Dear Dr. Warren

Manuscript ID BMJ.2014.023534 entitled "Service user and provider organisation characteristics associated with experience of general practice out-of-hours clinical care: results from the English General Practice Patient Survey"

Thank you for sending us this paper, which we were pleased to have the chance to consider, and enjoyed reading. We recognise its potential importance and relevance to general medical readers, but I am afraid that we have not yet been able to reach a final decision on it. This is because several important aspects of the work still need clarifying.

We hope very much that you will be willing and able to revise your paper as explained below in the report from the manuscript meeting, so that we will be in a better position to understand your study and decide whether the BMJ is the right journal for it. Looking forward to hearing from you again and, we hope, to reaching a decision.

Deadline: Your revised manuscript should be submitted within 6 to 8 weeks

Online and print publication: All original research in the BMJ is published with open access. The full text online version of your article, if accepted after revision, will be the indexed citable version (full details are at http://resources.bmj.com/bmj/about-bmj/the-bmjs-publishing-model), while the print and iPad BMJ will carry an abridged version of your article, usually a few weeks afterwards. This abridged version of the article is essentially an evidence abstract called BMJ pico, which we would like you to write using a template and then email it to papersadmin@bmj.com (there are more details below on how to write this using a template). Publication of research on bmj.com is definitive and is not simply interim "epublication ahead of print", so if you do not wish to abridge your article using BMJ pico, you will be able to opt for online only publication. Please let us know if you would prefer this option.

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You will be unable to make your revisions on the originally submitted version of the manuscript. Instead, revise your manuscript using a word processing program and save it on your computer.

Once the revised manuscript is prepared, you can upload it and submit it through your Author Center. When submitting your revised manuscript, you will be able to respond to the comments made by the reviewer(s) and Committee in the space provided. You can use this space to document any changes you make to the original manuscript and to explain your responses. In order to expedite the processing of the revised manuscript, please be as specific as possible in your response to the reviewer(s).

IMPORTANT: Your original files are available to you when you upload your revised manuscript. Please delete any redundant files before completing the submission.

Many thanks again. We look forward to seeing your revised article within 6 to 8 weeks.

Yours sincerely

Dr. Wim Weber
European editor, BMJ
wweber@bmj.com

**Report from the BMJ's manuscript committee meeting**

These comments are an attempt to summarise the discussions at the manuscript meeting. They are not an exact transcript. Members of the committee were: Elizabeth Loder (Chair), Tim Cole (Statistics advisor), Navjoyt Ladher, Georg Röggla, Alison Tonks, Tiago Villanueva.

Decision: request revisions

Detailed comments from the meeting:

The finding that commercial providers of out-of-hours primary care were associated with less patient satisfaction is interesting. It will be of great interest to a broad readership in the UK, but we wondered about the international context. You could improve on that, by explaining the UK system better and placing this research in the context of other work from other places on the link between profit and standards/quality.

Likewise, there is a lot of UK jargon (PCT, CCG). Please simplify/ clarify for non-UK readers.

The low response rate is an issue. The discussion of the biases or lack of biases associated with the poor response is thorough and convincing. But we feel that you should caution readers about the low response rate in the abstract too.

The results and conclusions sections of the abstract and the paper seem lopsided. You announce 3 objectives: look at SES characteristics, work hours and commercial vs. private. Then you focus heavily on the findings about commercial vs. private. The discussion and presentation of results should be more balanced.

First and foremost, please revise your paper to respond to all of the comments by the reviewers. Their reports are available below.
IMPORTANT
When you revise and return your manuscript, please take note of all the following points. Even if an item, such as a competing interests statement, was present and correct in the original draft of your paper, please check that it has not slipped out during revision.

a. In your response to the reviewers and committee please provide, point by point, your replies to the comments made by the reviewers and the editors, and please explain how you have dealt with them in the paper. It may not be possible to respond in detail to all these points in the paper itself, so please do so in the box provided.

b. If your article is accepted it will then be edited, proofed, and - after your approval - published on bmj.com with open access. This open access Online First article will not be a pre-print. It will represent the full, citable, publication of that article. The citation will be year, volume, locator (a unique identifier for that article): eg BMJ 2008;337:a145 — and this is what will appear immediately in Medline, PubMed, and other bibliographical indexes. We will give this citation in print and online, and you will need to use it when you cite your article.

c. Please write an abridged version of the article for the print and iPad BMJ using the appropriate BMJ pico template for your study’s design. Please be reassured that it doesn't take long to complete this. When your BMJ pico is ready please email it to papersadmin@bmjgroup.com. The templates for you to download are at http://resources.bmj.com/bmj/authors/bmj-pico

Please include the items below in the revised manuscript to comply with BMJ style:

* the title of the article should include the study design eg "a retrospective analysis of hospital episode statistics"

* ID of ethics committee approval and name of the ethics committee/IRB; or a statement that approval was not required (see http://resources.bmj.com/bmj/authors/editorial-policies/guidelines)

* Please complete the following statement and add it to your manuscript: “All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: no support from any organisation for the submitted work OR [author initials] had support from [name of organisation] for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous 3 years OR [author initials] [had specified relationship] with [name of organisation] in the previous 3 years; no other relationships or activities that could appear to have influenced the submitted work OR [initials of relevant authors] [had specified relationships or activities of this type]”

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* signed patient consent form(s), if the article gives enough personal information about any patient(s): this sometimes occurs even in research papers - for example in a table giving demographic and clinical information about a small subgroup in a trial or observational study, or in quotes/tables in a qualitative study - (see http://resources.bmj.com/bmj/authors/editorial-policies/copy_of_patient-confidentiality)

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* for any other registered study (eg a systematic review), the registration number and name of register – in the last line of the structured abstract

*a data sharing statement declaring what further information and data you are willing to make available. Suggested wording: “Data sharing: technical appendix, statistical code, and dataset are available at this repository or website OR from the corresponding author at “. If there are no such further data available, please use this wording: "Data sharing: no additional data available"

* please write the discussion section of your paper in a structured way, to minimise the risk of careful explanation giving way to polemic. Please follow this structure:
  * statement of principal findings of the study
  * strengths and weaknesses of the study
  * strengths and weaknesses in relation to other studies, discussing important differences in results and what your study adds. Whenever possible please discuss your study in the light of relevant systematic reviews and meta-analyses (eg Cochrane reviews)
  * meaning of the study: possible explanations and implications for clinicians and policymakers and other researchers; how your study could promote better decisions
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We do want your piece to be easy to read, but also want it to be as scientifically accurate as possible. Please include in the results section of your structured abstract (and, of course, in the article's results section) the following terms, as appropriate:

For a clinical trial:
- Absolute event rates among experimental and control groups
- RRR (relative risk reduction)
- NNT or NNH (number needed to treat or harm) and its 95% confidence interval (or, if the trial is of a public health intervention, number helped per 1000 or 100,000)

For a cohort study:
- Absolute event rates over time (eg 10 years) among exposed and non-exposed groups
- RRR (relative risk reduction)

For a case control study:
- OR (odds ratio) for strength of association between exposure and outcome

For a study of a diagnostic test:
- Sensitivity and specificity
- PPV and NPV (positive and negative predictive values)

For research articles
As well as submitting your revised manuscript, we also require a copy of the manuscript with changes highlighted. Please upload this file with file designation 'Revised Manuscript Marked copy'.

REFEREES COMMENTS

Reviewer: 1

Recommendation:

Comments:
Title: Service user and provider organisation characteristics associated with experience of general practice out-of-hours clinical care: results from the English general Practice patient Survey
Date: 18 November 2014
Level of interest: An article of high importance in its field

General comments:
Researching the GP out-of-hours service is highly relevant and important both in the light of quality improvement and in the light of certain exposed groups of patients. The present manuscript is pointing out some very interesting issues and perspectives, and therefore it contains important information and results in its field. However, the manuscript wants to communicate all the important points that points in many directions in only one article. Unfortunately it makes the manuscript very hard to read and makes it very hard to keep focus. It is in particular difficult to navigate in the very long and very advanced methods paragraph; although it is very interesting and relevant analyses the authors are using to reach the aims. I therefore suggest that the manuscript is divided in two parts according to the two aims; in a patient perspective and in an organizational perspective, respectively. Both perspectives are of high importance and all the results of the patient survey will come to its right.
Specific methodological comments:
Validity: The very low response of 35% rate is bringing the external validity under hard pressure and need a more thorough discussion of the risk of information bias as well as of selection bias. Maybe it is not possible to make exhaustive conclusions from the results, but I need a less conclusive deduction of the results that rather points out issues of relevance for the clinical practice. I’m aware that you have discussed it in line 337 but precisely this issue is highly important and an important argument that needs to be acknowledged in a thorough discussion.
I also need a discussion of potential risk of recall bias introduced by the questions about OOH service within the preceding 6 month.

Minor essential revisions:
1. Please move the reference for the GPPS from line 84 to line 81.
2. Line 109: the text state that four questions was included but you only mention three of them. What about the fourth question?
3. Line 287: It is tempting to compare with findings from USA but the American health organizations are quite different from the English ditto. Maybe just a short sentence that account for this difference would be appropriate.
4. Line 343: you write that "For all these reasons, we believe these findings presented here are both relevant, and of importance to service users, healthcare professionals, policy makers and out of hours providers". Please explain why it is so. And maybe also include that it is important for the patients. Just a line or two in the light of the clinical importance both for daytime care and the care provided out-of-hours.
5. Just a short comment regarding line 350: It is a pity that you have no time-stamp on the contacts, because it often affects how the service users cope with the given service. But often it is so, and we have to realize that the IT-system is not always offers these data.
6. Tables: The tables are easy to read.
7. Maybe it would be useful for you to read the following literature. Maybe it will bring in some new perspectives to your knowledge about the out-of-hours:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217866

Additional Questions:
Please enter your name: Lone Flarup
Job Title: MHSc., PhD, consultant
Institution: Central Denmark Region
Reimbursement for attending a symposium?: No
A fee for speaking?: No
A fee for organising education?: No
Funds for research?: No
Funds for a member of staff?: No
Fees for consulting?: No
Have you in the past five years been employed by an organisation that may in any way gain or lose financially from the publication of this paper?: No
Do you hold any stocks or shares in an organisation that may in any way gain or lose financially from the publication of this paper?: No
If you have any competing interests (please see BMJ policy) please declare them
Reviewer: 2

Recommendation:

Comments:
Manuscript BMJ.2014.023534

Title: Service user and provider organisation characteristics associated with experience of general practice out-of-hours clinical care: results from the English General Practice Patient Survey.

Reviewer:
Professor Gunnar Tschudi Bondevik, MD, PhD, specialist in Family Medicine
Department of Global Public Health and Primary Care, University of Bergen, Norway
National Centre for Emergency Primary Health Care, Uni Research Health, Bergen, Norway

This paper investigates service users’ experience of GP OOH services using data from the English General Practice Patient Survey from July-September 2012 and January-March 2013. The response rate was 35%. A total of 934 931 services users were mapped to one of 91 providers of OOH primary care. The subjects included in the study were 110 716 service users aged 18 years or over, being patients themselves, or contacting the GP OOH service on behalf of someone else – during the 6 months period prior to sending the questionnaire. Possible associations between socio-economic factors, provider organisation type and service users’ experience of care were investigated.

Data collection included the following socio-demographic factors (ethnic group, ability to take time away from work during working hours to attend the GP, gender, age, parent status, deprivation), provider organisation type (not-for-profit, NHS, commercial), service user experience (timeliness of receiving care: about right - took too long - don’t know/doesn’t apply; confidence and trust in the OOH clinician: yes, definitely - yes, to some extent - no, not at all - don’t know/can’t say; overall experience of GP OOH care: 5-point Likert scale from very good to very poor).

Analyses showed that commercial providers of OOH care were associated with poorer experience of care than not-for-profit and NHS providers. Asian service users reported lower scores for all three experience outcomes (timeliness, confidence and trust, and overall experience) compared with White service users. Service users who were unable to take time away from work - reported lower scores for all three experience outcomes, compared with service users who did not work.

Methods:
In the methods, the authors describe four statistical models (Model A-D). The aim with introducing different models was to investigate whether differences between service users was due to clustering of users within providers that had low scores, whether associations were consistent across providers, and the degree of between-provider variation attributable to provider organisation type. The description of these statistical models is relatively complicated, particularly Model C and Model D. The authors should reformulate the two paragraphs (page 6, line 168 – page 7 line 193) making it easier to understand for the readers.

Manuscript and Table 1:
Nearly twice as many women (63.5%) than men (36.5%) had attempted to contact the OOH service – what could be the explanations for such a difference?
Manuscript and Table 2:
The question regarding timeliness “How do you feel about how quickly you received care from the OOH GP service” had only 2 options for reply (besides “don’t know”): “It was about right” (62.9%) and “It took too long” (30.6%). The limited number of options is problematic. If the respondents had been able to give their reply to this question on a 5-point Likert scale, the authors would have more precise information regarding this topic. As timeliness is a variable with a particularly low score, this issue (having only 2 options) should have been discussed more thoroughly in the manuscript.

Manuscript and Table 3:
The number of providers (44 not-for-profit, 21 NHS, and 21 commercial) should have been included in the table.

Commercial providers scored significantly lower than the reference category not-for-profit providers for all three outcomes, and the standard mean difference indicated a moderate (timeliness) or large (confidence and trust, and overall experience) effect size attributable to commercial provider status. Mean scores for not-for-profit vs. commercial providers were 68.4 vs. 64.9 (timeliness), 66.2 vs. 63.0 (confidence and trust) and 72.1 vs. 69.0 (overall experience), respectively. Although the differences in centiles observed across the provider types are convincing, it should have been discussed more in detail to which degree the magnitude of difference in mean scores (approximately 3 percentage points for all outcomes) – although statistically significant - is “clinically” significant. As this is a potential sensitive finding, it is important to discuss the results more critically. Why do commercial providers score lower?

Manuscript and Tables 4-6:
The number of respondents in each category of the variables “Ethnic group” and “Able to take time away from work during typical working hours” should have been included in the tables.

Service users of Asian ethnicity reported poorer OOH care of all three evaluative questions compared with White respondents, but particularly regarding timeliness of care. Possible explanations could have been more adequately discussed. Is this finding from the OOH setting in accordance with findings among Asian service users in in-hours GP practices?

What was the socio-demographic variation of the overall experience in in-hours primary care (manuscript reference no. 11) – any differences compared to this study? Could there be cultural differences regarding expectations, and what is considered acceptable waiting time?

Could Asians have other experiences of timeliness in their home country? Is there any relation between experienced timeliness (“How do you feel about how quickly you received care from the OOH GP service”), actual waiting time, and the quality of care in the OOH setting? Does poor experience regarding timeliness indicate poor health care?

Services users being unable to take time away from work to attend their GP practice reported lower scores across all three outcomes. Possible reasons for this finding should have been discussed more thoroughly. The authors suggest that service user expectations may vary by work status, in which way? Are expectations different in the OOH setting compared with in-hours primary care services?

For service users who are unable to take time away from work, OOH would be the only option for primary care service – this group has no other alternative. Service users that are able to take time away may choose between GP contact in-hour and OOH service. What characterises the group of service users that are not able to take time away from work?

Why were service users being unable to take time away from work compared with users that did not work – rather than with users that could take time away
from work to attend their GP practice? Would these persons use the OOH to a lesser degree?

Conclusions:
This is an interesting paper describing important findings from general practice out-of-hours clinical care in England. However, the manuscript, particularly the Discussion, needs revision in line with the suggestions above to make it acceptable for publication.

Additional Questions:
Please enter your name: Gunnar Tschudi Bondevik
Job Title: Professor, MD, PhD, Spesialist in Family Medicine
Institution: Department of Global Public Health and Primary Care, University of Bergen, Norway & National Centre for Emergency Primary Health Care, Uni Research Health, Bergen, Norway
Reimbursement for attending a symposium?: No
A fee for speaking?: No
A fee for organising education?: No
Funds for research?: No
Funds for a member of staff?: No
Fees for consulting?: No
Have you in the past five years been employed by an organisation that may in any way gain or lose financially from the publication of this paper?: No
Do you hold any stocks or shares in an organisation that may in any way gain or lose financially from the publication of this paper?: No
If you have any competing interests (please see BMJ policy) please declare them here:

Reviewer: 3
Recommendation:
Comments:
The authors use data from the English GP Patient Survey to investigate factors affecting the experience of users of out-of-hours services. I have some comments on the study design, analysis, presentation and interpretation.

1. The EGPP Survey has a response rate of only 35%, which gives considerable leeway for possible response bias. It is important to provide evidence to validate the quality of the survey data, as only a small bias could significantly affect the findings. Some reassurance is given in the Discussion, but it also needs to be referenced when the Survey is first described.

The second weakness of the study, again addressed in the Discussion, is the lack of information on the nature of the out-of-hours complaints. This to my mind reduces the value of the findings, as there is no objective confirmation of for example the timeliness of attendance, that can be linked to the user reports.

2. Four statistical models were developed, where model A is a fixed effects regression, B adds a random provider intercept to A, C adds a random socio-demographic slope to B, and D add a provider organisation fixed effect to B.
Random effects for practice were not fitted, on the grounds that the random provider effect would adequately model the clustering. This to me is a serious problem when interpreting the socio-demographic factors of ethnic group and ability to take time off work, in Tables 4 to 6. The latter factor has three levels: not applicable, yes and no, and so is a potent measure of socio-economic status, those in the first group including students, the elderly and the unemployed, while the second and third groups are relatively higher and lower status employed. My feeling is that the three groups cannot realistically be compared without further socio-economic adjustment, such as would be provided by including a practice random effect. This would also address to some extent the issue of ethnic minority users clustering within poorer providers.

Model C is mentioned only once, in relation to Figure 2, where the effect of the random slopes is not shown. I would omit all mention of model C as it adds nothing to the story.

4. The outcome scores were transformed to a 0-100 scale, but this does not, as claimed, allow differences on the scale to be interpreted as percentiles (or centiles). Centiles represent the distribution split into 100 parts, and the distance from say the 3rd to the 4th centile is considerably greater than from the 53rd to the 54th (for a normal distribution it’s >5 times greater). What is more important is the SD on the transformed scale, and it’s easiest to express differences in terms of the SD, as done in Table 3, where it is called the standardised mean difference.

5. Table 3 strikes me as unnecessarily complicated, with its marginal means, estimated scores and equivalent centiles (note that these centiles differ from the percentiles claimed for the 0-100 scale). The first two of these columns can be omitted, and the final centile column restricted to the mid-centile value, which is the centile corresponding to the standardised mean difference. I’m not clear why three centiles are given rather than one, it just complicates things.

Also it is not clear whether the p-value column is comparing NHS and Commercial or all three provider groups, and this applies to later tables too. The cells describing model D need expanding to a readable size, and the between provider variance can be omitted. It would be possible to omit the Not-for-profit rows entirely, which would simplify the table.

6. In Table 3 and elsewhere, is it appropriate to the three provider groups separate, as opposed to say combining Not-for-profit and NHS for comparison with Commercial?

7. The results for Table 2 show that the three provider organisations affected all three outcomes, with \( p < 0.02 \) globally. This to my mind is a remarkably weak association, given the size of the dataset, and should be acknowledged as such.

Additional Questions:

Please enter your name: Tim Cole

Job Title: Professor of medical statistics

Institution: UCL Institute of Child Health

Reimbursement for attending a symposium?: Yes

A fee for speaking?: No

A fee for organising education?: No

Funds for research?: No

Funds for a member of staff?: No
Fees for consulting?: No

Have you in the past five years been employed by an organisation that may in any way gain or lose financially from the publication of this paper?: No

Do you hold any stocks or shares in an organisation that may in any way gain or lose financially from the publication of this paper?: No

If you have any competing interests (please see BMJ policy) please declare them here:

END

Date Sent: 16-Jan-2015