HEALTH AND SPORT COMMITTEE

AGENDA

2nd Meeting, 2010 (Session 3)

Wednesday 20 January 2010

The Committee will meet at 10.00 am in Committee Room 2.

1. **Subordinate legislation:** The Committee will consider the following negative instruments—

   The Food Enzymes (Scotland) Regulations 2009 (SSI 2009/435)
   The Food Additives (Scotland) Regulations 2009 (SSI 2009/436)
   The Food (Jelly Mini-Cups) (Emergency Control) (Scotland) Regulations 2009 (SSI 2009/437)
   The Food Supplements, Vitamins, Minerals and Other Substances (Scotland) Regulations 2009 (SSI 2009/438)

2. **Inquiry into out-of-hours healthcare provision in rural areas:** The Committee will take evidence from—

   Barbara Hurst, Director of Public Reporting (Health and Central Government), Audit Scotland;

   Dr Frances Elliot, Chief Executive, NHS Quality Improvement Scotland;

   David Heaney, Associate Director, Centre for Rural Health;

   Prof Allyson Pollock, Director, Centre for International Public Health Policy, University of Edinburgh;

   Dr Andrew Buist, Lead on remote and rural issues, British Medical Association;

   and then from—

   Dr Susan Taylor, Remote and Rural Lead, Royal College General Practitioners Scotland Membership Liaison Group;

   Linda Harper, Lead Nurse G-MED, Royal College of Nursing Scotland;
David Forbes, Regional Organiser and Secretary to the Scottish Ambulance Committee, UNISON;

Dr Paul Kettle, Out-of-hours GP, Remote Practitioners Association of Scotland;

Dr Ewen Mcleod, Vice Chairman, British Association for Immediate Care Scotland.

Callum Thomson
Clerk to the Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5210
Email: callum.thomson@scottish.parliament.uk
The papers for this meeting are as follows—

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Health and Sport Committee

2nd Meeting, 2010 (Session 3), Wednesday, 20 January 2010

Subordinate Legislation Briefing

Negative instruments

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<td>the <strong>Food Additives (Scotland) Regulations 2009 (SSI2009/436)</strong></td>
<td>1 Feb</td>
<td>No</td>
<td>These Regulations apply in relation to Scotland only. They revoke the Food Additives Labelling Regulations 1992 (S.I. 1992/1978), the Sweeteners in Food Regulations 1995 (S.I. 1995/3123), the Colours in Food Regulations 1995 (S.I. 1995/3124) and the Miscellaneous Food Additives Regulations 1995 (S.I. 1995/3187) (each of which extends to the whole of Great Britain) and re-enact with changes and on a transitional basis certain provisions of the last three of those instruments. The SLC reports that the Government’s response clarifies that the effect of regulation 4(d) is to directly implement the requirement in Article 2(8) of the Directive 94/36/EC on colours for use in foodstuffs, but that it does not clarify how (in practice) persons requiring to mark meat are to establish what an appropriate mixture of (b) and (c) is.</td>
<td>The SLC reports that the Government’s response clarifies that the effect of regulation 4(d) is to directly implement the requirement in Article 2(8) of the Directive 94/36/EC on colours for use in foodstuffs, but that it does not clarify how (in practice) persons requiring to mark meat are to establish what an appropriate mixture of (b) and (c) is.</td>
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### Agenda Item 1
20 January 2010

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**The Food (Jelly Mini-Cups) (Emergency Control) (Scotland) Regulations 2009 (SSI2009/437)**

- **1 Feb**
- **No**


The SLC had no comments to make on this instrument.

**The Food Supplements, Vitamins, Minerals and Other Substances (Scotland) Regulations 2009 (SSI2009/438)**

- **1 Feb**
- **No**

These Regulations, which extend to Scotland only, amend the Food Supplements (Scotland) Regulations 2003 ("the 2003 Regulations") and the Addition of Vitamins, Minerals and Other Substances (Scotland) Regulations 2007 ("the 2007 Regulations") in order to provide for the execution and enforcement of Commission Regulation (EC) No. 1170/2009 amending Directive 2002/46/EC and Regulation (EC) No. 1925/2006 as regards the lists of vitamins and minerals and their forms that can be added to foods, including food supplements. These Regulations also update the references to Directives referred to in the 2003 Regulations.

The SLC drew to the attention of the Committee the following:

- Regulation 6(3)(e) of the Food Supplements (Scotland) Regulations 2003 as substituted by regulation 2(6)(b) of this instrument is defectively drafted as it should refer to the list in Annex I to Directive 90/496 and not simply the Annex to that Directive;
- It is recommended that the Scottish Government rectify this error to ensure proper operation of the 2003 Regulations;
- New regulation 12 of the 2003 Regulations as inserted by regulation 2(7) of this instrument
could have been more clearly expressed since not all the changes made by regulation 2(2) are relevant for the purposes of the transitional defence;

• While it is accepted that there has been no breach of the requirements of article 2 of Directive 2008/100/EC, the SLC considers that it is good drafting practice to refer to all community instruments being implemented in the explanatory note as this assists the reader’s understanding of the instrument;

• It is content, for its interests, with the reason given for the 21 day rule not having been complied with.
Inquiry into out-of-hours Health Care Provision in Rural Areas

Audit Scotland

Thank you for your letter dated 25 September 2009 setting out the Committee's call for written evidence to inform its inquiry into out-of-hours health care provision in rural areas. Audit Scotland published a report on Primary care out-of-hours services in August 2007 which is available on our website:


The Auditor General briefed the Parliament's Audit Committee on the report findings in September 2007. In this report we reviewed changes to the delivery of primary care out-of-hours services following the introduction of the new General Medical Services (nGMS) contract for GPs. We looked at national and local planning for out-of-hours care; how much these services cost the NHS; and how the delivery of out-of-hours services affects patients and GPs. Our response largely relates to this study.

Sustainability and cost effectiveness of out-of-hours services

In part the nGMS contract was introduced because of a concern about the sustainability of out-of-hours services, as the increasing on-call commitment outwith normal working hours was a deterrent to recruitment and retention in general practice. Under the new arrangements, GP practices could choose to opt out of providing out-of-hours services and 95 per cent of practices opted out in 2004.

We found that NHS boards had managed to implement the nGMS contract and maintain out-of-hours services to patients although this was a major challenge. NHS boards in remote and rural areas had to develop more innovative ways to sustain these services to patients, such as developing extended roles for nurses.

At the time of our 2007 report, out-of-hours services were under continuing pressure as fewer GPs were reproviding services. We highlighted that new ways of working were required given the significant risks that existing models of service delivery were not sustainable in the long term.

The cost of providing out-of-hours primary care services varies across Scotland. In 2005106 costs varied from £43.63 per head of GP registered population in the Argyll and Bute area to £7.61 in the Greater Glasgow area. The cost of these services is directly linked to remoteness, with higher costs in more remote or rural areas. This is due to a range of factors such as sparse population and large geographical areas to cover. We recommended that the Scottish Government work with the NHS to share data on costs associated with out-of-hours services including costs associated with different models of care, and to reflect the impact of rurality.
Fees that are paid to GPs for reproviding out-of-hours services are negotiated locally and therefore vary across Scotland and depend on local market forces, such as pre-existing arrangements and availability of GPs willing to provide the service. For example, rates in areas where there are more GPs willing or available to reprovide some sessions tend to be lower than in those areas where there are less GPs willing or available to reprovide. NHS boards worked together to negotiating fees and share information for payments for one of the most frequent out-of-hours sessions - a weekday evening.

This successfully led to a common approach and around £50 per hour was paid to GPs across most areas in 2005/06. Payment rates for other times in the out-of-hours period were less consistent across Scotland. In 2005/06 payments for a weekday overnight per hour varied from £50 in NHS Dumfries and Galloway and NHS Forth Valley to just over £80 in NHS Tayside, NHS Grampian, NHS Lanarkshire and NHS Western Isles. This variation reflects local market forces at work in determining GP fees. We found that payments at Christmas and New Year varied even more widely across Scotland, ranging from just under £81 per hour in NHS Tayside to £150 in NHS Highland and NHS Grampian in 2005/06.

**Quality of out-of-hours care in rural areas**

One of the main aims of the nGMS contract was to improve access to and quality of out-of-hours care for patients, with patients receiving treatment from the most appropriate professional. Strong links to other services are critical to the provision of high quality out-of-hours primary care services. In our report we recommended that these links, for example with NHS 24, need to be strengthened.

NHS Quality Improvement Scotland published a set of standards for primary medical services out-of-hours in August 2004. All providers were required to comply with the standards from January 2005. Although the NHS QIS standards are a useful start in defining a minimum standard for all out-of-hours service providers, a system of clear performance indicators focused on patient out-of-hours care was not in place at the time of our review. The NHS QIS standards explore the processes and procedures underpinning the delivery of out-of-hours care rather than assess the quality of services provided to patients.

**Accessibility and availability of out-of-hours care in rural areas**

The focus of our report was on the implementation of the new GP contract and the impact on patients. Part of this relates to how easily patients can access out-of-hours services. We highlighted the changes and variation in route to access these services, and carried out a survey of GPs and patients. Only one in ten GPs (11 per cent) responding to our survey felt that patient care had improved under the new arrangements. Over half (52 per cent) feel that patient access and the availability of out-of-hours services have not improved. Our patient survey, however, showed that over 80 per cent of
patients who accessed out-of-hours services were satisfied with the service they received, and understood how to access services through NHS 24.

NHS boards have met the current NHS target that they must ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours.

**Links with NHS 24 and the Scottish Ambulance Service**

We are currently carrying out a review of emergency departments and links to NHS 24 and the Scottish Ambulance Service. This review focuses on emergency departments but will also touch on the role of GP services. We are considering issues relating to remoteness and rurality as part of the study. This report will be published in August 2010. The project brief for the study sets out in more detail the scope of this work:

http://www.audit-scotland.gov.uk/docs/fwd/pb_emergency_care.pdf

I hope that this outline of our work relating to out-of-hours services is helpful but please get in touch if you have any further questions.

Barbara Hurst  
Director of Public Reporting (Health and Central Government)  
Audit Scotland  
4 November 2009
Introduction

There is little robust academic evidence, either from the UK, or from other countries, which directly addresses any of the four questions posed by the inquiry. They are, without doubt, difficult questions which require to be addressed in Scotland. Most of the relevant publications identify the difficulty of addressing the issue of out of hours healthcare provision in rural areas, involve descriptive accounts of service delivery, and suggest potential solutions. Analytical work has tended to focus on the views of stakeholders rather than assessment of outcomes. There is little rigorous evidence in favour of any one particular model.

I present my evidence in six sections. I have summarised the recent work of the Remote and Rural Implementation Group, summarised a report on out of hours services produced by the Centre for Rural Health, outlined some recent and ongoing evaluation on the role of community first responders, provided some personal views on the delivery of out of hours services in remote and rural area, and attached a brief description of the role of the Centre for Rural Health.

Remote and Rural Implementation Group

The Remote and Rural Implementation Group has recently produced a strategic options framework on emergency and urgent response to remote and rural communities which is of relevance to this inquiry. This was designed as a tool to be used by the Scottish Ambulance Service, in partnership with NHS Boards, Community Health Partnerships and local communities, to establish, over time, a response appropriate to local circumstances. Work involved in developing the framework included a literature review, a mapping of the current emergency and urgent service provision, development of Standards for Emergency and Urgent Response, supported by a Framework of possible response models for remote and rural communities, and an analysis of the costs of implementing and not implementing models. The responsibilities of various organisations are described and supported by standards that service responses will be expected to achieve. Seven recommendations were made about standards, service delivery and community engagement in remote and rural areas. Parallel to the framework, an evaluation of Emergency Medical Retrieval Service for Remote and Rural Scotland Pilot was commissioned, results of which are now available, which are also of interest.

The literature review conducted as part of development of the strategic outcomes framework identified UK and international models of remote and rural acute and emergency care, and evidence to support these models:
• Volunteers are used extensively internationally in emergency care delivery in remote and rural areas. Community engagement is a key element of this. First responders have the ability to deliver defibrillation and life saving first aid measures to the seriously ill and injured.

• The community practitioner response is described as a primary response; a tiered response and a response to provide an increased skill level to patients.

• Retrieval systems are usually clinician led and activated. The use of telemedicine allows specialists to assist remote and rural clinicians while the retrieval team is in transit. Additional boat and air infrastructure is discussed.

The literature describes relevant emergency and urgent models of care but there is a lack of rigorous analytical research. Because of this, the review concludes that any service changes require careful monitoring and proper evaluation from the outset.

Out of Hours Care in Remote and Rural Scotland 2005 Report

The most relevant piece of work that CRH has conducted was a report completed in 2005. While some of the results have been superseded by events, the report remains relevant, as many issues remain unresolved.

The key findings of the study were as follows

• the structure of OOH services in remote and rural areas prior to the introduction of the new General Medical Services contract had evolved according to local circumstances. GP co-operatives had been an important development where geography allowed, but delivery in remote and island areas remained practice based.

• difficulties relating to access were identified as the primary barriers to change in remote and rural areas.

• across the Health Boards proposed changes had many similar features - centralisation of care with patients encouraged to travel, patient transport systems, fewer doctors on call, the creation of multi-disciplinary integrated teams, and with NHS 24 as first point of contact.

• these major changes in service delivery were being introduced within a short time scale and were causing much uncertainty, exacerbated by a lack of detail of the new service structure and organisation.

• uncertainty was reflected in the wide range of opinions expressed by rural GPs about their contribution to the new services, the viability and safety of new services, and the future role of rural general practice.

At the time of the study, OOH service redesign in remote and rural areas was a contentious and complex subject, and this remains the case today. One respondent likened it to “wrestling with an octopus”. Geography, weather, transport infrastructure, population distribution and structure, and recruitment
and retention of health care personnel all conspire to make it more difficult to modernise services in these areas. All these factors combine to produce a set of constraints, resources, attitudes and demands for services that shape the re-design process. Farmer et al (2003) proposed that existing services may, however, represent a successful model of care. Rural areas are diverse and services are likely to have evolved in ways that fit the local environment, culture and geography, resulting in a delicate balance of what is possible, given the circumstances.

The study concluded that other workable solutions were needed in the most remote areas. Major redesign had been possible in urban parts of Scotland but localised appropriate solutions for relatively small populations were identified as time consuming, expensive and requiring flexibility, imagination and political will.

Community First Responder Schemes

CRH is in the process of evaluating the introduction of the community first responder scheme in Rannoch and Tummel. Also, CSO have just confirmed the award of a grant to CRH to assess the role of CFRs across Scotland during 2010. This study also aims to contribute to our understanding of public participation in healthcare services. The concept of community resilience will be explored, and the study will examine social and cultural impact of public involvement in healthcare delivery. International evidence suggests a trained community response during a healthcare emergency can have an impact on patient survival rates, particular evidence relates to cardiac arrests. However, to date the role of community first responders has been unevaluated in Scotland.

We are able to report some early interim findings from the study in Rannoch. A survey was conducted in Rannoch & Tummel prior to the introduction of the CFR scheme. A total of 266 of 606 questionnaires were returned, a 44% response rate. In the last year, 72% of respondents had been seen or had been visited by a GP, 46% by a nurse, 15% had called NHS 24. Respondents made a total of nine 999 calls in the last year. Of responses received, 6 people had volunteered to join the scheme, and a further 27 indicated they may do in the future. A range of views were expressed about the scheme:

- 36% of respondents agreed the scheme would be good as an addition to service, 18% were neutral and 46% disagreed.
- 65% agreed that they would have concerns about the safety of the scheme, 18% were neutral and 17% disagreed.
- 68% agreed that in a life-threatening emergency, they would be satisfied to be seen by anyone who is appropriately trained and skilled, 15% were neutral, and 17% disagreed.
- 24% agreed that current arrangements for healthcare emergencies were satisfactory, 11% were neutral and 65% disagreed.
73% agreed that GPs from the local practice should be available 24 hrs, 14% were neutral and 13% disagreed.

This survey will be repeated once the scheme is fully established and in operation. We are also conducting interviews with local stakeholders and early evidence shows there is confusion in the community over the role of a first responder scheme.

**Personal views on out of hours healthcare provision in rural areas**

My impression is that since the 2005 report has been produced, little progress has been made in resolving the difficult issue of the delivery of out of hours services in remote and rural areas – hence the need for this inquiry. Often the current configuration of services is expensive, unsustainable and inefficient. My view is that the most sustainable and cost effective way to deliver adequate out-of-hours services in rural areas is to focus on the emergency and urgent response, as my perception is that this is the element which causes concern in communities. Non-urgent primary care cases should be triaged where possible to adequate day time services. Solutions need to be tailored to rural communities, as there are many different sets of circumstances, and existing resources should be used to deliver a team-based approach including general practitioners, nurses, paramedics, ambulance technicians, pharmacists and community first responders. There is potential for more communities to contribute to improving the accessibility of service delivery through first responder schemes, but it is important that volunteers are used appropriately and supported in their role, and not seen as a replacement for services. At the moment, it is my perception that rural areas are not best served by the number of different agencies involved in the delivery of out of hours care, and communities are confused by the different roles each organisation plays. Better co-ordination is required between Scottish Ambulance Service, NHS 24 and GP out of hours services, with co-location or integration of these services as future possibilities. This has been identified by the services themselves. Exploration of the use of technology to support remote models of care should be continued and supported as this has the potential to transform the quality of care delivered. The proposed standards for different levels of response recommended by the Remote and Rural Implementation Group should be introduced with support from the Scottish Government, and changes in service delivery required to meet these standards carefully monitored.

**Centre for Rural Health  www.abdn.ac.uk/crh**

The Centre for Rural Health is a collaborative venture between the University of Aberdeen and the UHI Millennium Institute. The CRH mission is “to advance knowledge of health and health services in rural and remote communities”. Those communities currently face a number of important challenges including: changes in demography; changes in the nature of health care provision; and increased expectations of the community. CRH is
developing the evidence base for rural health care by carrying out relevant primary research; developing collaborative research; and bringing the international perspective through appropriate collaborations. David Heaney is a senior research fellow at the Centre. It is also worth noting that he lives in the remote Wester Ross village of Achiltibuie, and while he is a member of a community first responder scheme there, he remains neutral in academic exploration of the role of CFRs in the provision of care.

David Heaney  
Senior Research Fellow  
Centre for Rural Health  
12 January 2009

References

1. Emergency and Urgent Response To Remote and Rural Communities Strategic Options Framework October 2009 Accessible at http://www.nospg.nhsscotland.com/?page_id=292
Inquiry into out-of-hours Health Care Provision in Rural Areas

The Centre for International Public Health Policy

Questions

To inform the inquiry, the Committee is seeking views on the following questions:

- What do you think is the most sustainable and cost-effective way to provide adequate out-of-hours services in rural areas?
- What are your views on the quality of out-of-hours care provided in rural areas, in particular clinical safety and effectiveness?
- What are your views on the accessibility and availability of out-of-hours care in rural areas?
- How well do you think does NHS 24 and the Scottish Ambulance Service link in with existing out-of-hours services?

Context and principles

1. It is important to have regard to the core principles of the NHS; namely, universal care, equal access for equal need and services provided free at the point of delivery. Cost is not a reason for departing from these principles. The whole point of public services is to distribute funds and resources on the basis of need by pooling the risks and costs of care across its communities so that those in rural areas, where unit costs may be higher, will not be denied care because of population sparseness and small numbers. This is the principle which underpins all public services. It is important to pay close attention to the mechanisms for funding, which enable risk pooling across the whole population in order to ensure that communities are not denied core entitlements to care.¹

2. The citizens of Scotland have had universal access to primary care since 1948 and the GP is both the gatekeeper to other care and the family/community physician. There is a strong evidence base to underpin the importance of this role, especially in vulnerable communities. The UK GP gatekeeper role and primary care system has become the model for many health systems across the world, based on its integration, continuity of care, cost efficiency and holistic approach to family and community-based medicine.
3. The 2004 UK GP contract enabled health boards to contract out primary care, GP and other services to a range of alternative providers—including commercial providers—for the provision of GP out-of-hours (OOH) care. This policy involves a radical change to the mechanisms for funding, allowing the break-up of risk pooling mechanisms. The justification for this was to increase efficiency and control costs through market competition.

4. Until 2004 the majority of GPs provided OOH services directly or used GP cooperatives to provide services. Since 2004, the responsibility for providing OOH services now lies with Health Boards in Scotland.

5. Some health boards are using the opportunity afforded by the new contract to withdraw GP OOH care from local communities, thereby removing what has been a core entitlement for citizens for 60 years. The effect will be to introduce unfairness and inequality of access and to deny local GP care to some groups of citizens—between 6.30 pm and 8 am, Monday to Friday, and all day on weekends and bank holidays—simply by virtue of where they live. In essence, for about two-thirds of the week patients no longer have continuity of care from their GP and are dependent on OOH services, some of which employ GPs or are run by GPs.

Quality of care

6. Many of the alternative providers of OOH care (i.e., NHS 24, community pharmacists, the Scottish ambulance service) are—though highly skilled—neither medically qualified nor trained in the full range of clinical emergencies or treatment provision. They cannot substitute for GP care.

7. Some health boards are also advocating the use of supplementary support from volunteers in the community under a system known as First Responders, for which the community may also have to pay. This has been both in addition to, or as a substitute for, GP services. Yet only a relatively small proportion of medical emergencies fall into the categories of care which First Responders can handle, and there is no evidence to support the service as an alternative to traditional GP cover. There are, however, considerable opportunity costs for the NHS, for community volunteers and for the public in time and money foregone, none of which have been systematically evaluated.

8. The evidence base for the cost-effectiveness, quality and safety of alternative systems and providers of care is not well-established, but some official evaluations raise concerns. In 2006, the National Audit Office reported that many OOH providers in England were not meeting national Quality
Requirements for access and clinical assessment, and that poor data management made it difficult to fully monitor and enforce mandated quality standards. An ongoing Care Quality Commission enquiry into OOH provider Take Care Now has found that nationwide monitoring of out-of-hours GP services may be inadequate. In 2007, Audit Scotland also highlighted: 1) no coherent national approach for monitoring and enforcement of standards; 2) a lack of clear quality standards for OOH services; and 3) no routine monitoring of how OOH services impact locally on other aspects of the NHS.

9. Some 13% of the population are estimated to use OOH care, and the NAO found that one in five patients reported having a negative experience. Research studies have also highlighted that many patients are confused by the new models and providers of care, unsure about whether and how to access it.

10. However, surveys of patient satisfaction with OOH care are not a proxy for data and information on access, quality, safety or coverage. Too often these are used as a substitute for adequate data on access by policy makers.

11. Contracting out introduces new costs, but so far as we are aware these have not been estimated in the case of OOH services. However, evidence is available from other parts of the NHS, where alternative providers are being introduced. For example, Independent Sector Treatment Centres and the Private Finance Initiative in hospitals have demonstrated increased transaction costs as a result of commercial contracting. They are also associated with loss of efficiency and integration, deskilling of staff and lower quality of care; all of which have implications for safety and quality.

Need for and access to care

12. Research evidence has shown that the opening hours of general practices influence patients’ healthcare seeking behaviour, and that lack of access may increase delay both in seeking treatment and obtaining assessment for certain conditions, such as minor strokes. Delay in seeking care is also associated with increasing age. People in remote and rural areas tend to be older, and already face substantial access barriers related to travel time, distance and lack of public transport; the removal of out-of-hours service will only increase barriers to care. People in rural areas are also more likely to delay in seeking care and to wait until they can see a GP.

13. A small population will generate low numbers of contacts and emergency contacts, but the need for care or the risk to that population is no less than
elsewhere; indeed, the older age profile of populations in rural areas would suggest quite the contrary. One local medical committee in Tayside misinformed the public and the panel in their evidence on KLR by equating small numbers of people living in a rural area with low clinical need and low risk.16

Cost and efficiency and affordability

14. The decision to remove services cannot be taken on cost grounds alone and is not a primary reason for departing from the core principles of the NHS and denying access to needed care. However, at least one health board, Tayside Health board, has tried to justify the removal of GP out-of-hours services on these grounds.

15. The total cost of providing OOH care in Scotland was estimated at £67.68 million in 2005-6, but there has been no evaluations of the costs and benefits of the changes to OOH provision.

16. Tayside health board has estimated the costs of restoring GP OOH service in one rural area, KLR at in excess of £500,000.17 These figures postdate the decision to withdraw the GP OOH service in KLR and are an ex post rationale for denying care. The health paper on costs in KLR is an illustration of the additional transaction costs of breaking up GP services and introducing a market in alternative providers, thus departing from the principles of risk pooling and cross-subsidization and seeking to devolve the risks and costs to small communities through contracting mechanisms.

17. In 2004, GPs were able to opt out of providing OOH care by forfeiting £6,000 per year per GP from their practice allocations. Tayside health board has not explained why in the case of KLR the cost of opting out from 24-hr care should be £12,000 (as there were 2 GPs who opted out), but that the cost of re-providing it should be in excess of half a million pounds. The NAO 2009 found that the amount of money that resulted from GP practices opting out of OOH care covered only 30% of the actual OOH costs in 2005-6, leaving a gap of 70%. Extrapolated to KLR, this would be at most £24,000 of additional funding at the level of the Scottish government or health board.

18. Through the mechanisms of risk pooling, service planning and reintegration, it is possible to arrive at efficient and clinically effective local solutions for OOH GP services, as in the case of Applecross and other rural areas.
20 January 2010

Agenda Item 2

Service data and information for monitoring

19. It is important to note that because rural areas are small and sparsely populated communities it will be difficult to monitor adverse events as a result of the denial of care, as deaths and poor outcomes will not reach statistical significance. Small numbers of people are not a reason for removing entitlements; to do so is to remove core entitlements from a particular group of citizens, undermining their rights to health care.

20. We have undertaken a review of the core data available to monitor access, quality and outcomes of new services for out-of-hours care and shown that the data and systems to monitor access to health care and coverage for out-of-hours services are fragmented, not comprehensive or integrated, and that it is impossible to monitor access, quality, safety or outcomes of care. This lack of consistent data besets ambulance service, NHS 24 and other alternative providers of care as well.

Key conclusions

21. The decision to remove a universal entitlement to OOH GP services in remote and rural areas—or indeed any area—is ultimately one for the Minister and for Parliament, as it goes to the heart of the principles of the NHS. The removal of GP OOH services will introduce unevenness and unfairness in provision of core services and could create a new minimum standard which could be used as a justification for removing care in future.

22. No evidence has yet been provided to support the changes and the introduction of alternative providers to GPs for OOH care.

23. The provision of GP services has been both affordable and efficient for sixty years, and by paying close attention to the mechanisms for funding and planning, other health boards have and continue to provide OOH care through GPs.

24. The claims about the rising cost of providing OOH GP services and the unsustainability of GP services need to be examined and subjected to scrutiny in the context of market transaction costs and the contribution that integrated services make to cost-effectiveness. For example, one of the consequences of breaking the link between OOH care and individual general practices has
been an increased rate of emergency admission, which has both cost and quality implications.¹⁹

25. Health boards should not be able to remove core rights and entitlements from groups of the population without the assent of the Minister or Parliament, and without undergoing a proper consultation with the local community that shows what the implications of the alternatives are.

26. In the case of KLR it is clear that public consultation was bypassed by virtue of a peculiar deficiency in the statute regarding the appeal mechanism for GPs and the panel. The community was denied the opportunity for a challenge, and this injustice has not been remedied.

27. The Scottish government should consider reviewing the UK GP contract with a view to replacing it with Scotland-specific primary legislation, building on its programme of service reintegration, planning and risk pooling; this will enable it to preserve universal access to essential skilled GP OOH services.

Prof Allyson Pollock
Director
The Centre for International Public Health Policy
9 November 2009
References:

12 Lasserson DS, Chandrathева A, Giles MF, Mant D, Rothwell PM. Influence of general practice opening hours on delay in seeking medical attention after transient ischaemic attack (TIA) and minor stroke: prospective population based study. BMJ 2008;337:a1569
17 NHS Tayside. FOISA Response 089709.
Inquiry into out-of-hours Health Care Provision in Rural Areas

NHS Tayside GP Sub Committee

Enclosed (below) is correspondence sent by NHS Tayside’s GP Sub Committee to the Board Chairman outlining the committee’s view of the OOH situation in Kinloch Rannoch, Perthshire.

In summary the committee is of the view that:

- Due to diseconomies of scale Out of Hours care costs more per head of population in rural areas.
- There are health advantages of living in rural areas.
- We need to be mindful of the Government Inequalities agenda within the context of our limited health resources.
- We need to modify urban solutions to Out of Hours care with multi-faceted solutions tailored to local circumstances including NHS 24, Health Board OOH services, the Scottish Ambulance Service, community nursing, community hospitals, non opted-out general practitioners, Community First Responder schemes and other voluntary community services.

I trust you find this information of use in your deliberations.

Enc – Ref: AB/HD

19 October 2009

Board Chairman
NHS Tayside

Dear Mr Watson

Kinloch Rannoch OOH Provision

I write as chairman of the General Practice Sub committee of NHS Tayside’s Area Medical Committee to express the profession’s view of the debate regarding the OOH arrangements in Kinloch Rannoch (KR).

The committee believes that since becoming responsible for OOH cover in May 2006, NHS Tayside has worked hard in partnership with the KR community to develop solutions to meet their OOH needs and we support the actions taken by NHS Tayside to secure what are in our view, comprehensive and appropriate arrangements that meet the level of demand.

This now includes:-
Agenda Item 2
20 January 2010

- NHS24 nurse advisers
- NHS Tayside OOH visiting doctor service with based at Pitlochry/Aberfeldy
- Nurse led minor injury unit in Pitlochry
- SAS Rapid response vehicle based in Aberfeldy
- Community First Responder scheme linked to SAS
- Ambulance service based in Pitlochry
- Emergency Medical Retrieval Service helicopter cover

We must now ensure that these services are well integrated and co-ordinate their operations optimally and that these service options are understood within the locality.

The committee is aware that in the last year the NHS Tayside doctor has visited Kinloch Rannoch patients on a total of 19 occasions during the OOH period. In more than 3 years since NHS Tayside took over responsibility there have been no reported significant adverse outcomes. That is of course not to say that one will never occur but we do not support the additional investment of a figure reported to be around £150,000 in order that a doctor be based in the village throughout the OOH period. At a time where the NHS is required to offer value for money on public spending, this cost of around £12,000 per month for one or two patient contacts cannot be justified. From a professional perspective, it is also highly questionable whether this low level of activity could maintain a doctor’s clinical skills.

For the residents of KR, living in this community has many advantages that benefit health such as a healthier environment, lower crime rates, and low unemployment. Due to diseconomies of scale, NHS Tayside invests significantly more per patient in order to support a full time doctors’ surgery providing a range of GP-led services during surgery hours, and, as a consequence of low patient numbers relative to doctor availability, we consider that residents of KR have a superb day time service with arguably the best patient access in Tayside.

We must ensure that our health resources are utilised where they can do most good for our patient population. We recognise that that means difficult choices have to be made as expenditure in one area may come at the expense of another. We believe Kinloch Rannoch to be a relatively healthy place to live and that while due to its rurality, NHS Tayside rightly provides extra per capita resources for health care, there need to be limits. The most recent life expectancy data available show that the average man living in the KR postcode area will live for 79.3 years, this compares with the Scottish average of 73.9 years (and just 65.1 years in the most deprived part of Dundee). Such a difference in life expectancy within Tayside makes it difficult to justify the cost of providing permanent OOH cover in the community – particularly when such resource could be targeted towards meeting the health needs of the poorest patients in Tayside, and where there is no evidence that the current service delivery provision is adversely impacting on the residents of KR.
Finally, as you will be aware, the Scottish Government through *Better Health, Better Care* (2007) and more recently *Equally Well* (2008) has identified addressing health inequalities as a major priority for the health service. For all of the reasons given above we believe that there are greater health priorities in Tayside that we must address.

We would welcome your comments on the contents of this letter.

Yours sincerely

Dr Andrew Buist
Chair
NHS Tayside GP Sub Committee
28 October 2009
Introduction

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 doctors representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 13,400 doctors.

The British Medical Association (BMA) welcomes the opportunity to provide the Health and Sport Committee with written evidence on the changes to out-of-hours provision in rural areas and the effects of these on the quality, accessibility, availability, sustainability and cost of out-of-hours care in rural areas.

Each year more than a million contacts take place with primary care out-of-hours services across Scotland. Prior to 2004, GPs were responsible for providing out-of-hours services to the population. Following the introduction in 2004 of the new General Medical Services contract, NHS Boards took over responsibility for providing out-of-hours care to the majority of the Scottish population. One of the major drivers behind the new contract was to alleviate the pressure on GPs to provide a 24-hour on call commitment which had contributed to a crisis in GP recruitment and retention. Doctors were working excessively long hours, and rural communities in particular were at risk of losing daytime GP service at the expense of out-of-hours availability. A minority of GPs, mainly those in remote and rural areas, have retained responsibility for the 24 hour care of their patients, primarily because no sustainable alternative arrangement could be put in place. In 2008, 51 out of 1025 GP practices continued to be responsible for the provision of out-of-hours cover in Ayrshire and Arran, Grampian, Highland, Orkney and the Western Isles. Although 95% of GP practices in Scotland no longer have responsibility for the provision of out-of-hours care to patients, many GPs continue to perform out-of-hours services on behalf of NHS boards.

The term "remote and rural" is often seen as synonymous with the "Highlands and Islands", but almost all NHS boards in Scotland include GP practices which can be classified as either remote or rural, so the problems of geographical remoteness and accessibility are fairly widespread. It is recognised, however, that the degree of remoteness or rurality differs enormously across the country in terms of accepted indicators such as sparse population, distance from centres of population and the perception of being rural.

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1 Primary Care Out-of-Hours Services, Audit Scotland Report, August 2007.
2 Information Services Division Scotland (ISD).
4 Rural General Practice, Fact sheet 23, November 2004, Royal College of General Practitioners.
Earlier this year, the Scottish General Practitioners Committee of BMA Scotland consulted with stakeholders across Scotland on *The Future of General Practice in Scotland: The Way Ahead* seeking to define a long term vision for Scottish general practice. It is expected that the final report, which will include recommendations on out-of-hours care, will be published in early 2010.

1. What do you think is the most sustainable and cost-effective way to provide adequate out-of-hours services in rural areas?

The cost of providing out-of-hours primary care per head of population varies across Scotland, with the degree to which each Board is remote and rural being the single biggest determinant of that increased cost. According to Audit Scotland, in 2005/06 the cost of primary care out-of-hours services per head of GP registered population was £7.61 in NHS Greater Glasgow against a figure almost six times higher in Argyll & Bute of £43.63.\(^5\) The out-of-hours service provision in Argyll & Bute has to cover a number of small islands and a scattered population across a large geographic area, and this difference in cost of out-of-hours service provision between urban and rural areas is replicated across the rest of the country.\(^6\)

It is essential that NHS Boards do not simply seek to replicate out of hours services that mirror those established in urban communities. One size does not fit all and unique solutions are required to overcome the challenges of providing this care in remote and rural communities.

Robust, flexible and sustainable out-of-hours care should be provided as locally as possible to patients in remote and rural areas. There must be a whole system approach for service provision in rural areas which develops and integrates all services available, including GPs (including those trained in BASICS\(^7\)), NHS 24, the Scottish Ambulance Service (SAS), community hospitals, community nursing, the Community First Responder scheme, the Emergency Medical Retrieval Service helicopter cover, the air ambulance service, and voluntary community services.

To ensure that the strategic planning, commissioning and delivery of out-of-hours services are appropriate and adapted to local needs, NHS Boards and NHS 24 should work in greater partnership with community and service providers to develop solutions which meet local out-of-hours needs. In particular, they should draw on GP expertise which is based on a long history of providing 24 hour care to patients in remote and rural areas.

\(^5\) Primary Care Out-of-Hours Services, Audit Scotland Report, August 2007.
\(^6\) Ibid.
\(^7\) BASICS Scotland is the British Association for Immediate Care, Scotland. Immediate care doctors are specialists, trained to provide medical support at the scene of an accident or major medical emergency, or while patients are transit to hospital [http://www.basics-scotland.org.uk/](http://www.basics-scotland.org.uk/)
The rapid increase in the numbers of patients aged 65 and over who experienced two or more emergency admissions in a single year highlights the importance of preventive and anticipatory care for older people which can prevent multiple admissions.\(^8\) A report on Managing Long Term Conditions published by Audit Scotland identified the management of long term conditions as the biggest challenge facing healthcare systems worldwide.\(^9\) One of the key factors in providing sustainable and effective out-of-hours care in rural areas is the importance of work with patients during daytime hours on self-care, anticipatory care and long term condition management, all of which will reduce the need for patients to access out-of-hours care, reduce hospital admissions and prevent life-threatening episodes. Low GP list sizes and better daytime access to GP services with increased opportunities for proactive anticipatory care are included in the many health advantages of living in a rural as opposed to urban areas. Anticipatory care in general practice has also been substantially enhanced by the introduction through the nGMS contract of the Quality and Outcomes Framework (QOF). The QOF has helped general practice to further improve on the provision of quality evidence based care to patients with long term conditions.

2. What are your views on the quality of out-of-hours care provided in rural areas, in particular clinical safety and effectiveness?

NHS Quality Improvement Scotland (NHS QIS) reviews of out-of-hours provision in Scotland against NHS QIS standards have demonstrated that quality performance targets have been met across Scotland.\(^10\) To maintain quality, clinical safety and effectiveness in out-of-hours provision, skilled medical input should be available at the triage stage to ensure appropriate response times and prevent unnecessary transfers or hospital admissions.

Although the cost of providing out-of-hours care is higher in rural areas, reductions to existing service provision must not be made on the sole basis of reducing costs. NHS Ayrshire has recently reduced the number of mobile cars available overnight by one third which has led some GPs to raise questions about patient safety and risk, and could potentially increase pressure on the Scottish Ambulance Service.

It is important that there is appropriate and ongoing training for all out-of-hours service providers in rural and remote areas. Doctors who do not routinely participate in out-of-hours care may become deskillled in providing emergency care. It is important that educational training programmes comprise appropriate remote and rural placements, particularly at an early stage in a doctor’s career, which may include more Foundation Year attachments in rural practices. The GP Rural Fellowship Programme offers qualified GPs a further year of supported training in rural practice which gives GPs the

\(^8\) “The system of unscheduled care in Scotland: variation in the level of emergency inpatient admission by GP Practice”, Delivering for Health Information Programme, ISD, December 2006
\(^9\) Managing Long Term Conditions, Audit Scotland, August 2007
\(^10\) The Provision of Safe and Effective Primary Medical Services Out-of-Hours, Summary of Follow-up Assessments, April 2008, NHS Quality Improvement Scotland.
opportunity to develop a career in rural practice. This may encourage doctors to choose to continue their careers in remote and rural areas, and could help with recruitment and hence long-term and stable provision of out-of-hours services to rural communities.

3. What are your views on the accessibility and availability of out-of-hours care in rural areas?

Inevitably there are differences in the accessibility and availability of out-of-hours care in rural and urban areas across Scotland. All patients, however, should receive a high quality, seamless service that is safe, reliable and efficient. The geography of Scotland precludes a one size fits all approach and we consider that a greater emphasis on collaborative work between different service providers in developing out-of-hours services, that are tailored to local circumstances, would ensure maximum efficiency, effectiveness, patient safety and value for money in rural areas.

Patient expectations must be managed appropriately as urban solutions cannot be replicated across all parts of Scotland where there are significant geographic and transport differences. There needs to be flexibility to allow for local variation, and access to out-of-hours provision should be as local as possible, utilising the best skill mix available in each area. It is inevitable that in some remote locations it will not be possible to have 24 hour GP presence within the locality and that alternative arrangements involving the full range of service providers may be more appropriate.

It should be noted that access to high quality general practice ‘in hours’ (i.e. 8am – 6pm) can reduce demand on out-of-hours services.

4. How well do you think NHS 24 and the Scottish Ambulance Service links in with existing out-of-hours services?

Out-of-hours care includes all areas of the health service, and it is important that people are well-informed about available services to help patients make informed decisions about how to access the most appropriate treatment at the right time. Integration and co-ordination between the out-of-hours services provided by local NHS boards, NHS 24 and the Scottish Ambulance Service should be improved to promote whole system efficiency.

It is also important that NHS 24 continues to focus on the existing core triage services it offers; improves the way in which these services are delivered to patients; and prioritises efficient delivery of its core business. The continued improvement of out-of-hours service provision should be NHS 24’s primary priority and the main focus of NHS 24 activity. Anecdotal GP evidence suggests that there are unresolved issues with NHS24 communication in some remote and rural areas, and the national model is sometimes seen as having insufficient knowledge of local service delivery. It is vital in remote and rural areas that local circumstances are fully understood and taken into
account when decisions are being made on the appropriate out-of-hours response. There is a need for further improvement in triage and call back times. Development of the NHS 24 service should include greater local coordination and active engagement with NHS boards at a local level.

The provision of immediate life support and the appropriate transport of patients must remain the first principle of the Scottish Ambulance Service (SAS). The SAS has a crucial role in responding to life-threatening rural emergencies, and the air ambulance service and the Emergency Medical Retrieval Service are valuable resources in the provision of out-of-hours care. The SAS first responder system is valuable for community resilience and for providing initial support, but as a volunteer system it must be fully supported. The seven possible models of care outlined in the SAS consultation Our Future Strategy to improve emergency response models in remote and rural areas are currently being appropriately explored in local areas to establish the combination which most suits specific circumstances. These possible models of care provide a flexible emergency response system which can be tailored appropriately for communities.

In conclusion, all patients in Scotland should expect to receive a high quality, seamless out-of-hours service that is safe, reliable and efficient. They should experience good continuity of care through close co-operation between different service providers. However, one size does not fit all in a country with the geography of Scotland and while it must be accepted that per capita costs rise with rurality we must also ensure that we make best use of increasingly scarce NHS resources and find an appropriate balance between the competing health needs of the Scottish population.

Dr Andrew Buist
Joint Deputy Chairman, Scottish General Practitioners Committee, Lead on Remote and Rural issues
British Medical Association
6 November 2009

Inquiry into out-of-hours Health Care Provision in Rural Areas

Royal College of General Practitioners Scotland

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the ‘voice’ of general practitioners on education, training and issues around standards of care for patients.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish Health Service. We currently represent over 4000 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

Supporting GPs in Remote and Rural Areas

The Royal College of General Practitioners as a whole is committed to supporting the specific needs of GPs in remote and rural communities and recognise that the training and support needed for our members in these areas is markedly different to that required by GPs in urban areas. The College has recently introduced the RCGP Rural Forum which has been created to support GP revalidation and investigate education that seeks to ensure recruitment and retention in rural practices. It will also be the focus for improving communication with rural members, offer input for CPD programmes and research, and will provide the rural perspective in shaping College policy.

The aims of the RCGP Rural Forum are:

- To represent rural and remote GPs, and promote rural issues inside and outside the College faculties
- To encourage rural GPs to engage with the College
- To advance the College’s objectives in rural practice
- To facilitate communication and networking of rural doctors in the UK
- To support the professional development of rural GPs
- To promote remote and rural issues at appropriate levels, engaging with the profession and managers, and informing political debate

Membership of the Rural Forum is open to members across the UK. In addition to the RCGP Scotland response we have attached a formal response from the RCGP Rural Forum as an appendix to this response document. The RCGP Rural Forum response has drawn from the views of Scottish members of the RCGP Rural Forum.
RCGP Scotland also works directly to support its Scottish members in remote and rural areas through various events and initiatives. Currently Dr Susan Taylor acts as the Remote and Rural Lead on the RCGP Scotland Membership Liaison Group in order to inform work in relation to remote & rural activities through the development and facilitation of relevant programmes of work. Dr Susan Taylor is also the Chair of the Remote Practitioners Association of Scotland.

Response to the Call for Evidence

The call for evidence request received from the Health and Sport Committee of the Scottish Parliament was circulated to RCGP Scottish Council, Executive Board, Membership Liaison Group (MLG) and the RCGP Scotland patient group, P3 for comment. In particular responses were sought from grassroots members working directly in remote and rural areas through the five Scottish Faculties.

We received a large number of detailed and lengthy responses to this consultation, which highlights not only the importance of this topic, but also the strong views held by many of our members (who are directly involved in the provision of out of hours care in remote and rural communities). We received responses from members across a wide spread of Scotland including significant responses from in and around the Isle of Skye, Isle of Lewis, Kyle and Lochalsh, Ullapool, Gairloch, Inverness, Fort William, Oban, Aviemore, Moray and Glenelg. In order to reflect the views of our members in a meaningful way, we have included large sections of the responses received in order to best reflect the voices of GPs in these areas.

1. What do you think is the most sustainable and cost effective way to provide adequate out of hours service in rural areas?

From the large number of responses received, it is our view that ‘a one size fits all’ approach is not feasible for remote and rural areas across Scotland. GPs who responded to this call for evidence felt that remote and rural out of hours (OOH) care features a wide variety, but low frequency of any particular clinical problem. Those responsible for providing OOH care in remote and rural areas must be fully trained and confident to deal appropriately with an extensive range of clinical issues.

As such, suggestions received for the provision of a sustainable and cost effective OOH service varied slightly but key themes were strongly evident throughout the individual responses received.

- I think that provision of OOH primary care and emergency response to medical emergencies would be best provided by local doctors who know the patients and the area well. This means a better standard of care and is likely to reduce admissions to hospital as doctors who know the patients
are more likely to elect to manage the patient at home and to be able to follow them up. Local doctors are trained in pre-hospital care and are able to provide a good minor injury service. Local doctors are also well placed to provide a high standard of palliative medicine and terminal care at home.

- Support local GP cooperatives to provide local and sustainable solutions. These should allow opt in/out of individual doctors, but seek to use local staff to provide a service with good continuity with daytime general practice.
- Over the last 8 years there have been so many options explored and for certain areas we come to the same conclusion that a motivated BASICS (The British Association for Immediate Care) trained GP is virtually impossible to replace.
- One option would be to adopt the Scandinavian model where small remote and rural practices would revert to being single-handed and the GP on-call 24/7.
- In Glenelg a GP needs to be part of the out of hours team 24/7, 365 days per year but I emphasise definitely needs to work as part of an evolving out of hours team.
- Giving contracts to local GPs to organise and subcontract to known local sessional doctors must be the way forward, perhaps operating as cooperatives. They would not be expected to provide all the service provision personally. However this would have to be done on a 3 or 5 year basis, so they could plan how to provide this cover e.g. by taking on extra doctors as partners/salaried or by using nurses for parts of the shifts.
- Incentivise the local GPs to deliver the service or support paramedics to act as the first line of response/assessment with GP to back up more centrally.
- If local GPs are prepared to cover larger localities during OOH (accepting busier OOH shifts with the advantage of less frequent OOH duties) then this can usually be done with the GP and a dual role driver/receptionist. Having nurses working alongside you is a luxury in rural OOH but not essential in my experience of OOH.
- Many years ago, the Highlands were given special provisions to ensure GPs in all communities. The community is reliant on the availability of adequate care for its survival. A group of other providers would be more expensive, difficult to coordinate (and look at the coordination problems we have already) and difficult to train, recruit and retain staff for (also demonstrated by existing difficulties). There are GPs already in rural areas and where possible they should be used to provide OOH services.
- I think that the most sustainable and cost-effective means of provision may vary according to population density and distribution of existing services, but central, protocol assisted nurse triage, supported by local General Practitioners with training and experience of unscheduled care works well. General Practitioners are trained at great expense to be good at assessing and managing risk. It is a waste of resources to have
General Practitioners working in rural areas but not involved in OOH care. At present, many rural GPs do not provide OOH care, for a variety of reasons, and it is impossible and undesirable to have all rural GPs involved in OOH care, but steps should be taken to encourage more GPs to be involved.

- Properly trained GPs are able to provide a complete and broad range of services. This allows patients with all conditions to be dealt with primarily at one source. They can provide GMS services but also minor and major injuries, emergency mental health (for instance section patients), palliative care, medical emergencies and life support, BASICS type trauma work, midwifery support, deal with borderline clinical decisions (for instance in elderly patients who may be better kept at home). The list is large and not complete. There are numerous occasions when we have dealt with incidents where only a GP in the community can deal with it. It would take an impossible raft of alternative care providers to give this breadth of service. Suggestions of using nurse practitioners have been made. However the difficult situations and breadth of problems dealt with by GPs providing OOH care would mean this would be grossly inadequate. Simply the long time (up to 4 hours) until ambulances can be obtained is enough to make this unsafe.

As such, RCGP Scotland believes that the model for the most sustainable and cost effective way to provide OOH care in remote and rural areas of Scotland would utilise both the skill set and local knowledge of General Practitioners in order to maintain (as far as possible) good continuity of care for patients in these areas. Options would be dependant on local geography and service provision but examples provided above such as the Scandinavian model, locally run GP cooperatives or a BASICS trained GP as part of a response team would all be viable options in certain areas. Some GPs felt that nurses and nurse practitioners have a viable role in their local areas, but some also felt that their areas did not require such provision and as such, this may need to be reviewed on a local level to ascertain effectiveness. Clearly a strong multi-disciplinary team approach is necessary with strong working relationship between all members of the team including the Scottish Ambulance Service and NHS24 but greater cost effectiveness can be achieved with the strong inclusion of General Practitioners with their own multi-disciplinary skill set to deal with or support a wide range of cases.

General Practitioners (particularly those who possess training under BASICS run Local Immediate Care Schemes) possess a broad scope of training and experience which allows them to respond well to situations which require either sophisticated risk management and/or the advanced skills to deal with serious acute medical and surgical emergencies. Knowledge of local geography and local service provision is regarded as an absolute requirement in remote and rural areas as it ensures not only a rapid response but also one which safer for
patients, more efficient and more cost-effective. This will be discussed further in relation to clinical safety and effectiveness.

2. What are your views on the quality of out-of-hours care provided in rural areas, in particular clinical safety and effectiveness?

RCGP Scotland received responses from members in remote and rural areas across the geographical spread of Scotland. Views on the current quality of out of hours care varied across responses but it was acknowledged that current services work well in the Mid-Highland area including Ullapool, Aviemore, Fort William, Isle of Skye and Gairloch:

- We receive excellent support from the air ambulance and the Coastguard helicopter when required. District Nursing support has changed significantly recently, with nurses no longer being on duty OOH in the more rural parts of our practice. This has led to people in these rural areas becoming concerned at the level of local health care provision and has led to the introduction of a self help first response scheme. We consider ourselves to be part of the emergency service, in a way that would not be appropriate in a city, attending medical emergencies (for example providing thrombolysis) and attending road traffic accidents that would not be seen by city GPs. We also provide a much more extensive minor injury service than would be the case in a town with an A&E department.

- In Fort William, we have a very high value cost effective out of hours system which has led to the maintenance of peripheral daytime rural GP provision in outlying areas. It is now a better service for patients and is safer for the GPs involved and manageable with daytime provision of care within current funding arrangements. It is evolving into an out of hours team approach and the governance standards through focussed out of hours online learning and incident reporting is a welcome new initiative.

- I can only speak for myself and the knowledge I have of my area and it is of excellent quality all round. On a more general note, if it is co-ordinated locally it works well but if it is run from another area, where the distances and road conditions are little understood then there are problems.

However, many responses were also received which cited problems with the current provision of out of hours:

- While I believe that the current service, which uses local GPs, has very good standards of clinical safety and effectiveness, I do however have concerns about the lack of clinical governance support and structure. We rely on the use of informal systems within individual practices, and are therefore missing the opportunity to learn as an OOH service from our strengths and weaknesses, and by not having a clinical governance mechanism specific to OOH, those clinical staff who are not also routinely
employed in daytime general practice (all the nurses and some GPs) miss out on this essential learning activity. I do not think it is acceptable for any clinical service to function without clinical governance mechanisms in today's world, and OOH services should have this built in, and allowed for in all cost calculations.

• As I've stated earlier, an up to date BASICS trained GP is almost impossible to better. Particularly if this is backed up with a paramedic ambulance crew within 30 minutes travel time. Where this occurs quality is good. It deteriorates when the ambulances become single-manned or doesn't even exist. Also some locum provision in some areas leads a lot to be desired.

• The organisation of the service is weak and fragmented, it is not clear who is responsible for what and the governance systems are poor. I have never been asked for proof of my qualifications/experience. Feedback and questions about the service go unanswered. Communication with OOH GPs is variable. The system appears to be run by administrators without a strong sense of leadership or clinical responsibility. These problems with the organisation of the service increase the risk of patients receiving poor care or a serious adverse event.

• The model for rural OOH in Highland at present we feel could be sustainable, safe and reasonably cost effective given our rurality, if it was better managed. The main problem has been the disenfranchising of local GPs with the attendant loss of goodwill. Many do provide OOH cover during the week, but some have opted out of weekends, either completely or partially. Using locums per se is not an issue if local sessional doctors are used, but it becomes enormously problematic when doctors are shipped in from overseas for a single weekend, with no prior knowledge of the geography or local service provision. Single track roads and patchy mobile coverage are not something that overseas or urban doctors are used to and of the patchy ambulance coverage, the OOH GP must also be BASICS trained, which is not a given for most overseas or urban doctors.

• The system we have here is safe and effective. The least safe and effective part is NHS24. When GP cover was taken away at nights and weekends from most rural practices, no attempt was made to beef up cover by the Ambulance service, and this is often the rate-limiting step in the process.

• Living in an area remote from frontline medical help and, by definition, from acute secondary care carries risk. The aim must be to reduce the risk as far as realistically possible within acceptable limits.

• On the whole, in my experience, the current system provides high quality OOH care in most areas. Difficulties arise when ambulances are single-manned due to sickness absence or annual leave of crew, or when the nearest ambulance is engaged in another task. In such circumstances it is clearly especially vital that a GP is available to provide an additional emergency response in the community.
• There have been fairly serious concerns about locums employed for OOH cover on occasions. On one occasion we had to ask the OOH manager to tell the locum to stop working and take over ourselves as they were inadequately prepared and trained and had very poor English. On another occasion a complaint was made leading to a GMC referral on one of the locums. The locums sometimes come from other European countries and cannot speak or understand English very well and additionally do not have the breadth of training and experience of general practice in Britain let alone remote and rural areas. GP training and GP work is not the same all over Europe and understanding and dealing with this is vital to prevent dangerous practice.

• As a GP continuing to provide OOH services to my own patients, I certainly meet all the quality targets, although the ability of patients to actually get put through to my care, using NHS24 systems is constantly being challenged. Patients with minor injuries are frequently told to drive to the nearest A & E dept in either Oban or Fort William (at least 90 minutes away) if the local ferry is running. We also have a misleading postcode which identifies the village as Oban and patients can be given appointments for the Primary Care Emergency Centre in Oban. I have a notice in my practice leaflet informing visitors and patients not to accept this advice, but to insist that there is a local GP on duty, who can be contacted via the Highland Hub system. Because the NHS24 system is so slow. Many patients (around 30 % of all OOH calls) will use a direct approach to the GPs in the area - whether they are on duty or not.

• The quality of care currently provided is variable and there are concerns about clinical safety e.g. some areas currently operate a ‘see and treat’ service where the patient is seen by a paramedic and a nurse rather than a GP. In those instances there is concern about the level of care being given and the follow up of the patient. It is important that adequate feedback is given on the quality of care provided from both the patient and their usual medical attendant. There are currently many inconsistencies in the service which need to be addressed through a rigidly enforced system of clinical audit against clear national clinical standards.

In summary, whilst in urban areas OOH care can be managed effectively on an increasingly centralised basis, the most effective system in remote and rural areas continues to be through locally run service provision. The main areas where problems are arising, based on the anecdotal evidence we have received, seem to be around local geography issues and postcode confusion.

Another safety issue for OOH in remote and rural areas is the danger of the roads, for both patients and healthcare providers. Provision of service on a local level lessens this risk by ensuring as far as possible that staff are familiar with the roads and difficult to find locations. For OOH healthcare providers there are specific risks which must be taken into account, for example deer jumping onto icy or windy roads in the path of the car, as well as lack of mobile reception.
The introduction of drivers, trained in basic life support to provide transport for OOH GPs and staff has been a major benefit, but it must be noted that drivers can cover over 300 miles during the course of three call-outs often under the conditions listed above.

Whilst some GPs are reported as feeling disenfranchised, some are highly enthusiastic about the provision of OOH cover as demonstrated by the high volume of responses we received from OOH GPs. Some OOH GPs also reported being bypassed by NHS24 with patients being asked to travel to the hospital unnecessarily. Where such long distances on difficult roads are involved for patients to attend accident and emergency departments there is a clear need to triage calls efficiently to prevent these unnecessary referrals by utilising the full extent of local resources available.

3. What are your views on the accessibility and availability of out-of-hours care in rural areas?

As mentioned above, the main barrier to accessibility and availability is generally considered as geographical exemplified by postcode and area confusion; the long distances which are needed to be covered to provide and access care and the danger of the roads themselves particularly in the winter months. In addition to this please find below a list of some of the individual comments received from GPs in remote and rural areas, many of whom are directly involved in OOH care provision:

- Our practice area has a Primary Care Emergency Centre based 20 miles away in Portree and a somewhat more acute centre based in Broadford some 50 miles distant (around an hour away). Just now we have OOH cover provided 1800-2300 at Portree; it then switches to Broadford after 2300 but with a 'second on' doctor in or near the hospital available if needed. It is largely a doctor lead service, staffed mostly by the rural practitioner team from Broadford, but also by a number of North Skye GPs including myself. This situation has served since 2004 and all involved acknowledge it is of a good standard, very safe and effective. There is no doubt that the public view is that it should simply continue.

- NHS24 find dealing with the geography of the Highlands difficult. The Highland Hub on the other hand is very good, and once the patient call gets through to the Hub they are dealt with in a very sensible manner.

- I have regularly worked out of hours shifts on the west coast of the north of Scotland, namely Ullapool, Gairloch & Aultbea and Lochcarron & Torridon. Currently I have been working 2 weekends a month in these areas. These practices are approximately 90 minutes road time from the nearest district general hospital in Inverness. There is also a Scottish Ambulance Helicopter based in Inverness, as well as the RAF and coastguard helicopters that are sometimes deployed in particular for hill
walkers/climbers. They have populations of around 2000 each with 4 local GPs in each patch. Each patch includes a local nursing home. In two of these areas there are some patients who can only be reached by boat or a 4 mile path which is unsuitable for vehicles. In each patch the geographical coverage can be up to one hour driving time from the base practice. Each patch has an ambulance, but this does not always have a paramedic and is sometimes only single manned. The average number of patient contacts over a 62 hour weekend period is 6 - 8. But this can double, especially during summer months or holiday periods. In the areas I work this is pretty good, there is probably a financial and clinical argument for reducing and centralising the number of GPs employed in each patch, which would lead to longer waits or journey times for patients and stretched GPs. Patients frequently report dissatisfaction with the length of time it takes to have calls taken and triaged by NHS24.

- My practice in Fort William provides training, student training, occupational health services to local industries, police work and some of the partners are Major Incident Medical Management Support trained and BASICS trained. We have excellent relations with local paramedics, Macmillan nurses, community psychiatric nurses, social work and the local hospital. We work out of a purpose built new health centre with two other teaching practices and community services. This has facilitated closer working. The appointment of a social work manager to a health care manager’s post made a huge impact on closer working between social work and health which lingers on. There is a rural general hospital in the town with an A+E department, consultant surgeons, anaesthetists and physicians. The A+E deals with A82 road trauma and Mountain accidents of which there are many. There is a Midwife Unit, a (privately purchased) CT scanner and a renal dialysis unit. Chemotherapy is carried out at the hospital and some bowel cancer surgery and minimal access surgery.

- My only experience is in Lochaber which seems to provide excellent availability and accessibility.

- In Inverness services can be delayed at times given the geography difficulties and sometimes phone lines direct you to an inappropriate plan of action.

- The service is fairly accessible up to 11pm. After that, there is only one Primary Care Emergency Centre open, in Broadford, so patients in the North of Skye will have at least a 100 mile round trip to see a doctor. If you told people in Brighton that after 11pm they would have to drive to London to see a doctor there would be uproar, but our patients have to cope with single-track roads, gales, ice and snow and driving through mountain passes at night with only one petrol station open at night in the whole island as well as the very real risk of a collision with a deer.

- In our area of Berwickshire the service is excellent.

- Good at the moment on the Isle of Lewis as it is quiet and there are few people. Services may be poor in the future when many extra tasks will be added.
• Access to OOH is reasonable in Gairloch as long as a GP remains in the area. There are no other supports for primary care such as A+E and there is limited support from services such as district nursing and psychiatry. The GP remains a vital piece of OOH care particularly with the distances involved. Availability is generally good; however integration of the new systems such as NHS24 and the increased use of the Scottish Ambulance Service need to be improved. This should then mean the service will be safe and effective.
• Currently the accessibility and availability of OOH care is satisfactory in most areas. If there were any reduction in GP cover then this would suffer considerably.
• Within my own area of Morvern, patients will easily be seen within 1 hr as long as they can get through to NHS24 and get the call correctly triaged, so the GP is always available, but NHS 24 systems can sometimes prove a barrier to accessibility.
• In Badenoch and Strathspey some elements of the care package are less accessible, e.g. patients can no longer speak directly to their own GP. But others elements are more accessible – many patients value the ability to obtain telephone advice from someone professional, but anonymous, without fear of ‘disturbing’ them. Most patients who are fit to do so, seem happy to attend the OOH centre, and are complimentary of the care that they receive there.
• There is a service in place in the east of Scotland but there is a question around the quality of this service and who is providing it e.g. is the patient being seen by a GP or under the ‘see and treat’ service.
• There is good accessibility and availability in Dunoon.

4. How well do you think NHS24 and the Scottish Ambulance Service links in with existing out-of-hours services?

As noted above, anecdotal evidence from our members suggests that whilst service provision from both NHS24 and the Scottish Ambulance Service is generally sound, there are some inconsistencies largely on a local level which need to be addressed. In particular this refers to the lack of local geographical knowledge encountered when using NHS24 for service in some remote and rural areas and the issue of single manned ambulances. Both these issues were recurring themes in the responses received and both of which need to be resolved in order to both protect patient safety and ensure an efficient cost-effective service.

Please find below an outline of some of the responses we have received from grassroots GPs in relation to this question, which may provide more detailed insight on the regional variations of service provision:

• In Gairloch I feel that by and large with the current situation the clinical quality and effectiveness of OOH care has been reasonable. There is
always a GP available in the area and district nursing teams provide additional OOH care for known palliative care cases. NHS24 has been used in the area since the New Contract. It has been fraught with problems particularly with regards to rural/remote type areas. The system used does not understand that our practice is 70 miles from the nearest A+E unit and therefore we provide a service for these patients. They often do not know that there is a doctor in the area as we are apparently not able to be marked as a Primary Care Emergency Centre here. Initially the service was dangerously slow for emergencies, but this has been improved. In addition we have tried to inform our practice population to call 999 for more severe emergencies where they would previously have called the GP directly. However the NHS 24 system still fails to obtain a GP directly and often the Scottish Ambulance Service or ambulance crew have to request this once the call has been passed through to them. Minor injuries are occasionally told to go to A+E 70 miles away whereas the GP could deal with it and in other cases the patient has been put in danger or discomfort by having to delay assessment until arrival in the A+E unit.

- More significantly injured patients have been left without analgesia or assessment (e.g. fractured hips) waiting for the ambulance when the GP has not been called by the NHS24 system. The ambulance service has had additional pressure to provide OOH care and, as noted above, is called more frequently now. They do often request GP assistance for several reasons, mainly trauma situations, medical emergencies and upon direct request by the ambulance crew. We are often called because the ambulance is unavailable and this is one of the reasons the GP in the area is so important. This may be due to them taking a patient to the hospital already (a 4 hour turn around at least) or if they are called to another area. Additionally ambulances are more frequently used for patient transport (as there is now no ambulance car service in the whole area). They have been single manned on many occasions which makes the ambulance unable to transport and deal properly with patients. In the area we do not have the adequate number of paramedics to have a paramedic on the ambulance at all times. I believe the numbers are fewer in neighbouring practices. Sometimes it has been suggested that the helicopter service is a useful back-up but this is only an additional service, as an ambulance is usually needed to get the patient to the landing site and the helicopter cannot land in the dark or fly in bad weather.

- NHS24 and Scottish Ambulance Service links have improved considerably, particularly with the opening of the Hub in Inverness. However there is still a lack of appreciation of the differences between a Primary Care Emergency Centre, which is staffed, and an on call doctor who has to work the day before and the day after being on call through the night. This means that the triage is sometimes inappropriate. Patients are also sometimes directed to A&E when it would be appropriate for them to be seen locally by the GP on call, meaning that they have a 110 mile round trip which could have been avoided by the local doctor dealing with
their case. Integration with the Scottish Ambulance Service is patchy, with the GP sometimes not being called to a serious incident. There used to be a “dual response” system where the GP and ambulance were tasked at the same time, but this system has been abandoned (without GP consultation). Recently a volunteer First Response scheme has been set up, which is useful, but sometimes does not integrate particularly well with GPs (i.e. we are not called). There are still geographical misunderstandings which could easily be sorted out by consulting a map, a patient in Ullapool was asked to attend the hospital in Stornoway as it was the closest geographical hospital despite it being across the Minch.

- NHS 24 usually links in well, although at times, the centralising of the telephone triage results in delays in access to medical care due to central high call volumes, even when the local service is quiet. The Scottish Ambulance Service also appears to use us appropriately, by and large, and I feel that our support by receptionist and driver helps with both of these areas.

- On the Isle of Skye as you would expect, local doctors know the local ambulance crews well and we are mutually supportive: the best for a very sick person in a remote place is that we work together in this spirit. This is really the same point about using well what [few] resources we have on the edge. The out of hospital response can and should be augmented by BASICS GPs, both in hours and OOH. There needs to be a hospital with medical staff at reasonable proximity to a very sick person to which the ambulance crew can proceed. I would like the local GP community to be seen as an important part of the solution not some kind of problem.

- Were I work in Glenelg, dual responses (when the patients dial 999) demonstrate how well the Scottish Ambulance Service can link with the OOH GP. The 999 call will be processed; the ambulance despatched and the on-call GP phoned by the Highland Hub to attend. The GP will start treating the patient before the ambulance arrives, and in many cases realise the ambulance isn't required and cancel it. NHS 24 has affected accessibility in bad ways and good ways. The traditional GP living in the centre of the village was probably too accessible and the in-hours care just blurred into the out-of-hours care. Having said that NHS 24 are and remain clueless about the geography of the Highlands. The Highland Hub on the other hand is very good, and once the patient call gets through to the Hub they are dealt with in a very sensible manner.

- In the Ullapool area, Scottish Ambulance call handlers are in the same room as the Highland Hub GP call handlers which lead to reasonably good coordination and communication. However patients frequently report that NHS24 call handlers will tell them that there is no GP/minor injury service available and advise the patients to travel to Inverness when actually I could see them locally On one occasion I specifically asked the patient to let me know via NHS24 when they would arrive for a follow up appointment the next day. The patient never attended because NHS24
refused to pass on the message to me. This was a sick breathless child and the consequences could have been severe.

- In the Fort William, OOH calls are triaged by NHS24 and then go to the Highland Hub call centre in Inverness where a call handler passes the call to the primary care centre at the Belford hospital (separate to A+E) who then contacts the on call GP. Sometimes the patient travels to the Primary Care Emergency Centre and other times the GP offers advice or visits. Taxi services are employed when a patient doesn't have transport. This triaging of calls has meant a sea change in quality of life for GPs and families. The type of calls we now receive at night are filtered by NHS 24 and my impression is that the quality of calls is medically more appropriate. In fact the night time GP work often exposes the GP to really serious pathology which requires all of his/her diagnostic skills. With the latter in mind, an important issue to consider is that a GP can be faced with any manner of atypical presentations in someone’s house in a remote geographical location. It is not the desperate situation of a cardiac arrest which necessitates a 999 call and so bypasses the NHS24 and Highland Hub to Scottish Ambulance Services but the other more insidious illness which can result in death or serious morbidity if not dealt with over a period of hours.

- In Fort William, links with NHS24 and OOH are good but there is sometimes a delay in patient’s requests coming through to OOH still—although this is improving. Links between Scottish Ambulance Service and OOH generally good.

- Ambulance provision is patchy in the more remote areas, which means that savings cannot be made in reducing the number of GPs per geographical area as, if they need to transport a patient to secondary care, the area will be left without ambulance cover for many hours. We have also had repeated reports of single manning of ambulances, as a routine occurrence, not just an emergency cover situation. Better management with ambulance and GP cover would greatly help. Attempts have been made to enlist nurses for shifts, but there are not enough suitably trained nurses living locally. Even with the best trained nurse, a doctor will still be required 50% of the time, and the nearest Primary Care Emergency Centre might be over 2 hours away with only a single doctor on duty there too, already covering a huge geographical area. NHS24 is usually much less useful in a rural area, as they can't possibly understand the local geography. The money used for the nurses here (who triage on average only 3 patients an hour) could be put into the GP system as detailed above. The use of a local ‘Hub’ is essential though, to keep track of the calls, addresses and the doctors.

- In Tain the perception is that the Scottish Ambulance Service is the emergency response and the OOH GP provides routine medical treatment. In my view the Scottish Ambulance Service is stretched beyond belief. It is very common in NHS Highland for there to be no ambulance available from Dingwall to Wick, covering 100 miles of East Coast
Communities, for 5-6 hours at a time. This is one of the reasons I have such a high OOH call-out rate. In saying that, however, all the calls I get are appropriate for an emergency GP trained in Pre-Hospital Care, bar a few poorly triaged NHS 24 calls inappropriately passed to the Scottish Ambulance Service.

- In Grantown services seem to link in very well with appropriate use by the Scottish Ambulance Service of the Primary Care Emergency Centre to look for medical advice or bring patients for assessment rather than taking them to A&E. However, the practice of single manning ambulances is still a problem and this can tie up the GP to remain with a patient until a dual-manned crew arrive. NHS24 get better and better at what they do. Their response times to calls seem to be a lot faster too. There is a lot less grumbling from patients and a lot more praise of NHS24.

- The Scottish Ambulance Service still has single-manned ambulances on call at certain times. This means that an ambulance can attend the scene and give some treatment, such as oxygen, but is not allowed to move the patient until a double-manned vehicle arrives, often from over 30 miles away. We were assured that single-manning would be a thing of the past, but when I was working last weekend it was not a thing of the past. The single-manning problem arose from the Agenda for Change negotiations and has not yet been fully resolved because of issues about payments to staff for being on call. If you are going to take away GP cover from remote rural practices then the minimum provision should be a paramedic staffed ambulance in that area. There is not much evidence that the Scottish Ambulance Service has risen to this challenge, in spite of their latest round of public consultation.

- Could be better links in the Western Isles if direct contact were possible in small areas rather than through centralised coordination where staff do not know the area. A more cohesive team approach would be more effective.

- It has always been a fundamental part of GP work in remote and rural areas to provide assistance in emergencies whereas in urban areas an ambulance may simply be called to run the patient quickly into hospital. Improvements in the link up between OOH, NHS24 and the Scottish Ambulance Service may include recognising individual remote GP locations within the entire NHS 24 system. Additionally understanding that the GP is required in many different scenarios to be in attendance in less remote areas. Particularly when calls are re-routed to other call-centres outside the local one the NHS24 staff are unaware of the local geography and lack of any other OOH services. The Scottish Ambulance Service also has to be encouraged to draw on the GP OOH resource. I understand that the Scottish Ambulance Service is reluctant to ask for GP assistance to their calls. In a less remote places this may be fine as the patient can be quickly brought in to hospital and additionally should the patient be left at home they can again be brought in rapidly if they deteriorate. The local crews lucky are more conscious of this need and often do ask for a GP. In this sort of area a GP is able to provide necessary extra treatment and
support for patients prior to long journeys to hospital and also can anticipate where patients need earlier admission due to the distances involved. This change can probably only be achieved a high level as we have already discussed this problem and various incidents with the Scottish Ambulance Service and found their operations unchanged.

- In my experience in the Highlands, a combination of NHS24, Scottish Ambulance Service and GP cover works well. I have often attended incidents in rural areas together with the local ambulance service and on such occasions it has generally been entirely appropriate and necessary for both GP and ambulance to be present.

- Within my own area of Morvern, patients will easily be seen within 1 hr - as long as they can get through to NHS24 and the call is correctly triaged - so the GP is always available, but NHS24 systems can prove a barrier to accessibility. There has been some improvement with Scottish Ambulance calling the OOH GP for Immediate Care issues - through the new NHS Highland Basics Liaison group we are about to get a vehicle locator device, to improve this further.

- Generally services link in well together in Strathspey. Problems arise when ambulances are unmanned, and in the inflexibility of the response time categorization of 'blue light' or 'within an hour'. A recent example was a psychiatrically disturbed patient whose cooperation was dependent on a response within about 15 minutes, but where blue lights would cause further disturbance. NHS24 has in the past asked GPs to give telephone advice to patients out with their locality at times of high clinical activity, when local GPs are unavailable. This is often unsatisfactory, and is potentially unsafe. It is not at all unusual for the Scottish Ambulance Service to ask the GP OOH service in Badenoch and Strathspey to respond to a 999 call because their service is overwhelmed.

- BASICS is an organization that has done tremendous work in the education and support of clinicians in pre-hospital care, and it is active in delivery of care as well as education in this locality. Most of the GPs providing OOH care from the Primary Care Emergency Centre are BASICS trained. Some GPs as part of their BASICS commitment provide care independently of the OOH service, and so there would seem to be a degree of duplication of provision of GP emergency services, or at least a lack of clarity of division of responsibility between the GP OOH service and the independent GP providers of BASICS care in the locality.

Response Summary

Based on the receipt of these comments and on our existing knowledge, RCGP Scotland believes that a ‘one size fits all’ care model is not suitable to support the various and differing needs of patient in remote and rural communities. It is exceptionally important given the circumstances in remote and rural communities, in particular with issues of rural deprivation, that the system devised for remote and rural out of hours care is safe and effective. We would
suggest that an increase in emphasis towards local service provision would serve to benefit patients in such communities by ensuring that care is available at a local level when needed. In this respect utilising the services of out of hours GPs is extremely important as they provide a vital multi-disciplinary link within the community.

In particular we would like to praise the work of The British Association for Immediate Care for their efforts in training GPs in emergency situations and for the positive impact that BASICS trained GPs have had on out of hours care on remote and rural communities. It is our view that the Scottish Government should work to increase the number of BASICS trained GPs in remote and rural communities for this reason in order that they can work in conjunction with the Scottish Ambulance Service to be available on a local level where immediate care is required. The driver/receptionist services provided for out of hours GPs and healthcare professionals was also highly praised for increasing efficiency and safety for patients and healthcare professionals who may previously have worked alone in very remote areas.

We would like to suggest that further work must be undertaken to tackle the issues which have been raised by respondents in relation to postcode and geography confusion from centralised services such as NHS24. Clearly this poses great risk to patients by significantly delaying care or sending patients in need to inconvenient treatment centres. Greater links are needed between NHS24 and localised services such as the Primary Care Emergency Centres and out of hours GPs. Where such distances are required to be travelled for patients to receive care NHS24 must ensure that it can triage patients to the most effective and convenient care option. In addition to this it is our belief that the issue of single manned ambulances must be addressed as this poses risks to patients, is inefficient and creates delays in service. Overall we would acknowledge that when services run well, the Scottish Ambulance Service and NHS24 provide a vital resource for patients. However these services should not be perceived to compete with each other but rather should complement each other to ensure streamlined, efficient and safe care for patients.

We hope that these comments are useful and we would be happy to be involved further with this inquiry. Should you wish to review any of the individual responses received please do not hesitate to contact Julianne Reddin, Executive and Policy Administrator for RCGP Scotland who will arrange this for you.

Dr Kenneth Lawton  
Chair  
Royal College of General Practitioners Scotland  
7 November 2009
Appendix

RCGP Rural Forum response to the Inquiry into out-of-hours health care provision in rural areas of Scotland

What do you think is the most sustainable and cost-effective way to provide adequate out-of-hours services in rural areas?

We feel that the 4 questions as written are rather simplistic and limited, and caution should be applied when considering the responses. There can be a marked variation in the way primary care is delivered in rural areas in Scotland, largely dictated by the individual characteristics of each area. Practices can vary from a group practice with up to 6 or more GPs providing both in hours and out of hours (scheduled and unscheduled) care from an attached community hospital, to a small single handed practice which may or may not also provide unscheduled care. Access to secondary care can vary widely according to geography with particular problems for highland and island practices, the latter being limited by the availability and reliability of ferry services. Ambulance service and response times are also variable according to locality but generally fall well below what is provided and achieved in urban areas (see enclosed copy of our response to the Scottish Ambulance Service consultation). We believe because of this wide variation of circumstances that it is inappropriate to consider a “one glove fits all” solution to the provision of unscheduled care. However we feel it is important that the following principles should be recognised:

- The separation of scheduled care and unscheduled care is appropriate wherever it can practicably and adequately be provided. Given the ever increasing demands and complexity of scheduled primary care it is in the interests of patients to have their health needs provided by a health care professional that has not been up all night providing unscheduled care.
- There are some areas where it has been deemed appropriate, in the absence of a viable alternative, that the local doctor or doctors continue to provide unscheduled care. In such circumstance we believe it is essential, and in the best interest of patients, that the Scottish Parliament and Health Boards ensure that the necessary financial and service support required by health care professionals are put in place. Schemes need to be in place to ensure adequate locum cover for holidays, sickness and adequate weekend cover. This is particularly important for single handed practices.
- Politicians and Health Boards need to understand that diseconomies of scale apply to rural practice and that there should be acceptance of the need to provide a higher level of funding per resident than might be appropriate for urban populations which benefit from unit cost economies of scale. Rural communities deserve to have the best health service that is
It is essential that adequate resources be put in place to enable healthcare professionals to have good access to the necessary training and educational facilities required to maintain and develop their skills and knowledge, particularly for those having to provide emergency, pre-hospital and minor injury services. Again schemes should be put in place to provide locum cover to allow doctors and nurses to attend courses preferably by health professionals who are familiar with the practice area.

What are your views on the quality of out-of-hours care provided in rural areas, in particular clinical safety and effectiveness?

We do not think it appropriate to generalise here. Clearly quality of service may vary in accordance with local circumstances and problems. Access to secondary care for example will vary according to locality and will largely be inversely proportional to the degree of remoteness. Access to tertiary care such as emergency coronary angiography for example may simply not be available in the more remote areas. We believe that the Scottish Parliament and Health Boards should make every effort to improve resources for the service providers in any locality where there might be evidence of service failings or difficulties.

What are your views on the accessibility and availability of out-of-hours care in rural areas?

See responses to question 1 and 2.

How well do you think NHS 24 and the Scottish Ambulance Service links in with existing out-of-hours services?

Feedback from numerous doctors throughout rural Scotland suggests that there is variance in the standard of service provision. In some areas the service links seem to work well but in other areas particularly parts of the West Coast and Islands there appear to be problems as highlighted in our response to the Scottish Ambulance Service consultation. Concerns included issues around air ambulance versus terrestrial ambulance, inappropriate diversions, prioritisation and misconceptions about community hospitals being regarded as places of safety. This particular issue relates to when there is a call for urgent transfer from a community hospital for a patient in need of emergency treatments or investigations that cannot be provided by a Community Hospital. Even though a patient may be critically ill an ambulance (whether air or terrestrial) may be diverted to a call to a patient whose need is less serious.
The consensus view is that this sort of problem is less likely to occur where there is locally centralised co-ordination and links between NHS24, out-of-hours providers and ambulance services so that communication between staff with clinical experience and local knowledge can lead to more efficient call handling and prioritisation. We understand that this is increasingly being recognised and that control of out-of-hours calls are already being handled in a single control room in Glasgow for example. Many rural and remote general practitioners have regular BASICS training and I understand that areas where the Scottish Ambulance Service engages with, and works with such doctors, patients value that service.

Dr Malcolm Ward
Chair
RCGP UK Rural Forum
7 November 2009
Inquiry into out-of-hours Health Care Provision in Rural Areas

Royal College of Nursing Scotland

RCN Scotland welcomes the opportunity to submit evidence to the Health and Sport Committee on this important area of patient care for NHS Scotland. Our position on out-of-hours (OOH) healthcare provision in rural areas is based on the views of our members which have been collated from responses to an online survey. The survey asked for responses to the questions posed by the Health and Sport Committee’s inquiry.

RCN Scotland view on the principles of OOH care

OOH care should not be seen as separate or additional but should be embedded in whole systems across health and social care. The healthcare infrastructure should support ‘in hours’ and OOH care equally with clear referral routes and access to healthcare 24 hours a day, 7 days a week, 365 days a year. This would enable continuity of care, particularly for the elderly and other groups who require care throughout the 24 hour period.

There appears to be considerable variation in the range and nature of OOH services provided across the health board areas. This is appropriate to some extent as services must be designed to meet the needs of local communities, taking into account demographics, geography and resources. However, this localised approach must be balanced with a need for consistency, quality and safety across all OOH services. Variation in OOH services which is responsive to local requirements must not compromise access to care or quality and safety of care, particularly for those whose need is greatest.

Challenges to consistency in quality and access to OOH care in rural areas

There are a number of significant challenges in different areas of Scotland that must be overcome to make embedded OOH care a reality. One of the most significant of these challenges is delivering safe and effective care for patients with mental health problems in some remote areas of Scotland. Respondents to the survey shared examples of where there are nursing and other staff on call but no safe environment in which to treat patients. In some areas acute receiving centres only operate during the day and cannot receive patients overnight. When there is no overnight ‘mental health place of safety’ available in healthcare premises, it can mean that people in mental health distress are held overnight in a police station. This can only serve to heighten distress and does not represent a good standard of care. Another example was given of a continuous lack of inpatient hospital based registered mental health nurses to care for those awaiting OOH transfer to a mental health unit.
A further challenge is that of meeting the needs of babies, children, adolescents and their families in OOH care. Children must be cared for by specialist children’s health staff, with access to specialist advice and expertise available at all times. However, in some parts of remote and rural Scotland this is simply not the case and this can make it very difficult for health care staff who have to balance risk with delivering care close to home for children. RCN Scotland has set out an approach to community nursing and primary care which, if developed and invested in, would mean that children and families would have access to the specialist, comprehensive and joined-up care they need.¹

Another particular challenge is meeting the needs of those requiring palliative or terminal care. The importance of providing high quality palliative care to adults and children in the OOH period was a recurring theme from survey respondents especially during the night when people can feel very isolated. The challenge includes that of communication between NHS 24, primary care, community services and the voluntary sector who are important providers of care in this area.

If the RCN Scotland approach to the future of community health services was implemented it would allow better integration and co-ordination of OOH services between health, social care and the voluntary sector. A joined-up approach to the provision of these services based on the needs of people, not service providers, would benefit all patients whether receiving care during the day or during the night.

There is some inconsistency between health boards as to the approach that they take to travel and transport for patients requiring OOH care. According to our survey respondents, some health boards provide transport for people who cannot afford to travel to emergency OOH centres and others do not. In Angus, a ‘see and treat’ model is being piloted where paramedic and nurse practitioners assess and treat a patient at home. This is expected to reduce the number of admissions which in turn means less upheaval for patients, which can be much more keenly felt in remote and rural areas when hospitals are generally much further from the patient’s home. Best practice must be identified in order that it can be shared across health boards to ensure access to OOH services. Localisation of services is also very important in improving access to OOH care. Local triage centres, OOH units or minor injury units are central to OOH service delivery. More of these centres are required as the most common complaint from patients and families is the distance they have to travel to access care. Survey respondents also raised the issue of the weather and the importance of contingency planning so that OOH services remained available and accessible in bad weather.

The potential of ehealth and telehealth to improve health services for patients in remote and rural areas, particularly OOH, must not be underestimated. Access to telemedicine is vital to nurses and paramedic practitioners to enable them provide effective and safe care. Improved access to shared

¹ A Sustainable Future: The RCN vision for community nursing in Scotland, April 2009
electronic patient records will make it much easier for staff to manage care for patients across settings. RCN Scotland is pleased that the Health Committee recognises the potential that ehealth has to improving patient care and looks forward to contributing to the forthcoming inquiry into this area of healthcare.

Workforce development

The current approach taken by health boards in some areas to employ locum GPs to provide OOH services is unsustainable and does not provide value-for-money. Health boards must consider the range of patients’ needs and invest in multi-disciplinary teams so that appropriately skilled staff are available at all times to meet the health and care needs of local communities. The emphasis should be on skills, competencies and capabilities, with appropriate systems and support in place, rather than on traditional professional boundaries. In the long term this would save money by reducing emergency admissions and would support the Scottish Government’s aim to ‘shift the balance of care’ from the acute sector to the community.

Many of the problems patients encounter in the OOH period can be treated effectively by an advanced nurse practitioner. There are examples of nurse-led services being provided, with excellent back-up and support, linked to the OOH hub Primary Care Emergency Centre (PCEC). In NHS Grampian, advanced nurse practitioners and paramedic practitioners work together with GPs in rural areas overnight. The nurse and paramedic practitioners are in telephone contact with GP colleagues with telemedicine links to PCEC and A&E in Aberdeen for advice if required. Practitioners can assess, diagnose and treat a variety of acute conditions as well as make referrals to hospital for admission. The nurse practitioners also refer to the district nursing team and social services. This initiative has been a partnership between NHS Grampian, NHS Education for Scotland (NES) and Robert Gordon University, with practitioners having completed a wide range of accredited university courses.

NHS Education for Scotland (NES) through its out of hours unscheduled care work programme has delivered a comprehensive approach to supporting the development of extended and advanced roles for the health care team. The competencies developed by NES gives a clear framework within which to provide safe, efficient, reliable and equitable care outside normal working hours.

In England a range of models for OOH care have been introduced which has afforded significant opportunities for nurses to develop expertise in this area including nurse consultant and advanced nurse practitioner roles. A few of these advanced nurse practitioners have been accredited by the local deaneries as GP trainers. One provider of OOH care has undertaken a peer review audit of 100 OOH cases and concluded that 90% of consultations can
be safely treated by appropriately trained and educated nurses, leaving around 10% which require the input of a medical colleague².

The examples from Grampian and Angus highlight the importance of the role of advanced nurse practitioners in OOH service provision. Workforce development needs to remain high on the agenda in order to continue to develop career frameworks and succession planning for these key roles. The document Delivering for Remote and Rural Healthcare SGHD 2007³ makes reference to the ongoing work on the review of nursing in the community. Now that the Modernising Community Nursing board is in place, development of a highly skilled OOH workforce for remote and rural areas must be central to the remit of this group.

The role of NHS 24

RCN Scotland firmly believes that NHS 24 should be the cornerstone of OOH care in Scotland. The service is still evolving, and many challenges remain. The level of care that can be provided by NHS 24 nurses and other staff is very much dependent on their level of knowledge of a patient’s local area, both in terms of local geography and accurate knowledge of local services. This in turn depends on the relationship and sharing of information between the territorial health boards and NHS 24. It is also essential that GP practices and community services keep NHS 24 up-to-date with patients who are at risk, via OOH alerts and with changing service and capacity issues as they emerge.

NHS 24 has been shown to provide a reasonable framework for first-point-of-contact advice and referral during out-of-hours. NHS 24 is working towards achieving an appropriate balance between local service delivery and centralised funding and planning functions. In addition to existing regional centres, Audit Scotland reports that NHS 24 will be establishing local services within all mainland health boards ‘as a means of improving resilience and using local knowledge’⁴. Plans for expanded use of technologies, such as the internet, chat-rooms, and texts, will also enhance local presence in hard to reach areas. There is also a balance to be struck between planning which allows for a nationwide strategic direction, staff training, and monitoring of service delivery and local service planning which is responsive and appropriate. NHS 24 needs to continue to improve, in partnership with the territorial health boards, to meet the needs of patients regardless of location.

Investments in infrastructure and staff training at NHS 24 have both been cited in annual reviews and audits as having a positive contribution to current

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service delivery\textsuperscript{5}. In particular, development of the call handler role has been beneficial for timeliness and appropriateness of advice and referral for callers, by allowing better use of nurse practitioner time. We believe that efforts should be directed at further enhancing NHS 24 so that the learning already acquired can be built on.

**Conclusion**

In conclusion, RCN Scotland believes that OOH systems need to be more fully integrated into whole systems which currently operate ‘in hours’. There is a balance to be struck between designing services fit for purpose in a particular remote or rural area and consistency, quality and safety of service across NHS Scotland. There are a range of challenges to be overcome, particularly those requiring specialist skills; mental health, babies, children and adolescents and palliative care.

Workforce development is central to strategic planning, with advanced nurse practitioner roles providing an important resource alongside medical and paramedic colleagues. This development requires ongoing investment in training and education and career frameworks for staff. RCN Scotland also believes that further enhancing the role of NHS 24 is pivotal to providing consistent accessible high quality care across NHS Scotland. What is required is an increasingly integrated approach, both between in hours and out of hours services and between NHS 24 and the territorial boards.

Theresa Fyffe  
Director  
Royal College of Nursing Scotland  
10 November 2009

Inquiry into out-of-hours Health Care Provision in Rural Areas
Remote Practitioners Association of Scotland

After consultation with our members, our response to the consultation on “Inquiry into Out-of-Hours Health Care Provision in Rural Areas” is as follows:

What do you think is the most sustainable and cost-effective way to provide adequate out-of-hours services in rural areas?

Firstly, we would say that there is no “most sustainable and cost-effective way” and that solutions must reflect the local geography, demographics and existing service provision. Some areas are so remote that there is really no option other than the traditional model of a single GP, covering a defined geographical area 24/7; if that is the case, then said GP must be have adequate resources/backup to enable them to function, including support for time off. Other areas may be best served by “cooperative”-style arrangements of GPs, working out of an out-of-hours centre with driver if necessary to facilitate home visits. We are aware of controversial attempts in some areas of the UK to perform Out-of-hours care using Paramedics and Extended-Role nurses – whilst we believe these people have a role to play within an out-of-hours team in certain areas, our opinion is that the backbone of out-of-hours care should stay medical, both in terms of maintaining standard of care and reducing knock-on costs with hospital admissions etc. In particular we feel cost-effectiveness must take account of knock-on effects on the NHS generally – ie: a cheap Out of Hours service may result in increased and unnecessary hospital admission, vastly outweighing any short-term saving.

What are your views on the quality of out-of-hours care provided in rural areas, in particular clinical safety and effectiveness?

Our opinion is that the current standard of out-of-hours care is very good, as evidenced by the low rate of patient complaints. There is a danger in valuing only that which can be measured, which has the tendency to lead to one, centralised service which may meet every measured target but fails because it is a long way away from patients. One particular example being the standards imposed on telephone answering equipment etc. which are impossible to meet by single-handed GPs, resulting in the use of NHS24, which then fails due to lack of capacity and lack of geographical knowledge (q.v. 4 below).

What are your views on the accessibility and availability of out-of-hours care in rural areas?

Currently the availability and accessibility compares well with that available in urban Scotland – delays and inconvenience due to distance taking the place of those due to service pressure in a City. There will always be an issue with
geography – those of us who choose to live in rural areas cannot expect exactly the same service as is available in a city in terms of e.g.: emergency response time etc.

**How well do you think does NHS24 and the Scottish Ambulance Service link in with existing out-of-hours services?**

Unfortunately, our members report frequent problems with both these agencies. Examples include NHS24 directing patients to Accident & Emergency departments 50 miles away, rather than alerting a GP who is on duty just along the road; NHS24 accepting calls at 6pm then not passing them on to the responsible GP at 9pm, when a home visit within 4 hours has been agreed, when the patient is in fact on an offshore island requiring an oncall ferry to be mobilised. We would suggest that triage needs to be performed at more of a local level, by people who have knowledge of the local geography and local services.

As regards the Scottish Ambulance Service, we have frequent incidents documented of Ambulances failing to attend within specified time periods, non-availability of vehicles and crew, and single manning of ambulances – resulting in either lengthy delays or necessitating the GP to leave their oncall area to travel with the patient to hospital.

Dr Jim Finlayson  
Secretary  
Remote Practitioners Association of Scotland  
6 November 2009
Inquiry into out-of-hours Health Care Provision in Rural Areas

BASICS Scotland

BASICS Scotland is a registered charity, the aim of which is to promote excellence in pre-hospital care in Scotland. The main activity of the organisation is education, of health service professionals, in pre-hospital care. Most of our educational activity is financed by the NHS and in particular NHS Education for Scotland finances courses for practitioners working in rural areas. We have written educational material on out of hours care for The Scottish Ambulance Service and some of our members are members of the NHS 24 led group looking at dispatch systems used by The Scottish Ambulance Service.

We would not wish to comment on sustainability, accessibility or availability as these are not our areas of expertise. We would like to comment on:

- The clinical safety and effectiveness of out of hours care.
- The links between NHS 24 and The Scottish Ambulance Service and existing out of hours care.

With regard to clinical safety and effectiveness it would seem reasonable that GPs providing out of hours care were supported in providing this service to ensure they had a similar level of equipment and drugs as doctors working for the out of hours hubs. That clinical guidelines written for out of hours practitioners should be shared with these doctors and that any educational activities afforded to out of hours practitioners should also be available to GPs providing their own out of hours care. In addition many GPs who continue to undertake their own out of hours care do so because of the geographical isolation of their practice. This isolation often means that ambulance service resources may take longer to respond. In such cases the emergency medical skills and knowledge of these practitioners is vital and we would recommend the continued provision of the type of training we provide. We would recommend that to support this service funding is found to ensure such practitioners are supplied with vehicle location systems and have easy access to resupply of consumable items such as oxygen, intravenous fluids etc.

The Scottish Ambulance Service is well advanced in co-locating its control centers with those of NHS 24 and in some of these centers the out of hours hub communications desks are now located. We commend this approach and would like to see all out of hours hubs control desks located in these centers. It is to be hoped that the coordination of all out of hours resources in one centre would lead to a synergy providing more effective use of resources, greater cooperation between the different service providers and hopefully fewer long journeys in rural areas.

An addition to this concept, which could give added service, is to have out of hours vehicles fitted with vehicle location devices which would provide the ambulance service information on the location of these vehicles. Ideally these
vehicles would carry a defibrillator and set of basic resuscitation equipment for use in emergencies where they are the nearest resource to an emergency.

New communication technologies, such as videoconferencing of consultations and the transfer of electronically recorded clinical data could also be located in these centers. This technology could improve local access for patients and reduce the number of journeys undertaken by health professionals.

We would be more than happy to expand on any of these points should this be required.

Dr Colville Laird
Director of Education
BASICS Scotland
23 October 2009
INTRODUCTION
This briefing outlines the issues arising from submissions received as a result of the Committee’s call for written evidence on out-of-hours care in rural areas. The briefing outlines the key themes raised in response to each of the questions posed in the call for evidence.

RESPONDENTS
In total, 32 submissions were received following the call for written evidence. The full list of respondents can be found in Appendix 1. The various responses have been grouped into categories, and the distribution together with the number in each is summarised below.

Figure 1: Categories of respondees and numbers of each received

Respondents from Professional Representative Bodies make up the largest grouping followed by the area and special health boards. ‘Other’ includes
RESPONSES TO THE CALL FOR EVIDENCE QUESTIONS

The call for evidence posed a number of questions related to the remit of the inquiry. The key issues raised in response to these questions are discussed in the sections below.

HOW SHOULD OOH CARE BE DELIVERED IN RURAL AREAS?

Despite differences of opinion on how care should be delivered, there was a general consensus that people in remote and rural areas should have the same opportunity to access effective care as those in urban areas, although it was acknowledged that the shape of this provision may be different. Local flexibility was acknowledged by the majority of respondents as being key to the provision of OOH care in rural areas, with no ‘one size fits all’ solution.

Most of the responses to this question had a strong focus on the issue of GP involvement in OOH care. Some respondents thought it was necessary to remember that the changes in OOH care brought about by the nGMS contract were intended to address problems of recruitment and retention in general practice (Audit Scotland, BMA, RCN). However, others expressed concern about the consequences of these changes in remote and rural areas, specifically in relation to equitable provision of OOH care across Scotland:

“The whole point of public services is to distribute funds and resources on the basis of need by pooling the risks and costs of care across its communities so that those in rural areas, where unit costs may be higher, will not be denied care because of population sparseness and small numbers” (Centre for International Public Health Policy)

A large number of respondents were of the opinion that OOH care in remote and rural areas is best served by the involvement of a GP/doctor, although ideas on the level and shape of this involvement varied. This opinion was most likely to be expressed by individuals, community representatives, practitioners and professional bodies such as the Royal College of GPs.

A recurring rationale for medic involvement was that the input of GPs with good local knowledge, while maybe more costly, is cost-effective. This is because respondents were of the opinion that, due to their knowledge of the area, local services and patient histories, GP input is more likely to diminish the burden on back-up services and reduce inappropriate hospital admissions. It was also felt by some that Paramedics and First Responders are no substitute for doctors in diagnosing and treating all manner of conditions and that it would be more costly to try to replicate a GP’s breadth of knowledge and skills with a plethora of other health professionals.

Other respondents, such as NHS Boards, chose to focus on the benefits of other disciplines as a cost-effective response to rural OOH provision. This
included the utilisation of extended nursing roles and initiatives such as ‘See and Treat’\(^1\). Whole system approaches which seek to integrate all services available were also recommended by some and the influence of good ‘in-hours’ care on demand for OOH care was highlighted (BMA, Remote Practitioners Association).

**QUALITY OF CARE**

The overall opinion from respondents was that the quality of OOH care in rural areas was generally good, although some thought it was variable and highlighted inconsistencies (e.g. Royal College of Physicians and Surgeons of Glasgow, Scottish Ambulance Service, Royal College of GPs). The RCN highlighted poorer quality provision for particular groups, such as people with mental health problems, the terminally ill and children. NHS Lothian state there is no evidence that clinical safety and effectiveness are compromised and this was backed by the Remote Practitioners Association which points to the low rates of patient complaints.

Things that were thought to increase quality included:

- The involvement of doctors who have local knowledge
- Providing OOH GPs with the same drugs and equipment as OOH hubs
- Appropriate and ongoing training for all OOH service providers in rural areas

Things that were perceived to decrease quality included:

- A tendency towards risk aversion
- Poor public transport which can lead to unnecessary hospital admissions
- Substitution of doctors with first responders

Some submissions highlighted compliance with the NHS QIS standards as indicating the high quality of OOH services (BMA, NHS Tayside). However other respondents had criticisms of the standards and monitoring of services. For example, Audit Scotland state that a system of clear performance indicators was not in place at the time of their review and that:

*The NHS QIS standards explore the processes and procedures underpinning the delivery of out-of-hours care rather than assess the quality of services provided to patients.* (Audit Scotland, pg 2)

Other submissions had specific criticisms of the standards, for example, their lack of geographical dimension (Dick Barbor-Might).

Concerns were also raised by members of the Royal College of GPs about the clinical governance of OOH services. They believe there is a lack of governance mechanisms, that the organisation is weak and fragmented and that it is not clear who is responsible for what. An example given of poor

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\(^1\) This is a process whereby patients with minor conditions are treated by a clinician in an emergency department as soon as they arrive.
governance and audit was the use of ‘See & Treat’. This was mentioned by a few respondents who expressed concerns that it has not been evaluated and questioned its safety.

ACCESSIBILITY AND AVAILABILITY

While some respondents believed that differences in access were inevitable, given the inherent barriers of geography, others felt that this was not a justification for unequal access. Respondents generally thought accessibility and availability of OOH services varied depending on what was in place and, again, responses tended to link this with the presence of a GP.

“It is inevitable that in some remote locations it will not be possible to have 24 hour GP presence…and that alternative arrangements involving the full range of service providers may be more appropriate” (BMA)

“Removal of GP OOH services will introduce unevenness and unfairness in provision of core services” (Centre for International Public Health Policy)

Audit Scotland highlighted some of the results of a survey which formed part of their review. This found that 52% of GPs felt that patient access and availability to OOH care had not improved, although 80% of patients who had accessed OOH services were satisfied with the service.

Travel and transport was a recurring theme within the responses to this question. A lack of appropriate transport was recognised as being a factor in inappropriate ambulance use and unnecessary hospital admissions. NHS Tayside mentioned transport as a key factor in maintaining access to services. Some NHS boards will provide taxis for patients with no transport, although the RCN state there is inconsistency between boards in relation to transport provision.

The Scottish Ambulance Service reports that its recent consultation has shown that access to OOH services is unclear for the public and that patients are confused about the most appropriate route to care. The SAS believes this is especially true in remote and rural areas where there is an expectation that the GP is the first point of contact.

LINKS WITH NHS 24 AND THE SCOTTISH AMBULANCE SERVICE

Most respondents recognised the value of the work carried out by NHS 24 and the SAS. However a number of areas for improvement were highlighted:

- The risk averse nature of NHS 24 algorithms – it was felt that this leads to an increased burden on other services such as the SAS, and drives increases in hospital attendances.
- NHS 24’s lack of knowledge of local services and geography – this was felt to be crucial in deciding the most appropriate response. Examples were given of how this can be problematic. For example, patients being
directed to an OOH centre many miles away when a local GP is on duty just down the road.

- Inadequate communication between the SAS and local GPs – there were a number of respondents who mentioned poor communication with the SAS. Examples were given of the SAS not contacting the local GP about 999 calls despite the fact they would be able to attend the scene quicker than the ambulance.

- Some problems with poor response times, non-availability and single-manning of ambulances.

- SAS being used to fill gaps in provision e.g. when no GP is available or being used as patient transport.

In general there were calls for greater integration of NHS24 and the SAS with local OOH services and better joint planning between the 2 bodies and service planners.

Kathleen Robson
SPICe Research
18 August 2008

Note: Committee briefing papers are provided by SPICe for the use of Scottish Parliament Committees and clerking staff. They provide focused information or respond to specific questions or areas of interest to committees and are not intended to offer comprehensive coverage of a subject area.