NHSLA of any previous refusal to join the list or change in status. When an application is received in an AT, they have to complete due diligence checks (including with the NHSLA) who, as stated above, should have received notification from the AT who received the application."</p>	
<p>Recommendation 22</p> <p>In implementing the recommendations of the recent Performers List review, The Department of Health should consider whether all the requirements of the Regulations are appropriate for GP Trainees.</p>	<p>NHS England gave us the following comment in relation to the performers' list review:</p> <p><i>"The Department of Health considered the requirements for GP trainees and concluded that only minor changes were required to the Regulations. The changes were incorporated in the Performers List Regulations 2013."</i></p>	<p>Implemented</p>
<p>Recommendation 23</p> <p>PCTs [NHS England] should ensure that all doctors who have not provided primary medical services in the NHS previously are required to complete a period of individually tailored induction before starting to perform primary medical services.</p>	<p>NHS England is responsible for managing entry to the medical performers lists. This work is managed by the Area Teams of NHS England. NHS England has published a standard operating procedure for Area Teams for processing applications to join the medical performers list. This can be found here: http://www.england.nhs.uk/wp-content/uploads/2014/08/sop-med-perf.pdf. In addition NHS England provided the following statement,</p> <p><i>"NHS England is working with Health Education England to develop more formal Induction and Returners Schemes that assesses the needs of both doctors coming to England and those that have not</i></p>	<p>Implemented</p> <p>This policy has been implemented, but ongoing work still needs to be done to ensure this is consistently carried out.</p>

Recommendation	Update on progress	CQC's view of progress against the recommendations
	<p><i>practised here for over two years. Performers will be assessed on an individual basis by the Local Education and Training Board at the request of the NHS England Area Team so that the schemes can be tailored to individual needs."</i></p>	
<p>Recommendation 24</p> <p>The Department of Health should review how the exchange of information between PCTs [NHS England] and the GMC can be improved.</p>	<p>The GMC and NHS England have provided the following statement to provide an <i>update against this recommendation</i>:</p> <p><i>"The NHS England Area Team is a designated body under the Responsible Officer Regulations and, as such, the GMC's employer liaison service meets regularly with the Area Team responsible officer to discuss the GMC's fitness to practise thresholds."</i></p>	<p>Implemented</p>

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