The Committee will meet at 10.00 am in the Macdonald Loch Rannoch Hotel.

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

   Dick Barbor-Might, SOS Rannoch;

   Randolph Murray, Petitioner, Public Petition PE1272 on out-of-hours healthcare in Kinloch Rannoch;

   Keith Cameron, Communities Resuscitation Development Officer, Scottish Ambulance Service;

   Linda Entwistle, First Responder;

   Tom Forrest, and Roy Macpherson, Wester Ross Medical Practices Community Representatives Out-of-hours Group;

   and then from—

   Dr Michael Hall, Argyll & Bute Clinical Director, NHS Highland;

   Gerry Marr, Chief Operating Officer, NHS Tayside;

   Dr Sheena MacDonald, Associate Medical Director & Chair of Primary & Community Services, NHS Borders;

   Pauline Howie, Chief Executive, Scottish Ambulance Service;

   John Turner, Chief Executive, NHS 24.
Douglas Thornton
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—

**Agenda Item 1**

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

Dick Barbor-Might

The Committee will be aware that a number of the comments placed upon the Parliamentary website for the earlier e-petition (as also a large number of the signatures) were from local residents in Kinloch Rannoch and that these were complemented by other comments, some of these coming from areas of medical practices that still do have 24/7 local GP care.

This submission compares what has happened in Kinloch Rannoch with the out-of-hours service that is currently being provided in other remote Highland places and comments upon the policies that are being pursued by the Scottish Government and by different Health Boards. I contend that on a Scotland-wide basis these policies are neither fair nor coherent. The incoherence is due to different decisions about what constitutes an adequate out-of-hours service in places with a similar geography being made by different Health Boards. Inevitably per capita expenditures will be higher in the remote rural areas but this is no reason to dispense with the principle of equal entitlement which should apply as much to the people who live in these places as it does when the issues are disability or ethnicity, poverty or language and culture.

Geography

I suggest one additional question to add to the four posited by the Committee. This is:

*How well do you think that existing out-of-hours care and NHS Scotland Quality Improvement Standards ensure equal entitlement to service users in remote rural areas?*

The facts of geography affect not only the delivery of any element or package of health care but they also affect – or should affect – the planning and monitoring processes within the NHS. It does not follow that because some places are relatively well catered for by a particular service that it will suit in some other places with quite a different geography. Distance matters as also does the distribution of particular practice populations whether concentrated or thinly scattered or something in between.

The geographical factor: Highland Health Board

In some remote rural areas Health Boards took corrective action following the introduction of the new General Medical Services (nGMS) contract in April 2004 to ensure that patients did not lose their customary and much valued 24/7 local GP OOH service. These decisions were in recognition of the geographical factor. This is what happened with the Highland Health Board where, as has been explained to me by GPs in that area, they were given complementary contracts to the standard ones they were awarded for the 40
hours or so of the in-hours period. These complementary contracts covered
the much longer periods of evenings, nights and weekends and were
remunerated at different (and much lower) hourly rates than what was paid for
the in-hours period.

As of summer 2008, as was indicated in an answer to a PQ from Murdo
Fraser MSP, there were 16 medical practices in the Highland Health Board
and one in Grampian that operated 24/7. All were funded by the Health
Boards. In these places as also in a number of practices in the Scottish
Islands Health Boards recognised that geography did make a critical
difference to what kind of service should be provided. The consequence has
been that people in these areas have continued to benefit from having
experienced and committed doctors at all times and locally accessible,
whether directly or via NHS24.

The geographical factor: Tayside Health Board

This simple truth was well understood by the former Chair of NHS Tayside,
the highly regarded Peter Bates. Under his chairmanship NHS Tayside paid
due regard to the geographical factors. Tayside Health Board tried to pursue
the same policy for Kinloch Rannoch as was being followed by the Highland
Health Board with regard to its remote rural practices. Kinloch Rannoch was
and is something of a special case within the 3000 square miles of NHS
Tayside which includes the cities of Perth and Dundee and a well populated
countryside. Miles further on there is a corner of the Highlands where the
distances become long and the population is thinly scattered. This is Highland
Perthshire.

Kinloch Rannoch: the first attempt to secure 24/7 local GP cover

In the winter of 2005/06, the GP in Kinloch Rannoch wanted to opt out and
would accept no compromise. The opt-out was opposed by NHS Tayside.
The considerations were summarised in a memorandum from Dr Russell and
Dr Meikle of NHS Tayside in November 2005 that was sent to an
Assessments Panel. They highlighted the geographical issues. The
memorandum stated that “the place itself is remote and rural in an isolated
part of North West Perthshire and the delivery of OOH services is constrained
by geography.” The points made in the memorandum are important for
understanding the problems of distance in the remote areas generally, and
not only in Kinloch Rannoch.

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1 I understand that the extra funding, which comes via Health Boards, is additional to the 6% of the Global
Allocation Sum that is retained by GPs who cover out-of-hours.
2 The memorandum made the following points about the geography.
   • “The place itself is remote and rural in an isolated part of North West Perthshire and the delivery of OOH
     services is constrained by geography, single-track roads make routes more circuitous and difficult. Tayside
     OOH Service covers about 3000 square miles and journeys for both professionals and patients can be long
     and arduous as a result of limitations in the transport infrastructure.
   • The registered population is sparsely distributed and as previously indicated fluctuates in numbers at certain
times of the year due to temporary residents.
   • Patient culture in Kinloch Rannoch is shaped in part by the existing GP service; people are accustomed to a
     personal relationship, and this influences their expectations and attitude.
Kinloch Rannoch: the second attempt to secure 24/7 local GP cover

In June 2006 Peter Bates expressed his regrets at a Health Board meeting that the Assessments Panel had ruled in favour of the incumbent GP being allowed to opt out. However, the Health Board kept to its policy of recognising the primacy of the geographical factor. A second opportunity presented itself, while Peter Bates was still the Chair, when the incumbent GP approached retirement.

The Medical Practice Vacancy Notice that was issued by NHS Tayside, with interviews scheduled for 3 December 2007, was explicit on the question of OOH and of where the newly appointed GP or GPs would be required to live.

“4. AREA OF RESIDENCE: The successful applicant(s) will be required to reside in the immediate vicinity of Kinloch Rannoch.”

“8. OUT OF HOURS: OOH will be a core component of the specification. NHS Tayside will work in close partnership with the successful applicants with a view to seeking innovative solutions to the provision of out of hours care.”

At this time senior managers in NHS Tayside remained committed to the goal of assuring continuity of care and safe practice by stipulating that the new GP or GPs would be fully involved in the provision of OOH. That was the situation in November 2007 when, due to illness, Peter Bates stood down as Chair of NHS Tayside and Sandy Watson took his place.

The shift in policy

Immediately following Peter Bates’ resignation, and as was revealed during the interview process, NHS Tayside abruptly changed its policy, dispensed with conditions 4 and 8 and appointed the only one of the short-listed applicants who was not willing to provide any element of OOH. The door had been closed on the repeated calls from the community to restore OOH cover by the local GPs. And, for whatever reason, NHS Tayside had set aside what it had previously regarded as vital.

Having abandoned the geographical perspective in healthcare planning for Kinloch Rannoch, NHS Tayside completed the shift of policy to the “community resilience” agenda that is promoted by the Centre for Rural Health and that prominently features Community First Responders (CFR) schemes. Senior Managers then presented the community with four options

- There were further concerns expressed by the Practice and the local community regarding the ambulance response times from Pitlochry, i.e., a journey of around 20 miles via minor roads.”

This decision raises questions of fair practice as between different potential applicants. Some doctors might well have applied for the vacancy if they had known that the stipulations regarding residence and OOH as a “core component” would be discarded. There is also the question of why NHS Tayside did not re-advertise. It should be noted that the Scottish Government was made well aware of the issues. As one of the two local MSPs, John Swinney had agreed with Peter Bates in regretting the decision of the Assessments Panel to allow the opt-out in the spring of 2006. Mr Swinney said that there was a “diminution in service” and that some of his constituents were left feeling vulnerable. NHS Tayside is now misleadingly claiming that the OOH stipulation was merely an “option”. It was nothing of the kind but a “core component”.

3
for future “emergency response” cover which were subsequently presented to the Health Board. The options were: status quo, local GP 24/7 cover, a paramedic in the village, a CFR scheme. With the exception of one SNP Councillor the official report of the consultations showed that there were no calls from the community for CFRs but it was this option that senior officials recommended to their Board on 13 November 2008. Three non-Executive members asked for more time to consider the evidence for First Responders but this was denied.4

The exclusion of geographically determined inequalities by NHS Quality Improvement Standards (QIS)

NHS QIS “is committed to equality and diversity”. The six equality groups which they embrace are “age, disability, gender, race, religion/belief and sexual orientation”. What is missing is a recognition of inequalities that arise through geography: specifically, the disadvantages experienced by remote rural communities.

Our experience in Kinloch Rannoch is instructive. Rannoch and Tummel Community Council wrote to Nicola Sturgeon in her capacity as Cabinet Secretary for Health and Wellbeing on 17 November 2008, asking her to intervene. One of the points raised in the letter concerned Quality Standards:

“In their reports and in a presentation, NHS Tayside officials made repeated assertions, unchallenged at the Board meeting, that their provision of safe and effective Primary Service OOH meets the national standards. They omitted to acknowledge that these standards do not cover geographical dimensions and therefore do not take into account response times over B class roads in wintry conditions.”

The reply to this letter came eleven weeks later, from a civil servant, John Davidson. It ignored the point about Quality Standards as well as five other points. Since then solicitors acting for the Community Council have written to the Cabinet Secretary, again asking her to intervene under the terms of the 1978 NHS (Scotland) Act. She has rejected this request and has reiterated that: “the out-of-hours services provided by NHS Tayside achieved full compliance with Quality Improvement Scotland’s standards in December 2007.”5

This statement sidesteps the issue about the standard of out-of-hours health care available in remote rural areas such as Kinloch Rannoch.

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4 The recommendation to the Board was based in part upon a letter from Mr Heaney of the Centre for Rural Health in which he admitted that there was no “robust evidence” for the effectiveness of First Responder schemes but cited his own personal experience as a First Responder in Achiltibuie (see the minutes of the Health Board meeting agenda item 6.2). That was on 13 November 2008. On 7 September 2009 a fellow volunteer in Achiltibuie wrote a comment on the Parliamentary e-petition website about the local situation. He stated that the First Responders scheme was losing many of its volunteers and that the NHS service was so bad that if, as a vet, he was to provide it to his animal patients he would expect to be suspended or struck off by the Royal College of Veterinary Surgeons. NHS Tayside has set up a First Responders Reference Group with “community representatives” nominated by itself. Six local volunteers have been trained and are now providing a service.

5 Nicola Sturgeon’s letter of 11 October 2009 was in response to a letter from the Community Council’s solicitors of 17 August.
I conclude that NHS QIS do not, of themselves, ensure equal entitlement to service users in remote rural areas.

**Sustainability and cost-effectiveness**

This section is in response to the following question asked by the Committee:

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

**Sustainability:** The challenge of determining a policy framework to provide health care or any other vital service to remote communities should be addressed within the broader context of appropriate and sustainable rural development for Scotland. Ever since 1913 when the Highlands and Islands Medical Service was first established, experience in the “crofting counties” has demonstrated the value of having GPs and nurses available locally. This entailed a 24/7 service and helped to sustain communities.

The assessments made by Health Boards and by the Scottish Government should take account of factors such as:

- GPs skills in differential diagnosis based upon years of training and addressed to a wide range of medical emergencies which can occur at any time
- The continuity of care provided by local GPs
- The commensurate savings in very expensive unplanned hospital admissions
- Reduction in pain and distress to vulnerable patients and the occasional saving of a life
- The ready availability 24/7 of medicines from the dispensing surgeries
- The demand from holiday visitors and temporary residents
- The non-use of NHS24 by people who know how inadequate it is and therefore drive their relatives long distances to hospital. (These cases do not appear in the statistics).

**Cost effectiveness:** Adequate locally-based GP OOH services, can, as the community in Kinloch Rannoch has demonstrated, be provided for around one quarter, if not less, of the £556,876 cited by NHS Tayside. In order to determine the cost-effectiveness of a service, the correct figures must be available and be based on real historical and current experience.

I have carried out some inquiries on behalf of the community on the costs of providing the local GP element in out-of-hours care in remote rural areas. These inquiries have shown that NHS Tayside’s costings were exaggerated by a factor of about four as compared to the economical hourly rates that are paid to GPs in the Highland Health Board area. In contrast, the rates paid to

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6 The exaggerations were pointed out by the community both prior to the November ‘08 meeting of the Tayside Health Board and afterwards to the Cabinet Secretary, but to no effect.
NHS24 doctors are much higher. None of the GPs I have spoken to in the Highland Region use drivers or know of any other doctor in these remote places who would do so. Moreover, NHS Tayside’s premise was that there would need to be 3.8 GPs and 4 drivers and that the GPs would be paid at the high in-hours rates are incompatible with actual practice.

The public need to be reliably informed about the relative costs of providing local GP OOH service as compared with the costs of NHS24. Moreover, in Kinloch Rannoch, we have concluded that the service currently provided by NHS Tayside is not adequate to the needs of local people.

Dick Barbor-Might
Kinloch Rannoch resident
Member of the campaigning group SOS Rannoch
6 November 2009
This supplementary written evidence is submitted prior to the forthcoming session of the Committee which (weather permitting) is to be held in Kinloch Rannoch on 25 January. It follows on from ROH8.

Three of the submissions of evidence to the Committee relate directly and in their entirety to the situation in Kinloch Rannoch (ROH3, ROH8 and ROH19). A fourth submission from NHS Tayside (ROH18) covers the situation in Kinloch Rannoch without even acknowledging some of the key points in the record (a community perspective on the history is in my own earlier evidence at ROH8).

**Evidence relating to Kinloch Rannoch (ROH19)**

Dr Andrew Buist’s evidence is of particular interest in that its author has had and continues to have an important role in our local affairs. In 2006, acting on behalf of the BMA, he represented the then incumbent GP, Dr Roger Simmonds, who successfully appealed against the then leadership of NHS Tayside to be allowed to opt out of providing an out-of-hours service.

The two community submissions (Alex Grosset’s at ROH3 and mine at ROH8) are supportive of the majority view amongst residents, which is in favour of a restoration of the lost service. Dr Buist takes a different view and has become a critic of the campaign. He has made his views known in the pages of the *Scotsman*. More recently, in his capacity as Chair of the GP Sub-Committee of the Tayside Area Medical Committee, Dr Buist has repeated and amplified his criticism in a letter that he sent to Mr Watson, the Chair of NHS Tayside. He subsequently press released this letter to the *Courier*. It is this letter which forms the main content of ROH19. There is also, of course, a second evidence submission to the Committee from Dr Buist in his capacity as of BMA Scotland (ROH6).

In formal terms Dr Buist represents, amongst others, our own GPs, who are partners in the Aberfeldy and Kinloch Rannoch Medical Practice which is one of a number in the area of the Tayside Health Board. He raises a number of points that merit close attention for two reasons. First, he holds positions of influence and states that he writes to express “the profession’s view”. Secondly, what has been happening in Kinloch Rannoch can be seen as something of a test case and is therefore of wider significance. I should make clear that in my own view the claim made by Dr Buist is a blow against vulnerable people in this community.
The four issues I raise in relation to Dr Buist’s evidence are as follows:

1. Criteria for budgetary decisions
2. Costings
3. “Working in partnership with the community”
4. Geography

1. Criteria for budgetary decisions: deprivation and an ageing population

Dr Buist argues that the money for a local GP out-of-hours service would be better devoted to deprived people in Dundee. In parts of that city, he writes, average life expectancy for men is as low as 65.1 years as compared with 79.3 years in Kinloch Rannoch. To drive home his point Dr Buist reminds Mr Watson that the Scottish Government “has identified addressing health inequalities as a major priority for the health service” and that for this and other reasons “we believe that there are greater health priorities in Tayside that we must address.”

In this way Dr Buist sets up the needs of deprived people in Dundee as a kind of reproach to the campaigners in Rannoch and he covers Mr Watson (and the Scottish Government that backs him) with a cloak of righteousness. For it is these officials and politicians, we may infer from Dr Buist’s letter, who are upholding the cause of equality - and most certainly not the long lived people of Rannoch.

I have inquired into how NHS budgets are constructed and whether they take account of health inequalities. The Committee will have its own sources of information but, as I understand the matter, the Scottish system (much as in other parts of the UK) does take health inequalities into account. In terms of resource allocation it proceeds by dividing up the greater part of the overall NHS budget between the 14 different Scottish Health Boards (Tayside included) primarily on the basis of the relative size of their populations: the more people there are then, as is only fair, the more money Health Boards will receive.

But the process of resource allocation does not stop there. To quote from the NHS Scotland website: “…this on its own would not be a fair way of distributing resources as there is clear evidence that some groups, for example older populations, those with particular morbidity and life circumstances characteristics, need a higher amount of resources than average. For this reason adjustments are made to the base population of each area.”

These adjustments include the age composition of the population (for which read the ills of old age and the demand on the NHS), the “relative additional needs due to morbidity and life circumstances and other factors” (for which read deprivation) and “the relative unavoidable excess costs of providing services to
different geographical areas” (for which, amongst other things, read the disadvantages that spring from remoteness).

So, again as I understand the matter, the £750 million or so that Tayside Health Board receives each year is scrupulously calculated to meet a diverse range of needs, whether these be identified in terms of the age (and sex) composition of the population, deprivation or geography.

The resource allocation formula does not oppose one valid need against another which is also valid. On the contrary, it finds space for all valid needs. But Dr Buist identifies the longevity which results in a relatively large number of old people as a reason for not funding a local GP out-of-hours service and reduces the complexity of making budgetary decisions on the basis of public health criteria to a noxious choice between, as he expresses it, the Rannoch population with “many health advantages” as against the poor of Dundee.

2. Costings

Dr Buist informed Mr Watson that the figure for a doctor “to be based in the village throughout the OOH period” was “reported to be around £150,000.”

I have commented briefly upon the costings issue in my earlier evidence (ROH8) but in the light of Dr Buist’s remark I would add the following comments:

1. It is evident that decisions by NHS Boards on health care expenditures (as with all public expenditures) should be based upon realistic estimates of costs. This was not done in the case of Kinloch Rannoch where an inflated figure of £556,876 per annum for a local GP out-of-hours service was reported to Tayside Health Board by its two most senior staff, the Chief Executive and Deputy Chief Executive. These two officers did this in support of their preferred option of Community First Responders (CFRs) and despite efforts from this community before the critical Board meeting on 13 November 2008 to seek a correction to a more realistic figure. Dr Buist does not even refer to the fact that the Board was invited to decide against a local GP out-of-hours service on the basis of an inflated costing but in his letter he gives currency to an altogether lower and more realistic figure, the one of £150,000. But this begs a very large question: does it not matter when the Board of a public body is asked to make a decision on the basis of costings that are exaggerated “either by error or invention” to use legal phraseology? When this is drawn to the attention of the responsible Minister by the Community Council, not once but twice, should there not be some corrective action? In fact no remedial action has been taken by the Minister.

2. Dr Buist makes no reference to possible financial benefits from having a local GP in place, in other words, offsetting savings. This is strange since he
claims to speak for the profession and yet other GPs who provide an out-of-hours service have pointed out that there are (possibly very considerable) savings from reducing unplanned hospital admissions. Indeed, the combination of local knowledge/close familiarity with their patients and differential diagnostic skills possessed by experienced locally based GPs contrasts favourably with the more risk averse practice of other health professionals who will “play safe” and take a patient into hospital. The presence and availability of a local GP on-call can thereby reduce the burden on very expensive secondary care. Dr Buist ignores this dimension altogether even though it is highly pertinent to calculations of the cost benefits of particular services.

3. It is unfortunate that Highland Health Board has not sent in a submission to the Committee since they have the greater number of mainland practices that still do provide 24/7 local GP cover. The limited inquiries that I have been able to make suggest that at an hourly rate of £18 plus other costs and some locum cover for weekends the annual cost would be about £140,000. Advertisements by a local resident, Viscount Monckton of Brenchley, have elicited expressions of interest from doctors that are costed at about the same annual sum. However, it may well be that a local GP out-of-hours service could be costed at a much lower sum. I have been told that some Highland medical practices have been paid at the hourly rate of £10. I assume that it would be open to the Committee to find out for certain what the going rates are whether in Highland, Grampian or the different Island groups. That data would provide a more solid basis for decisions about the real costs of options for out-of-hours health care. It would also illuminate the process of public Parliamentary inquiry.

4. I have no figures for the payments that are made to doctors who work for NHS24 and do not know whether these are in the public realm. However, informally I have heard that the hourly rates for NHS24 doctors are very much higher than the relatively modest out-of-hours rates (reportedly £18 or £10 an hour) that are paid to local GPs in Highland. Apparently the rates to NHS24 doctors vary according to whether it is a weekday, weekend or public holiday. For example, I know of a case where it suits a GP to decline to undertake out-of-hours work in his own practice at a relatively low hourly rate but to take on much more lucrative shifts for NHS24 with, admittedly, a bigger workload over a wider area.

3. “Working in partnership with the community”

In his letter to Mr Watson (as incorporated in ROH19) Dr Buist wrote that “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.” In fact, there has been a marked lack of dialogue on the issue that most concerns most people in the community, namely, the restoration of a local GP out-of-hours service and a systematic refusal to respond to the much repeated community calls for restoration of this service. Dr Buist’s praise is echoed by Mr Watson’s own assessment that is contained in the NHS Tayside evidence to the Committee (ROH18): “We believe we have given all members of the Kinloch Rannoch community, both those who are involved in the Community Council and the many others who live in the wider community, the opportunity to put their views forward and we have listened.”

According to their own report on the consultations that NHS Tayside carried out in August-October 2008, there was only a single call for a First Responder scheme which came from an SNP Councillor who had previously worked for the Scottish Ambulance Service. He is a member of the First Responder Reference Group and is on record in the local press as charging the Community Council with being “out of step” on First Responders and as endangering lives.

Since the Board meeting on 13 November 2008 NHS Tayside has dialogued with individuals whom they have appointed to attend their “First Responders’ Reference Group” - the only exception being the Chairman of the Community Council, Alex Grosset, who attends Group meetings as an observer only (for his evidence see ROH3). The strength of local opinion on the restoration of local GP out-of-hours may be gauged through votes by large majorities at successive public meetings, through the approximately 200 letters that were sent to Mr Watson in December 2008 warning him of possible legal action and by the fact that about the same number of local people signed the e-petition that appeared on the Parliament’s website last summer (this was out of a total 445 signatures).

The Centre for Rural Health, in its capacity as consultants to NHS Tayside, has recently carried out a survey based on questionnaires sent to householders within the practice areas. Particularly relevant to the claim made by Dr Buist and Mr Watson are the responses to the following three questions:

- I believe arrangements in place to deal with a healthcare emergency in the Rannoch & Tummel area are satisfactory
  
  Disagree 65%    Neutral 11%    agree 24%

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1 Extracted from Introduction of Community First Responders (CFR) in Rannoch & Tummel. Summary of initial findings from baseline survey. Centre for Rural Health (undated). The report was obtained from NHS Tayside under an FoI request in December 2009.
• I believe the provision of OOH cover for emergency healthcare situations is the most important problem the Rannoch & Tummel community have to deal with

  Disagree 8%  Neutral 14%  Agree 78%

• I feel that NHS Tayside listens to our community

  Disagree 56%  Neutral 29%  Agree 15%

4. Geography

In ROH19 Dr Buist does not refer to the fact that there are places just like Kinloch Rannoch in terms of their geographical remoteness that still do have 24/7 local GP care - and that value it. In my own earlier evidence, and as a lay person, I drew attention to the geographical factor, contended that one size does not fit all and argued that there is good ground for retaining local GP cover, 24/7, in remote places.

This is what NHS Tayside itself believed before the change of regime which followed on from the appointment of Mr Watson to the chairmanship and which resulted in the denial of the community call for the restoration of the lost service and the opening of the door to the “community resilience model” that is promoted by the Centre for Rural Health. In reading evidence submitted to the Committee by, amongst others, the Royal College of General Practitioners I have been struck by the variety of opinion amongst doctors and also by the value that those who work in the remote rural communities place upon being available to their patients out-of-hours. With all respect to Dr Buist I do not think that he speaks for the profession. His is only one voice.

Dick Barbor-Might
Kinloch Rannoch resident
13 January 2010
Inquiry into out-of-hours Health Care Provision in Rural Areas

Randolph Murray

(A) Most sustainable and cost effective way to provide adequate OOH services in Rural Areas?

Remote and rural areas present a challenge to NHS concepts of equity and continuity of care. This has been brought out in Reports such as Heaney and Hall (2005) which emphasised the desire for "round the clock doctoring" where there were local doctors available for this, but at the same time the difficulty of attracting doctors to such a worMlife commitment in remote and rural areas.

But the evidence from those rural areas which were able to keep their locally based medQpl practicQs suggests that OOH cover by these practices (apart fro%4 'e sirable for clinical reasons) is both cost effective and sustainable. By definition and also by experience, using local GPs for round the clock cover on a rota basis (as, typically in Highland region) saves on outside expenses, travel costs and unnecessary burdens on backup services, A&E e.t.c., while giving a better service to the actual patients who know and are known to, their doctor, whose records are instantly accessible and are reassured by this. In-house OOH cover therefore has clear cost benefits, just as NHS24 has been found (e.g. by the Audit Commission 2003) to have clear cost disbenefits. Further, the SPICE briefing to the Public Petitions Committee on this subject in 2009 indicated that the NHS24 OOH provision in fact generated excessive costs, especially for NHS Boards with responsibility for Rural Areas. The Public Audit Committee was also cited as "expressing concerns regarding the ability of the (new GMS) Contract to effectively target issues of deprivation and rurality through the Contract".

This is in effect to admit that "making one size fit all" is neither the best system nor the most cost-effective one. All this argues for special provision to be made for locally based GP OOH cover where appropriate on both cost and clinical grounds. This is an area where GP services have been clearly undervalued in the past. But to write off altogether these services would be to compound this error. The new GMS contract established no absolute right to opt out, envisaging that special circumstances would and did exist where opt out was simply not appropriate. Doctoring in remote and rural areas of Scotland should surely rank as a special circumstance and one deserving of special treatment. Local doctors can save both lives and costs. This was proven at Rannoch over a period of well over one hundred years with a doctor or doctor and assistant locally resident and able to attend twery corner of this remote area within acceptable time limits and within reasonable cost constraints. This model of the country doctor practice needs to be looked at again.
(B) The Quality of OOH care provided in rural areas, with special reference to clinical safety and effectiveness.

Reference is made to the arguments in (A) which apply here in respect of clinical safety. Continuity of care is assured when rural GPs provide a 24/7 service. Quality of care is safeguarded because local doctors who know the patient are on hand to diagnose and treat, and this reduces the likelihood of clinical error or mis-diagnosis or failure to diagnose timeously where this could be critical. This is the essence of GP doctoring. Here the GP’s services are irreplaceable as clinically the most effective filter on the front line of Primary Care. Paramedics and First Responders have their place but are no substitute for GPs in diagnosing and treating all manner of patients from babies to the elderly—for all manner of illnesses and health conditions, often requiring the exercise of critical clinical judgement and the immediate administration of appropriate drugs.

(C) Accessibility and Availability of OOH care in rural Areas.

The papers relating to the withdrawal of OOH cover in Rannoch and Tummel have, I understand, been passed to the Committee. This is a classic case where it is strongly held that local GP OOH cover should never have been allowed to be withdrawn. In a sense this is a test case for rural exceptionalism, i.e. that where, because of geography, any OOH service has to be locally provided by existing locally based doctors, this should become the rule. Such a provision was arguably recognised by the new GMS contract which permitted "Opt out prevention" in suitable circumstances. This is in simple terms the remote and rural case.

A further point: Rannoch was offered an alternative to GP OOH cover, namely First Responders, being volunteers trained over five days in resuscitation techniques. The question of OOH doctoring was not addressed as such. The semi-autonomous Centre for Rural Health which pioneered use of First Responders was engaged by Tayside Health Board to advise on use of First Responders so that this would replace the doctors. But this body, CRH, has been described as "a research Institute which promotes entrepreneurship, self care ("Community Resilience") and e-health for those living in remote areas". It is involved in dedoctoring, in effect de-skilling rural areas which have OOH GPs or want these restored. It is not neutral on these issues. It wants to phase out the country doctor. Therefore, it is important to recognise the proper status and real value of the local rural doctor and to set up a model, based on that in Highland Health Bod for proper remuneration of GPs who choose to become country doctors in the traditional sense. This is vital for the wellbeing and continued viability of remote and rural areas of Scotland.
Examples of stress caused by lack of a local doctor

An 86 year old patient suffering from a very high temperature waited three hours for a doctor to attend from Perth 60 miles away. The doctor on arriving in the area was then unable to locate the patient even with the benefit of GPS system. There was then a further delay of an hour for an ambulance to arrive from Pitlochry. Meanwhile the concerned patient and his wife were left without the necessary medical assistance they justly required.

Elderly patient visiting the area was seen by a doctor from NHS 24 on the Saturday. The following day she required further medical attention but by the time the doctor arrived the patient was too ill to await the arrival of an ambulance from Pitlochry. This resulted in the patient’s daughter being asked to take her extremely ill mother 60 miles, over winding rural roads, to hospital. The patient was suffering from the life threatening condition of pulmonary embolism. This was an extremely stressful journey for the patient’s daughter and total distress for the patient.

This is not the only instance where patients have had to be transferred to hospital by their relatives. There was an incident where a patient sustained a serious head injury. An ambulance was called but never arrived. The relatives had no alternative but to take the injured patient a two and a half hour journey to Dundee for emergency treatment and admission to hospital. The patient’s relatives were later told that they should not have transferred the patient themselves but had no other alternative during the OOH. No doctor was available to diagnose or treat this patient prior to the transfer.

A further incident demonstrates the inadequacies of the ambulance service. A patient fell onto the road sustaining serious fracture. The ambulance personnel transferred the patient who was in severe pain to the hospital where fracture were diagnosed. The patient had to make the journey without adequate pain relief over twisting turning roads causing extreme distress. On arrival at the hospital the doctor stated that the patient should not have been transported in this fashion.

Situations like this have resulted in the residents advising their elderly relatives and those with young children not to visit the area due to the totally inadequate OOH Medical response.

The lack of medical cover also has resulted patients who are chronically ill being transferred to hospital at weekends to ensure medical cover. This results in a great deal of distress not only to the patient but to the relatives. Previously the local GP would be able to attend to the patients requirements over the weekend and administer the necessary drugs.
A patient undergoing chemotherapy requiring treatment which could easily have been administered by a doctor locally had there been one available, had to make the journey to the cancer unit in Dundee for treatment by emergency ambulance. This resulted in an overnight stay in hospital for treatment. On discharge the patient had to take four buses and a taxi to get home from the hospital on a Sunday. This horrendous journey was totally unnecessary as a local doctor could have administered the treatment.

In this day and age patients should not be subjected to waiting hours for adequate pain relief until arrival at hospital. Ambulance personnel are unable to diagnose and administer pain relief other than gas and air which is insufficient for the journey over rural roads which depending on the weather conditions can add a considerable length of time to the already extremely long journey to hospital.

On three separate occasions an elderly man required medical attention and none was available. He was asked by NHS 24 to attend the cottage hospital in Pitlochry for treatment. Following this incident the local doctor gave him his private telephone number in order that the doctor could be contacted at all times despite NHS 24. A number of other residents were also in that privileged position due to the doctors concerns regarding the inadequacy of the OOH service. This facility was withdrawn after the doctor retired. Subsequently the same patient experienced a severe swelling in his leg which required instant medical diagnosis. This was not available OOH and he required to be driven to hospital for diagnosis and treatment. This same patient having sustained severe injuries in a fall over the festive period 2009 required diagnosis and treatment. Fortunately a GP on holiday in the area and a local resident orthopaedic surgeon were able to provide prompt and effective treatment prior to the patient’s transfer to hospital. He was found to have a fracture to the neck which had it not been diagnosed and treated effectively locally could have resulted in permanent disability or death.

Two occasions where patients have been told by the OOH doctor that it is a long way to come to Rannoch. On both occasions the doctor has attended. Patients within the Rannoch and Tummel unlike many in the city area will not call out a doctor OOH unless it is indeed an emergency.

Many of these incidents do not appear on the NHS Tayside statistics because the NHS 24 has been by-passed due to patients using any relevant personnel who can give immediate assistance. But getting casual help is no solution. These stresses are caused because there’s no locally available doctor if people feel or fall ill out of hours.
Accessibility and availability

The ambulance service in the cities are able to get the patients to hospital extremely quickly. (8 minutes) In this rural area the ambulance if there is one immediately available can take anything from an hour to an hour and a half to reach the patient in an emergency. There have been instances where the ambulance has been sent from Killin, Crieff or Perth which adds a considerable time to the response time. Ambulance personnel are unable to diagnose or treat the patient. When other areas in region become busy the ambulances are transferred from this area to assist, leaving no ambulances in Highland Perthshire.

As previously mentioned there have been instances where the ambulance has been unable to locate the patient. The Sat Nav System is often inadequate and vital time is wasted in emergency situations locating the patients. There are also black areas where mobile phones do not work, thus reducing the communications. This is a matter of local knowledge. A locally based doctor would circumvent these difficulties.

On occasions where there have been a shortage of paramedics on board the ambulance has resulted in the emergency being covered by two ambulance technicians who are inadequately trained for emergency situations.

How well do the NHS 24 and SAS link into the OOH services?

They are the OOH service.

Randolph Murray
Petitioner and Kinloch Rannoch resident
12 January 2010
Health and Sport Committee

31st Meeting, 2009 (Session 3), Wednesday, 2 December 2009

Note on Petition 1272
Randolph Murray on out-of-hours GP cover

Introduction

1. In September 2009, the Public Petitions Committee (PPC) referred Petition 1272 to the Health and Sport Committee.

PE1272 – Randolph Murray

2. PE 1272 was first lodged with the Parliament on 7 September 2009. The petition reads—

   Petition by Randolph Murray calling on the Scottish Parliament to urge the Scottish Government to ensure that there is adequate provision for out-of-hours GP cover in all remote and rural areas in Scotland.

3. On 16 September 2009, the Health and Sport Committee agreed to undertake a short inquiry into out-of-hours healthcare provision in rural areas. In the knowledge that the Health and Sport Committee was going to be running this inquiry, the PPC agreed on 21 September 2009 to refer this petition to the Health and Sport Committee, The PPC also agreed to write to the Scottish Government and NHS Tayside for their views on the petition.

4. The following documents are included at Annex A:
   - Background information from the petitioner in respect of healthcare provision in the Kinloch Rannoch area
   - Response from the Scottish Government to the petition
   - Response from NHS Tayside to the petition
   - Further comments from the petitioner in light of the letters from the Scottish Government and NHS Tayside.

5. The Committee is invited to note that, in response to this Committee’s call for evidence on out-of-hours healthcare provision in rural areas, three submissions were received which directly address the situation in Kinloch Rannoch.

6. The Committee will be considering its approach to this inquiry at agenda item 6.

Recommendation

7. The Committee is invited to consider whether it wishes to—
Agenda Item 1
25 January 2010

(a) close the petition on the basis that the inquiry into out-of-hours healthcare provision in rural areas will enable the Committee to examine the issues of wider application raised by the petition; or

(b) propose and agree an alternative approach.

Callum Thomson
Clerk to the Committee
Mr Fergus D. Cochrane
Clerk to the Public Petitions Committee, TG. 01
The Scottish Parliament
Edinburgh
EH99 1SP

Email: fergus.cochrane@scottish.parliament.uk

13 September 2009

Dear Mr Cochrane

**Consideration of Proposed Public Petition PP760**

As arranged, I submit an Additional Note background to the Petition for the assistance of the Committee on 21 September.

I am both faxing this 2 page document to you and emailing it.

Yours sincerely,

Randolph Murray
PP760 – Petition to protect and restore GP out of hours services in remote and rural areas:

Additional Note on background to the Petition

1880s – 2006.
Because of its remote situation in North West Perthshire, the Community of Rannoch and Tummel had enjoyed the benefit of a doctor living locally for well over a hundred years, long before the foundation of the NHS in 1948 or even the Highlands and Islands Medical Service in 1913. The practice area extends from Rannoch Station in the West (with a hotel and houses) to Trinafour and Tummel Bridge in the East, and as from the furthest extremity nearly 40 miles over narrow and difficult roads from both Pitlochry and Aberfeldy, and 70 miles from Perth Royal Infirmary. Because of its remoteness, Rannoch had what was termed quasi-island status and its doctors provided a round the clock service which was revered and cherished and saved many lives locally. Its ending in 2006 has been the subject of continuous protest ever since.

2004
The new GMS contract allowed GPs to opt out of providing OOH cover for their patients, except where special conditions applied. In Scotland, 90% of GPs opted out but the remainder did not, most of these being on islands or in remote areas of mainland Scotland. This petition is about these doctors, and about remote rural communities like Rannoch which have lost all-round doctoring and need this service back.

2005
The likely effect of the medical opt-out on rural areas was given serious consideration by David Heaney and Stephanie Hall in a Report ‘Out of hours Care in Remote and Rural Scotland’ in June 2005. This assessed the problems of a one-size-fits-all approach in rural areas like Rannoch which relied on traditional doctoring – i.e. a family doctor who was available on call round the clock. These doctors usually worked with an associate or in cooperatives. (In Rannoch, the doctor worked with an associate). The Heaney and Hall Report anticipated that there would be local resistance to any change in this pattern, stating ‘Managers predicted that a public and political outcry seemed likely….The public will need to be educated about these new roles…’ and ‘In rural areas patients were accustomed to a service with face-to-face consultations with a known GP.’ Many GPs themselves were cited in the Report as being concerned about this and had both moral and practical objections to opting out, some suggesting this would be the death of rural medicine and impossible to reconcile with the NHS principles of equity, universality and continuity of care.

Against the concepts of universal provision and continuity of care (formerly essential building blocks of NHS doctoring) was posed an alternative concept of Community Resilience. This meant, in rural communities, not having a locally based doctor any more, or, at least, not one who would be available...
when needed. To prepare the public for this new policy, an action plan, ‘Better Health, Better Care’ was rolled out, stating, unequivocally, that ‘there is no substantial demand for GP services to be available 24/7’, despite clear indications to the contrary in what public consultations had preceded it. A Remote and Rural Steering Group was set up to crack the nut of rural resistance to losing their GP-led out of hours services and to establish a new framework for establishing OOH cover without the frontline involvement of GPs.

2008
The Remote and Rural Steering Group duly reported to the Scottish Parliament. It had done its intended work well. Its Report, now entitled ‘Delivery for Remote and Rural Healthcare’, claimed to ‘form the basis of a safe and sustainable service for remote and rural areas that will increase community resilience.’ Community Resilience was defined bluntly as ‘facilitating communities to look after themselves’, and significantly, the Report adds, ‘Strong leadership and management will be required to facilitate the building of Community Resilience’. The burden of medical care in rural communities was now to be shared with others who were not doctors, and notably with First Responders, volunteers who, after five days’ training, were to become the new frontline of Extended Care Community Teams (ECCTs). Single-handed and small GP practices were to be phased out and replaced by these ECCTs, and local surgeries to be re-designated Community Response Hubs. Where now the family doctor? This downgrading of the country GP in both status and availability was to be disguised partially by creating a new specialist-type GP, a GPSI, who would have ‘a special interest in rural medicine’ but would no longer be in the frontline. (The very fact that GPs do not get a mention in this report until page 15 points to the seriousness of this downgrading).

The particularities of Rannoch are referred to in the Petition. But this is not just about Rannoch. It is about all other remote communities in Scotland who have lost their traditional doctoring or who are struggling to keep this, who need doctors not First Responders. The original thrust for replacing doctors in the community arose from a perceived shortage of doctors, which is no longer the case, and from alleged funding difficulties. But in 2008 the Audit Commission found NHS24 to be ‘unsustainable’ – i.e. too expensive. The evidence is that, as Dr. Brian Keighley, the new Scottish Secretary of the BMA has recently claimed, it would be appropriate, particularly in rural Scotland, to return responsibility for OOH cover to locally based GPs and thus to re-establish continuity of care that is economically sustainable and medically right. This Petition asks your committee to take this view and to urge the Scottish Ministers to act accordingly and pursue this policy change. I would draw your Committee’s attention to the under-noted comments placed on the Petition website.

Dr David Player MA, FRCP (Edin)
How tragic, then, that continuity of care has been so compromised by so many doctors withdrawing from providing out-of-hours cover as they responded to the financial incentives crafted into the new contract that
the Westminster government introduced throughout the UK on 1 April 2004. This was a retrograde measure and it should be the task of the Scottish Parliament to rescind it or at least mitigate its worst effects. The campaign that has been mounted by people in the Highland village of Kinloch Rannoch to restore 24/7 cover should be a beacon to us all.

Scotland Patients Association (SPA)
Unless government is aware of how isolated people are within these communities and rectify the situation it would be difficult to recommend that anyone should consider continuing to live in areas which are poorly served by GPs, qualified nurses and paramedics. If such areas only have people substituting for doctors, nurses and paramedics standards will fall and lives will be lost. It is the responsibility of the health board to provide GPs for Out of Hours.

Dr Simon Hurding – Glenelg, Ross-shire
I have lost count of how many out of hours meetings I have attended over the last eight years. All suggested solutions to the problem of remote and rural out of hours health care have been graciously considered. For certain general practices we always come to the same conclusion – that there is no reasonable alternative to the GP covering out of hours. There are GPs still willing to do this work and the level of service is high.

Iain Muir – First Responder and vet – Achiltibuie, Wester Ross
I am a vet and if I were to offer the level of service to my animal patients that opted-out GPs do to their human ones, without an out of hours provision, I would be up before the disciplinary committee of the Royal College of Veterinary Surgeons and could expect to be suspended or struck off.

13 September 2009
Randolph Murray
Dear Mr Cochrane

PETITION PE 1272

Thank you for your letter of 23 September to Roy Sturrock.

Health boards have a statutory duty to ensure that primary medical services are in place throughout their areas. In most cases this duty is met through individual contracts with GPs. A new national contract for primary medical services came into effect in 2004. In Scotland it is given force by the Primary Medical Services (Scotland) Act 2004, which amended the National Health Service (Scotland) Act 1978, and the NHS (General Medical Services Contracts)(Scotland) Regulations 2004 which came into effect on 1 April 2004.

The changes to out of hours services brought about under the new contract were significant. Under the previous arrangements GPs were responsible for the provision of services for their patients at all times. For the out of hours (OOH) period, defined as night time during the week, the weekends and public or local holidays, it was open to GPs to transfer their responsibility, at their expense, to another qualified practitioner with the approval of the health board. An alternative was for a GP to meet their responsibilities by sharing their duties with other GPs in the locality through a co-operative arrangement. Health Boards had only limited involvement in these arrangements and there were significant variations in the type of service made available to patients.

One of the intentions of the new contract was to address a serious recruitment and retention issue for GPs throughout the UK. Key to the recruitment issue was the requirement for GPs to provide OOH care while faced with an increasing patient workload during the day. General practice was not seen as attractive by medical trainees.
Under the new contract, the regulations provided that a GP could opt out of the responsibility for patient care during the OOH period. In return, the payment they receive from their health board is accordingly reduced. Where they did so the responsibility reverted to the local NHS Board. Most GPs exercised their right to opt out and it was a priority for health boards to ensure the availability of safe OOH service across Scotland. This was achieved by putting into place arrangements which typically incorporate doctors and other clinicians employed on either a salaried or sessional basis and which are supported by NHS 24 and the Scottish Ambulance Service. Since then we have been building on the arrangements to ensure their long term sustainability and improvement. OOH services must meet standards developed by NHS Quality Improvement Scotland to ensure a safe, quality service for all patients. These standards were developed with the support of healthcare professionals and members of the public; they were published as “The Provision of Safe and Effective Primary Medical Services out of hours”. The standards cover 3 key elements of OOH services – accessibility and availability at first point of contact, safe and effective care and audit, monitoring and reporting. All out of hours providers must register with NHS QIS and they have a statutory requirement to meet its standards.

In the case of Kinloch Rannoch the GP did not apply to opt out immediately the new arrangements came into effect. Notice to opt out was, however, submitted in early 2006. NHS Tayside did not oppose the opt out in principal but considered that it should be phased in to allow the development of a team approach along with the local community. The GP asked for the case to go to an independent assessment panel in terms of the Contract Regulations. The panel found, on the basis of experience with other practices in the local area, that there was no reason why the opt out could not safely proceed and it took effect on 1 May 2006.

The GP retired on 31 March 2008. In its advert for the vacancy NHS Tayside said that it would be interested in proposals to provide OOH at practice level. One bid proposed cover for limited periods only and not for “7/24”. The strongest bid overall for the provision of services in normal hours came from the neighbouring Aberfeldy practice proposing amalgamation. That practice had wide experience of primary medical services in a remote and rural area and its bid was accepted. Having opted out of its own provision of OOH it did not propose to provide those services for Kinloch Rannoch.

We are aware that there continues to be concern locally at Kinloch Rannoch about the provision of OOH services. The services put in place by NHS Tayside incorporate NHS 24, an OOH doctor (with a fully equipped car and driver), the Scottish Ambulance Service and other services provided by the board such as local hospital facilities. Since 2006 the Board has engaged with the Kinloch Rannoch community to develop services. This has included the establishment of a group of community first responders. It is important that the position of the first responders is clearly understood. In no way are they intended by NHS Tayside as the replacement of the local GP practice in the delivery of OOH services. They are a supplementary resource of the
Scottish Ambulance Service and their support is not limited to the OOH period.

We are committed to maintaining the high standard of OOH services. There has recently been an interim report from the Care Quality Commission in England following the death of a patient while under the care of an OOH locum doctor from abroad engaged by an independent company with a contract for such services. While the NHS in Scotland does not contract with independent companies in these circumstances we have asked all health boards to consider the matter to ensure that their own services have measures in place to safeguard patients.

Yours sincerely

FRANK STRANG
Deputy Director, Primary Care Division
NHS TAYSIDE SUBMISSION

The individual responsibility of General Practitioners (GPs) to provide out of hours services ended in Scotland in 2004, with the introduction of the New General Medical Services Contract (nGMS). Under the Primary Medical Services (Scotland) Act 2004, NHS Boards have a legal duty to provide primary medical services to their populations through either direct provision or by contract or agreement with a range of providers. Integral to these arrangements was the capability of GP Practices to continue to provide services during the out of hour’s period or to “opt out” of such provision, where Board agreed alternatives could be identified. Where GP practices exercise this right to “opt out”, they give up their personal responsibility for 24 hour provision and the NHS Board assumes legal responsibility to secure the provision of out of hours services consistent with the standards established by NHS Quality Improvement Scotland.

Following consultation, the vast majority of GP practices in Tayside decided to opt out of out of hours and this responsibility passed to the new NHS Tayside Out of Hours Service. The service in Perth and Kinross which was configured following community engagement and consultation incorporates:

- A Primary Care Emergency Centre (PCEC) co-located with A&E at Perth Royal Infirmary.
- Out of Hours GP with driver and vehicle based at PCEC to respond to home visits, and Out of Hours GP with driver and vehicle based at Aberfeldy/Pitlochry Community Hospitals to respond to home visits.
- Rapid Response Unit comprising paramedic single manned vehicle based at Aberfeldy/Pitlochry Community Hospitals to augment the double Crewed Paramedic Ambulance emergency response team based at the Pitlochry Integrated Care Centre.
- Nurse–led, extended hours Minor Injury Illness Units (MIIU), based at Crieff, Pitlochry and Blairgowrie Community Hospitals.
- A District Nurse evening and overnight service based in the localities during the evening and operating from Perth overnight.

In late 2005, the NHS Quality Improvement Scotland (NHS QIS) reviewed the NHS Tayside Out of Hours Service against their standards, and in the March 2006 report assessed the registration status of the service as “provider is largely compliant with standards”. Following the subsequent assessment and further report in December 2007, the registration was amended to level 4 (the highest rating) - “Provider has achieved full compliance with the standards”. This provides external review and clear evidence that the NHS Tayside Out of Hours Service is safe, effective and quality assured in accordance with the national standards.

The Kinloch Rannoch GP Practice, a single handed practice covering a population of just under 600 patients, was initially an exception to these arrangements and continued to provide out of hours services as a level one
provider under locally negotiated General Medical Services (GMS) contract arrangements. Although the Kinloch Rannoch Practice had applied to transfer their responsibilities for out of hours at that time, NHS Tayside agreed with the practice to defer the opt out for an initial period of 12 months. It is worthy of note that from the start of the deferment period in October 2004, patients registered with the practice, had their out of hour calls triaged by NHS24 and passed to the Tayside Hub at Wallacetown in Dundee, which in turn contacted the Kinloch Rannoch duty doctor. In October 2005 the GP practice expressed the opinion that, despite initial concerns about the change to nurse triage via NHS 24, this system had worked well and the number of calls during the out of hour period were described as light.

Following this, the practice exercised their right to permanently opt out and an external assessment panel approved the decision resulting in the practice ceasing to provide out of hours cover from 1 May 2006 and that responsibility for the Kinloch Rannoch and Tummel population passed to the established NHS Tayside Out of Hours Service. Subsequent to this decision NHS Tayside agreed to separately survey patients living in the Kinloch Rannoch area. Two separate surveys have been undertaken both with high overall satisfaction rates from patients who have used the out of hours service.

In 2007, the extant GP, Dr Roger Simmons intimated his retirement and a recruitment process was initiated for the provision of GMS services, and a specification was issued that included the option for prospective applicants to incorporate proposals for out of hours provision and offering guidance around residency being in Kinloch Rannoch or vicinity. Only one of the short-listed applicants offered any proposals for out of hours provision and this was only for limited provision at specified times, but this application was unsuccessful. On the recommendation of the appointment panel, that included community representation, NHS Tayside Board agreed to award the contract to the Aberfeldy Practice and the merged practice became Aberfeldy and Kinloch Rannoch Medical Practice.

Since the decision to allow the Kinloch Rannoch Practice to “opt out” of out of hours provision, the community of Kinloch Rannoch has been supported by the same high quality service as provided across the rest on the Tayside area, through the NHS Tayside Out of Hours Service, augmented through the enhanced service provision as detailed. The service is able to respond effectively to the limited demands for GP out of hours services in the area. During 2008, there were a total of sixteen home visits made to Kinloch Rannoch by the service and there were twenty-eight attendances at MIUs by people from the Kinloch Rannoch area. There were no attendances at the PCEC in Perth, a total of seven people were given telephone advice by an out of hours GP and the emergency ambulance service responded to twenty eight calls. Despite this, some members of the Kinloch Rannoch community, including the Rannoch and Tummel Community Council continue to voice concerns over the issue of out of hours cover.

During 2008, the report of the Remote and Rural Steering Group was published under an NHS Scotland Chief Executive’s Letter (CEL), requiring
NHS Boards and Special Health boards to take account of the recommendations in assessing and planning services for remote and/or rural communities. In August and September 2008, NHS Tayside through the Perth and Kinross Community Health Partnership in whose area the community of Kinloch Rannoch is situated, undertook a series of community engagement events to consider the issue of community resilience around healthcare. The conclusion from the process was that the overriding concern of the community was in relation to response in emergency situations. A number of options to improve emergency response in the area were identified and presented to the community in October 2008.

The NHS Board agreed the recommendation to establish a community first responder scheme, augmenting the pre-existing enhanced out of hours services, to establish a local reference group to secure an improved model of emergency response and to financially support the measures in collaboration with the Scottish Ambulance Service.

During 2009, the reference group has met seven times and has initiated a number of developments, including:

1. Establishment of a Community First Responders Scheme, which is supported by NHS Tayside and run by the Scottish Ambulance Service (SAS), now delivers to the people of Kinloch Rannoch an additional emergency response over and above the current arrangements for out of hours. There are six volunteers who have started the service (commenced in August), which will continue to be developed by the Scottish Ambulance Service, and there have been five responses made by the scheme since its inception.

2. During the in hours period, the Aberfeldy and Kinloch Rannoch Medical Practice now respond to emergencies with advance trained GPs equipped with emergency kit bags and connected via a vehicle location system to ambulance paramedic response.

The position of NHS Tayside can be summarised as follows:

- Ensuring appropriate standards of care either in or out of hours in remote and rural areas such as Kinloch Rannoch remains a priority responsibility of NHS Tayside.
- NHS Tayside’s provision of GP out of hours cover to Kinloch Rannoch is within a framework that meets and exceeds the legal, regulatory and inspectorate requirements and standards and has neither employed out of hours locum GPs from abroad nor employed GPs engaged by independent contracted companies.
- Evidence continues to demonstrate that requests for GP response in the Kinloch Rannoch area in the out of hours period average two per month, and that these requests are routinely met within the required timescales.
• We believe that the issue in Kinloch Rannoch is the community’s concern around providing an emergency response - this is very different from providing GP services out of hours.

• That additional emergency response service based in the heart of the community is now available through the Community First Responders Scheme, and is additional to the current out of hours GP provision which will continue to respond to non-emergency situations.

• The Community First Responder Scheme ensures the patient has rapid access to a specially-trained individual with life-saving skills putting an emergency response which is safe, sustainable and economically supportable, right into the heart of the community until a paramedic reaches them.

• We believe we have given all members of the Kinloch Rannoch community, both those who are involved in the Community Council and the many others who live in the wider community, the opportunity to put their views forward and we have listened.
Petition PE 1272 by Randolph Murray

I hereby submit final comments on the responses by the Scottish Government and Tayside Health Board to this Petition about restoration and protection of GP out-of-hours cover in remote and rural areas of Scotland, with particular reference to Kinloch Rannoch.

Firstly with regard to the response from Mr Frank Strang, Deputy Director, Primary Care Division, St Andrew's House, Edinburgh, dated 21 October 2009, on behalf of the Scottish Government, the following points need to be made:

1. Because, for sound geographical reasons, there had been a doctor in Rannoch for over 120 years, the local community has opposed any opt-out. NHS Tayside itself opposed the opt-out at first instance and then also at the panel hearing which the doctor (who had refused mediation) insisted upon. The panel decision was unsound, was conducted in a manner contrary to NHS guidelines and was criticised in the Scottish Parliament. Consequently, when the doctor later decided to retire and the post was newly advertised, this was, under pressure from the community, done on the clear basis of returning responsibility for out-of-hours cover to the new practice. This was to be a ‘core component’, not merely an ‘option’, the new doctors were to live locally, and there was stated to be funding in place for this. The decision by Tayside Health Board to ignore all this and appoint a practice which refused to do any OOH at all shocked the local community because it left them without an effective doctor for two thirds of the time. This issue is not resolved by replacing doctors with ‘Community First Responders’, as Mr Strang recognises, but by bringing back GPs to do OOH in remote areas where NHS24 can’t cope as is the case of Rannoch.

2. It is clear that the Scottish Government has been misled by Tayside Health Board as regards (a) the strength of local feeling on this issue, (b) the cost of restoring out-of-hours cover and (c) the absolute necessity for such continuity of care in remote areas like Rannoch. The true position on these three critical points is as follows:
a. The recent questionnaire for Rannoch residents by the Centre for Rural Health has revealed that 73% of respondents wanted a return to GP OOH cover;
b. There was funding available for OOH cover on the basis of the advertised practice specification, maintaining existing inducements for in-house OOH cover and offering new inducements for its continuation, all as per the specification; and
c. It is impracticable to try to cover the practice area by using NHS24 and a GP (operating for all of Highland Perthshire) based in Pitlochry or Aberfeldy bearing in mind the time required to reach all parts of the practice. A doctor is needed to live locally to do this and to dispense essential drugs from the in-house pharmacy when necessary. To claim that NHS QIS standards are satisfactorily met in Rannoch is an absurdity when it takes a journey equivalent to travelling from Edinburgh to Glasgow and back to get a prescription out of hours, and well over an hour for a Pitlochry or Aberfeldy based GP to reach all parts of the practice area. How can criterion 1(a)4 ‘...access to and delivery of services is not compromised by physical...and other barriers’ be upheld in any meaningful way in relation to Rannoch’s geographical situation? Does there have to be a death before NHS QIS will pay attention to this as the Care Quality Commission had to do in England?

3. As regards the submission of Tayside Health Board by letter from Professor Tony Wells, Chief Executive, dated 22 October 2009, I would submit the following points:

a. NHS QIS rating is not just meaningless in relation to Rannoch but wrong in that it ignores all the cases where NHS24 has been deliberately by-passed, people have had to be attended to by non-doctors or have arranged to drive sick relatives to hospital themselves without any reference to NHS24. Similarly, the Tayside Health Board statistics are seriously flawed and cannot be relied on. There is no local confidence in either the service or the statistics. This lack of confidence is apparently shared by the Public Audit Commission, which found NHS24 to be ‘unsustainable’ but also made special reference to the 2004 contract which, specifically, it concluded was not appropriate to deal with two problems, namely rurality and deprivation.
b. It is not accurate to suggest that anything other than a return to traditional doctoring was acceptable to the Rannoch Community. This issue was repeatedly evaded in Tayside Health Board Community Updates which, perversely, ignored criticisms of the status quo and punt First Responders as the preferred solution in Rannoch, contrary to all the evidence from public meetings and the Community Council. It has repeatedly pointed out to the Health Board that the community wanted doctors for doctoring and that this was not simply a matter of emergency
cover or ‘resuscitation’ (see Professor Allyson Pollock’s evidence).

Reference is made to the annexe in this letter which contains further detail relating to these and other matters relevant to your Committee’s enquiries and the documents produced.

Yours faithfully

Randolph Murray

Encl. Annexe referred to (below)
A powerful medical voice has been raised against having a local GP OOH service in Kinloch Rannoch on the grounds that the money would be better spent in a deprived area of Dundee. This viewpoint has been expressed in a letter that Dr Buist, Chair of the General Practice Sub-committee of Tayside Area Medical Committee, recently sent to Mr Watson, Chair of the Health Board. Dr Buist asserts that Kinloch Rannoch suffers no disadvantage in the health care service that it receives and concedes that rurality does have its costs. But he also writes that:

“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…”

This makes for disturbing reading, coming as it does from such an influential quarter. It is concerning that urban poverty in Dundee should be set up as a weapon against what Mr Watson and his senior officials have so disregarded and which this community believes is based both upon the principle of equal entitlement and upon the proven inadequacies of the NHS24 service in this remote area.

On broader public health grounds it would be worrying if Dr Buist’s argument gained currency in Tayside or elsewhere in Scotland. He bases his judgement upon the single factor of comparative life expectancy when the Scottish Index of Multiple Deprivation uses no less than 38 indicators across 7 domains: income, employment, health, education, skills and training, housing, geographic access and crime. Furthermore, research in other remote rural areas has established that these kinds of indices are fine for measuring deprivation where there are concentrations of population but are not so useful where people live scattered along secondary roads and miles from major services. For places like this you need to talk directly to people, so as to find out how rural households often face disadvantage in public transport, high costs of food and fuel, the lack of affordable housing, jobs and career prospects and access to services. And the existence of large elderly populations, so far from indicating comparative advantage, actually increase the need for the continuity of care that is assured by the traditional model of health care with 24/7 local GP cover.

NHS QUALITY IMPROVEMENT STANDARDS (QIS)

The underlying issue of geographically based inequality, that is so central to understanding the needs of people living in remote rural areas is not covered
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by NHS QIS which is “committed to equality and diversity [across] six equality groups which they embrace are “age, disability, gender, race, religion/belief and sexual orientation”. Thus is excluded any recognition of inequalities that arise through geography: specifically, the disadvantages experienced by remote rural communities.

The point is important since the Cabinet Secretary for Health and Wellbeing, in a letter to the solicitors acting for Rannoch and Tummel Community Council on 11 October has argued that NHS Tayside has been validated by NHS QIS in a report of December 2007. This validation excludes the vital factor of geography. This point is enlarged upon in other evidence that has been submitted to the inquiry that is being conducted by the Health and Sports Committee.

COSTINGS

A key question is how much it would cost to provide a locally-based GP OOH service, whether in Kinloch Rannoch or in a similar remote rural area. Despite an objection lodged during their local consultation process the Chief Executive and Deputy Chief Executive of NHS Tayside persisted in their course and presented to the members of their Board an extraordinarily high figure for what they claimed would be the annual cost of a local GP OOH service in Kinloch Rannoch. In a report to the Board and in a verbal briefing they claimed that the cost would be £556,876.

Inquiries by this community have shown that the commensurate cost in the adjacent Highland Health Board area (which had sixteen 24/7 medical practices as of the summer of 2008) is of the order of £140,000 a year. This is based upon an hourly OOH rate of £18. The community has also established that there are doctors willing to provide our OOH service in Kinloch Rannoch for about the same amount. This annual figure is close to the £150,000 that has been cited by Dr Buist in his letter to Mr Watson (see above), which he claims is too high to be justified. The salient points are that (a) Dr Buist is implicitly recognizing that the £556.876 figure was excessive (b) that members of the Health Board were given figures completely out of scale with any realistic costing and (c) the actual cost could be reduced quite drastically if GPs could be persuaded by their Health Boards to accept a lower hourly rate than £18. This, indeed, is the case in some places in the Highland Health Board area where the going rate is £10. As we understand the matter, a lower rate is paid in at least one of the island groups.

There has so far been no recognition by Tayside Health Board that their officials asked their Health Board to make an important decision on the basis of misleading figures. The matter has so far been disregarded by the Scottish Government.

We do not ourselves have the kind of access to costing figures that will be available to the Committee. However, we would make two further points. First, it is highly relevant to the debate about delivering OOH care to inquire
into offsetting savings. The obvious point is that there are considerable financial savings to be made by having a local GP OOH cover in reducing both unplanned hospital admissions and unnecessary ambulance call-outs (not to speak of less pain and distress for patients in emergencies that may not be life-threatening but that should not be allowed to arise in the provision of quality care). Secondly, we suggest that any investigation of costs should also encompass NHS24. This service would appear to be very expensive for what it is, not least because the doctors concerned would appear to receive vastly more than the comparatively modest (although varied) rates that are paid to local GPs who cover OOH within their own practices.
Introduction

There are five medical practices in Wester Ross; but no Community Hospital nor PCEC (Primary Care Emergency Centre). Wester Ross would not be classified as rural but rather as either remote or very remote having many small, widely scattered communities and miles of single track roads. It is not unusual for residents to live up to 10, 15 or even 25+ miles from their medical practice. No matter how remote communities are, they are affected by government decisions. These decisions are made many miles away by people who have little or no knowledge and even less understanding of how they will impact on areas like Wester Ross when they are implemented. It must be remembered that "one size doesn’t fit all".

Before the UK-wide GMS contract was implemented the HPCT (Highland Primary Care Trust) held consultation meetings in Skye and Easter Ross but failed to hold one in Wester Ross. In 2004 GMS was implemented and NHS Highland replaced HPCT.

Our group was established in December 2005; we have six members with each medical practice area represented by a Community Councillor who might be working for two or more CCs, there is also a group co-ordinator. The Group’s remit was to put forward our communities’ views and by using local knowledge work with Health Boards and Wester Ross medical, nursing and SAS (Scottish Ambulance Service) staff towards the provision of a safe, sustainable and affordable OOH service for our communities. The aim was to ensure that any patient requiring unscheduled OOH care could have face to face contact within one hour with a GP, Nurse or Unscheduled Care Practitioner e.g. nurse or paramedic. Our group was involved in working groups and larger consultation groups which addressed specific Wester Ross challenges and produced a recommended ‘new design’ OOH service to be implemented by March 2009; a date which was not met.

In 2005 OOH service provision was that one practice worked 24/7, but in the other four practices our own GPs provided OOH care Mondays – Thursday; two practices also covered occasional weekend and Bank Holiday shifts; all empty shifts being covered by Highland based locum GPs with vacant slots being filled by Agency locum GPs. Mid-Highland CHP has now used the Scottish Allocation formula, which takes into account factors such as rurality and deprivation, to the benefit of our area. This means that there is not an immediate pressure to re-configure OOH services in Wester Ross which is very encouraging and we are pleased that this has been achieved for “the foreseeable future.” However, we are mindful of the financial constraints that Health Boards are facing and are reassured that in future Mid-Highland CHP will "seek to implement a Community Advisory Committee to provide a forum
to allow on-going constructive engagement between CHP/Locality and community in respect of a range of service considerations."

Our Group has endeavoured to work in an open, transparent and collaborative way and has:

- issued Progress Reports which have been widely circulated
- undertaken research into activity and funding which necessitated use of FOI
- attended Annual Review visits to NHS Highland, SAS and NHS 24
- with the guidance of four Highlands and Islands MSPs and our Highland Councillors, we organised and hosted a visit to Wester Ross by the Nicola Sturgeon MSP, Cabinet Secretary of Health and Wellbeing, which involved producing a comprehensive brief that included results of research undertaken to ascertain Wester Ross communities’ and service providers’ views regarding current and proposed ‘new design’ OOH services
- referred system failures to relevant HBs; all dealt with courteously
- responded to BMA Scotland’s Consultation *General Practice in Scotland: The Way Ahead*
- hosted a Public Focus Group for NoSPG (North of Scotland Planning Group) to comment on *Emergency and Urgent Response to Remote and Rural Draft Standards for RRIG (Remote and Rural Implementation Group)*
- members involved in pfpi (patient focus public involvement) activities in NHS Highland, SAS, NHS 24 and SCT (Scottish Centre for Telehealth)
- continued to monitor OOH service provision
- sought and is awaiting views of Wester Ross CCs regarding its future having suggested it is retained to maintain links built with HBs for the mutual benefit of all concerned communities, local staff and Health Boards

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

A service can only be adequate if it is remembered that we are patients not parcels.

All areas will bring their own challenges, although these may be similar the solutions will vary according to local infrastructure. It is important that NHS Boards, local service providers and communities work together in an open, objective way to provide a service which meets jointly identified patients’ needs; all parties need to understand the financial constraints and NHS structures, such as Scottish Allocation formula, which are in place to meet needs of specific areas.

With the increased attention being paid to anticipatory care ‘during hours’, the need for unscheduled care may well diminish.
Far greater use of telemedicine would be of immense benefit to remote and rural communities but, in Wester Ross, there is a need for adequate Broadband infrastructure to achieve this; financial benefits are obvious as are the carbon emission savings which HBs are required to make.

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

With PCECs located so far from our Wester Ross communities and lack of access to telemedicine, we are fortunate that the quality of current service is safe and therefore effective. Any problems brought to our attention have been referred to relevant HBs and dealt with courteously with results reported to us and relayed to patients concerned. Clinical problems fall into the category of ‘Complaints’ and there are systems in place for these to be addressed. Any reduction in current service at this time would have an adverse effect on quality of care and give rise to concern.

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

NHS 24 is the access point to our OOH service. Initially the NHS 24 service was variable and caused concern, but it has improved considerably since it co-located a satellite with SAS and the Highland Hub; which are all based in the SAS Inverness EMDC (Emergency Despatch Centre). The OOH Group carried out a community survey to assess NHS 24 service; to preserve patient confidentiality patients’ comments were only shared with The Cabinet Secretary, NHS 24, NHS Highland, SAS and Wester Ross GPs; an analysis of the survey was shared with Wester Ross CCs and included in the Information Pack. After several months we asked HBs for their responses to the survey and these were shared with above named parties.

Any patient calling NHS 24 has to dial an eleven digit number; it would be helpful and make access easier if a three digit number could be introduced. If patients call their own medical practice OOH they are automatically transferred to NHS 24.

Current service availability is outlined in the Introduction.

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

NHS 24 – See above.

SAS – OOH Group requested activity figures from SAS and did a comparison between one full calendar year before GMS and one full calendar year after GMS. It showed an increase of 29.74%. For a short time there was a problem
with single-manning but recently additional staff have been employed and the situation is much improved.

There are three ambulances based in Wester Ross; in locations further away from these bases two community First Responder teams have been established and trained by SAS; these community volunteers are alerted by EMDC when required which is sometimes during OOH. Their contribution is much appreciated. The possibility of a third First Responder Team being established in the last remote location is currently being investigated. If it goes ahead it will mean that, in the event of an emergency, all areas of Wester Ross have help as early as possible either from an A&E crew or volunteer First Responders who will be joined by A&E as soon as possible.

We hope that the Introduction will explain our involvement to date which informs our answers to the questions.

Copies of the Information Pack and Response to BMA consultation can be supplied if requested. We will share our submission with NHS H, NHS 24, SAS and Wester Ross GPs.

Liz Pritchard
Group Co-ordinator
Wester Ross Medical Practices Community Representatives OOH Group
4 November 2009
Inquiry into out-of-hours Health Care Provision in Rural Areas

NHS Highland

1. **What do you think is the most sustainable and cost effective way to provide adequate OOH services in rural areas?**

The continued use of local GPs in remote and rural areas is essential but the reliance on individual local GPs, who may be on call very frequently, is unlikely to be sustainable in the longer term due to future potential recruitment of appropriately skilled and experienced young GPs.

Consideration of OOH care in remote and rural areas is closely linked with the provision of emergency response, i.e., response to immediately life threatening situations. This type of response is clearly the responsibility of the ambulance service, however in remote and rural areas the local GP would often be called upon in the absence of a timely ambulance response. For remote and rural communities access to this type of response is the core concern.

Work is currently being undertaken by the Emergency Response and Transport Workstream of the Remote & Rural Implementation Group to review both emergency response standards and the workforce/resources required to deliver this type of response. This does have implications for the provision of OOH primary as a proportion of OOH care will be urgent care requiring a response within one hour.

In remote and rural areas, due to the lack of accessibility and distance from definitive care, OOH primary care provision is necessarily linked to emergency provision. Therefore sustainable models will be those which build on existing resources and which link together a range of clinical skills across a local area.

Therefore a sustainable and cost effective provision of OOH will need to include contributions by local GPs; Ambulance Service including Paramedic Practitioner level skills, Community Nurses with Advanced Practitioner skills and local community/volunteer responders etc to support emergency response which will form part of the OOH requirement due to remoteness and rurality models will need to take account of low levels of activity and provide cover on an on-call basis; however this has implications for skills maintenance across all disciplines and is a particular issue for skills maintenance in Nurses and Paramedics with the Advanced Practitioner skills required to appropriately assess and manage primary care conditions at a distance from a source of definitive care.
2. **What are your views on the quality of OOH care provided in rural areas, in particular clinical safety and effectiveness?**

Current OOH provision in remote and rural areas provides an excellent level of safety and effectiveness. Home Visits are more common in such areas and patients have access to the most highly skilled clinical professional even for non-urgent conditions. Analysis of the NHS Highland service provides evidence of all response timescales (identified by NHS24) being met and extended, largely due to the extensive coverage provided in rural areas coupled with very low activity and therefore low utilisation of GP resources.

3. **What are your views on the accessibility and availability of Out of Hours care in rural areas?**

Current remote and rural OOH provision clearly provides gold standard accessibility if measured by response times. In the future there is the opportunity to link resources such as Nurse Practitioners, the Ambulance Service and Community First Responders together to provide the support which would allow GP cover to be spread over a wider area. In this way the utilisation levels of scarce resources, such as GPs, could be improved and more appropriate skilled practitioners used for cases which did not require GP input. Links with other response providers are essential to address community concerns regarding emergency response despite this not being the responsibility of the OOH service. Sufficient GP level coverage needs to be maintained in order to reduce the risks associated with distance from definitive care.

4. **How well do you think does NHS24 and SAS link with the existing OOH services?**

NHS24 is an essential part of filtering OOH calls; however there are ongoing issues regarding their ability to respond appropriately to remote and rural calls as a result of the infrequency of such calls and the different approaches taken to provision of care in these areas. Whilst triage of calls helpfully filters out those which do not need to be seen locally/urgently, the NHS24 contingency, at times of increased activity whereby calls are passed back untriaged, is unhelpful, as is the level of ‘speak to doctor’ advice calls which are required to be assessed by a GP despite passing through the NHS24 system.

Links with SAS at the frontline of response are good; however there is often a shortfall at control room level, whereby opportunities to link responses to urgent/emergency calls with resources already available locally is not taken, eg OOH GPs who are under-utilised may not be considered by SAS to support provision of emergency response. At the strategic level, contrary to the views of GPs, there is a degree of
organisational cohesion between planning for remote and rural response provision. This is evident in the Emergency Response and Transport Workstream which takes into account resources such as GPs and Nurses already available in hours and out of hours to respond to unscheduled events.

Dr Roger Gibbins
Chief Executive
NHS Highland
21 January 2010
Inquiry into out-of-hours Health Care Provision in Rural Areas

NHS Highland supplementary evidence

Highland NHS Board
3 February 2009
Item 5.4

FRAMEWORK FOR DELIVERY OF HIGHLAND OUT OF HOURS SERVICES

Report by Gill McVicar, General Manager, Mid Highland CHP and Tracy Ligema, Out of Hours Operational & Development Manager

The Board is asked to:

- **Note** the completion of scoping and modelling work undertaken to support local development of services.
- **Note** the high quality and effectiveness of the Out of Hours (OOH) service.
- **Agree** the principles and framework for the delivery of OOH services now and in the future.
- **Agree** the requirement to develop collaborative approaches.

1 BACKGROUND AND SUMMARY

This paper acknowledges the effectiveness of the current Out of Hours Service, highlights some inefficiencies and potential capacity and introduces a clear framework for the delivery of Out of Hours Services in Highland for the future that will ensure better value for money and local integration of 24/7 care. It acknowledges the clear need for ongoing partnership approaches, particularly with Scottish Ambulance Service and, where possible, local GPs.

Information gleaned from NHS 24 and local systems has been brought together with retrospective and prospective audit of clinical information to evaluate the effectiveness and efficiency of the current service and this information has also been used to simulate and model scenarios for future provision. A report submitted to the Direct Health Services (DHS) Management Team in April 2008 describes, in detail, the outcomes of this work and provides evidence of service performance that has, up until now been lacking. This demonstrates the high quality and effectiveness of the service and also that, on the whole, there is significant capacity in the system that in some areas will allow for changes to be made without substantially affecting the outcomes for patients. DHS Management Team supported the proposal to devolve responsibility for planning, monitoring and budgets to the Community Health Partnerships (CHPs) and their Localities and work has been ongoing to ensure that this work is supported within a clear structure. The mapping, modelling and simulation work has been used to develop a framework for future service configuration.

The framework is underpinned by service design principles, which CHPs can use to ensure delivery of safe and effective services meeting all stakeholder expectations. The principles can also be used to ensure that future developments allow CHPs the
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flexibility to meet local needs whilst assuring the Board of the continued consistency of quality and standards to deliver safe and effective services.

In common with all Boards in Scotland, NHS Highland has been responsible for the provision of Primary Care Out of Hours services, as a result of the New General Medical Services Contract, from 1st December 2004. Until that date, General Practitioners (GPs) were responsible for providing care twenty-four hours per day, and apart from co-operatives in Inverness and East Highland, little was known about the demand. Recent analysis of the current service has provided important information about demand, performance and the impact of service change which will assist in future developments.

The service is delivered through a mixture of Primary Care Emergency Centres (PCEC), Minor Injury/Ailment Centres, Individual GPs and Accident and Emergency Units. In the main, the gateway to the service is through NHS 24, but there are still some Practices who provide the initial call triage themselves. This situation is not encouraged as back up for the patient and the Doctor is not as robust as when NHS 24 is being used and the information requirements are more easily fulfilled when the same system is in operation.

It must be stressed that the service has been well accepted in local communities and has been safe and sustainable until recently when fewer local GPs have agreed to work in the system in some areas and there has been a reliance on Locums.

The major cause for concern in communities remains the speed of emergency response and availability of Scottish Ambulance Service. It has been helpful to have had clarification from the Scottish Government, through the transport sub group of the Remote and Rural Implementation Group, that there is now confirmation that the strategic responsibility for the provision of an emergency response lies with Scottish Ambulance Service (SAS). The SAS should be responsible for commissioning and processing the necessary service response, although this might be provided by territorial Boards through Community Health Partnerships. The Remote and Rural Implementation Group is developing a national framework for emergency response within which local operational plans can be developed.

NHS Highland is currently engaging with SAS to look at local solutions for particularly remote and rural areas, where both services face the challenge of providing staff on the ground to respond to out of hour, in the case of NHS Highland, and emergency calls to SAS. It is acknowledged that there is likely to be both synergy and cost benefits from the local collaboration and coordination of these resources which would result in more comprehensive care, and a timely response. It is assumed that transfer mechanisms should operate whereby SAS would fund such operational provision by other Providers.

The SAS have been fully involved in the development of the NHS Highland service provision statements to ensure that there is no unexpected consequence of any aspirations in the delivery of out of hours care.

1.1 SERVICE PROVISION STATEMENT

NHS Highland’s Out of Hours (OOH) service provides Primary Medical Services between 18:00 and 08:00 hours on weekdays, all weekends and public holidays. The services provided by the Board must provide access to
health care professionals for primary (general) health care when the clinical condition of a patient means they cannot wait until the next day for this.

NHS Boards have a duty to meet the standards established by NHS Quality Improvement Scotland (QIS). These standards cover:

- Access and availability at first point of contact
- Safe and effective care
- Audit, monitoring and reporting.

There has been considerable work done on QIS standards against which the Highland service evaluates well, reaching Level 3 compliance ahead of target.

QIS does not set any targets for timing of response to patients; however a number of Health Boards have implemented internal Key Performance Indicators (KPIs) in response to the QIS Standard 3(a) 1, which recommends that a set of provider-specific KPIs be implemented.

Although the analysis of OOH response and the proposed key performance indicators include a response within 1 hour, there is a strong argument that primary care OOH should not be expected to provide this level of response as it is not expected to provide emergency response services. There is an ongoing national debate on this point and NHS 24 has been asked to review the triage protocols that lead to a within one hour response request. National debate is also taking place to confirm the statutory responsibilities of the Scottish Ambulance Service in respect of emergency provision. Clarification of this responsibility is expected to lead to development of more collaborative approaches to the implementation of workforce structures which provide a more robust configuration to deliver timely emergency response.

1.2 QUALITY AND EFFECTIVENESS

Detailed analysis of the current OOH service configuration demonstrates that the service is provided to very high standards, with a minimum of 83% of patients assessed as requiring a home visit within 1 hour actually receiving this response. An average of 94% of patients in this category receive a response within the recommended 1 hour timescale. For PCEC appointments within 1 hour, an average of 94% of patients are seen within this timescale. Overall, average waiting times for both home visits and PCEC appointments are 30 – 40 minutes.

It should be noted that there is ongoing discussion with NHS 24 about the 1 hour triage category as it is rare that a Primary Care response should be required within an hour. These calls would normally constitute an emergency.

2 SERVICE DELIVERY FRAMEWORK

In April 2008 the OOH budget was devolved to CHP level as part of a fair share allocation. This aimed to provide flexibility across local systems to enable whole system design of services into the future, with opportunity costs being more easily identifiable at the local level. This is in line with the Integrated Resource Modelling approach and clearly supports Shifting the Balance of Care.
The service delivery framework is intended to provide support for CHPs in designing and delivering local OOH services. The framework describes the fundamental principles that should be built into OOH services delivery at the local level. The framework outlines the ways in which these principles should be operationalised, as well as potential measures through which the Board can be provided with assurance that required principles are being delivered and that the service continues to be safe and effective.

2.1 UNDERLYING ASSUMPTIONS

- **NHS24** will be the first point of contact for unscheduled care needs, providing consultation, advice and appropriate response referral. In future, it is expected that this will be part of an integrated communications structure providing first point of access for all unscheduled and emergency care requests. It is intended that future developments, including remotely based NHS24 provision in local areas, would support uptake of this service in areas where it is not currently utilised.

- **Emergency care provision** is the remit of the Scottish Ambulance Service in accordance with its statutory responsibilities. The framework clearly sets out the baseline requirements for NHS Highland’s OOH service as well as providing the principles on which future service developments should be founded. These include a presumption that in future there will be a need for collaborative approaches to the delivery of safe and effective emergency and unscheduled care services.

3 CONTRIBUTION TO BOARD OBJECTIVES

The delivery of Out of Hours services contributes to a number of specific corporate objectives of NHS Highland. These include:

- Improving the health of the most disadvantaged and, in particular in the case of Out of Hours services, by ensuring that health services are accessible to disadvantaged communities.

- Shifting the balance of care to enable as much care as possible to be provided in the home or close to it. Avoiding unnecessary and repeat admissions to hospital.

- Continuing to develop sustainable and safe services.

- Ensuring all resources are used most efficiently.

4 GOVERNANCE IMPLICATIONS

- **Staff Governance**
  It is essential that staff involved in delivering Out of Hours services are fully equipped and supported in the delivery of the service.

- **Patient and Public Involvement**
  Significant effort has been put into joint work with communities regarding Out
of Hours services and any changes to the services.

- Clinical Governance
  As described above, NHS Boards have a duty to meet the standards established by NHS Quality Improvement Scotland (QIS). These standards cover access and availability at first point of contact; safe and effective care; and audit, monitoring and reporting.

- Financial Impact
  CHPs review local services to ensure that they represent value for money. This may require OOH services being linked/integrated with core hours services in the community or an increase range of services being delivered during the OOH period in order to utilise available resources.

5 IMPACT ASSESSMENT

An Equality and Diversity Impact Assessment has not yet begun but will be completed by the end of February 2009.

Gill McVicar,
General Manager,
Mid Highland Community Health Partnership and

Tracy Ligema,
Out of Hours Operational & Development Manager

23 January 2009
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### 2.2 THE FRAMEWORK

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<th>Operational Delivery</th>
<th>Measure</th>
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<td>1. The OOH service will be clinically safe and effective, meeting the clinical needs of patients and supporting appropriate access to care.</td>
<td>1.1 OOH service will respond to patient needs within recommended timescales ensuring that patient needs (as demonstrated by clinical priority) are met.</td>
<td>NHS Highland performance indicators for response to patients calling NHS24:</td>
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<td><strong>Home Visit within 1 Hour</strong></td>
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1.2 OOH service will ensure that patients are able to access the service by telephone preferably via NHS24 and arrangements are in place to meet the needs of all those potentially using the OOH services to ensure access is not compromised by physical, language, cultural, social, economic or other barriers

- QIS delivery standards met to Level 3 (largely compliant with standards)
- CHP local responsibility for ensuring that service configuration matches needs is demonstrated in local OOH delivery plans.
- Use of NHS24 for first point of access to unscheduled care is consistent across all CHPs
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|-----------------|---------------|
| **1.3 Where face to face consultation is recommended to provide the required clinical care for patients this will be delivered by the nearest available clinician with the most appropriate skills** | • CHPs will ensure that local services are configured to provide the clinical skill mix required to meet patient needs. Health professionals providing this care will include GPs, as well as Nurses and Paramedics with appropriate clinical skills where available.  
• CHP workforce planning will clearly demonstrate skills profiles which match clinical need as identified by clinical data mapping for unscheduled care. |
| **1.4 Face to face consultations will be provided in the location which facilitates the patient receiving care most appropriate to their clinical need** | • The Board will receive assurance that patients with clinical need indicative of a home visit requirement will be provided with this type of care, e.g. patients with palliative care needs and patients with acute mental health problems. |
| **2. The OOH service is designed to meet required quality and performance standards** | **2.1 National quality and performance standards are embedded within operational service delivery** | • QIS Level 3 standard achieved as required during 2006/7  
• New national standards for OOH response performance and planned clinical performance indicators to be adopted when available. |
| **2.2 NHS Highland quality and performance standards which support safe and effective delivery of patient care as well as ensuring that the OOH service makes appropriate contribution to the overall delivery of patient care, e.g. supporting a range of Board targets/deliverables and helping to facilitate Board response to policy initiatives at the local level.** | • Board level performance indicators (as above)  
• Identified contribution to Board delivery of HEAT and other targets where applicable  
• Development of joint organisational measures to support more efficient unscheduled care and demonstrate |
| Agenda Item 1  
25 January 2010 | effective planned care, e.g.: |
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<td>1. Category A emergency response as joint target – SAS &amp; NHSH</td>
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<td>2. Return of spontaneous circulation (ROSC) achievement rather than 8 minute response target.</td>
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<td>3. Percentage reduction in emergency admissions and in ambulance conveyance (indicates increase in percentage of patients treated/maintained at home)</td>
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<td>4. Percentage increase in patients discharged at or before to EDD</td>
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<td>5. Percentage increase in patients with chronic conditions maintained in the community (i.e. reduction in numbers of admissions for this group of patients) with identified case managers which include SAS, community nursing, GP practice etc</td>
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| 2.3 Quality and standards of OOH service delivery, including performance indicators, will be monitored at CHP and Board level through existing governance structures. | • CHP Clinical governance groups will monitor clinical incidents and response performance exceptions which will be reported to NHSH Clinical Governance committee as appropriate. |

<p>| 3. The OOH service represents value for money and delivers within allocated budgets | 3.1 OOH budgets devolved to CHP level, spend managed locally as part of CHP total allocation. | • Financial management, CHP accounts |</p>
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| 3.2 CHPs review local services to ensure that they represent value for money. This may require OOH services being linked/integrated with core hours services in the community or an increase range of services being delivered during the OOH period in order to utilise available resources. | • CRS delivery based on re-configuration of services to deliver additional value.  
• Evidence of identification of opportunities to deliver enhanced services/added value by working synergistically across organisational (internal and external) boundaries.  
• Evidence of CHP review and consideration of the impact of local change on the wider systems. |
| --- |
| 4. The OOH service is built on sustainable, multi-disciplinary resource provision and is based on integrated workforce, coordination and education structures | 4.1 CHPs develop locally integrated services which link nursing, General Practice and SAS provision across 24x7. Develop structures and governance frameworks which support multi-professional teams delivering a range of complimentary services (e.g. delivering agreed joint targets) | • Existence of locally based plans and structures for implementation of integrated approaches to service delivery.  
• Evidence of local workforce planning to develop integrated service configurations which include new roles such as UCP from both Nursing and Paramedic backgrounds |
| 4.2 Development of Unscheduled Care Practitioner roles delivering care in a range of settings | 4.3 Implementation of integrated communications centre, including SAS, NHS24 and OOH Hub which coordinates OOH workforce, emergency response and provides call-handling and triage for primary care calls received via NHS24/999 services | • Existence of plans to develop integrated communications and resource management function for whole of Highland  
• Evidence of exploration of alternative approaches to the implementation of NHS24 first point of access to Unscheduled care including locally based provision linked with development of enhanced Nursing/Paramedic roles |
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<tr>
<th>5. The OOH service is flexible across organisational, professional and geographic boundaries</th>
<th>5.1 CHPs review services to ensure that they are integrated (as 4.1 above) across organisational boundaries. This should include integration of OOH PCECs and A&amp;E/Casualty/Minor Injuries departments to facilitate a streamlined approach to patient care which ensures that patients are referred directly to the most appropriate clinician within the most appropriate timescale.</th>
<th>• Evidence of integrated working across organisational and professional boundaries, e.g. integrated teams OOH and SAS, Community hospitals, A&amp;E units, Social services etc</th>
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<td>5.2 CHPs review services to ensure that delivery standards are appropriately maintained in areas of specific geographical challenge, e.g. remote &amp; rural.</td>
<td>• Evidence of review of service delivery against local needs, including risk assessment of any geographical challenges and demonstration of how service configuration addresses risks where appropriate.</td>
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<td>6. The OOH service delivers pan Highland consistency but has the flexibility to reflect local needs where required</td>
<td>6.1 CHPs review services regularly against performance, quality and integration standards</td>
<td>• Evidence that CHP plans and service delivery meets NHS Highland requirements for performance, integration and quality of services as set out above. • CHPs and Board will be assured of quality of provision through existing governance structures including local and Highland wide Clinical Governance and risk Management committees.</td>
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Introduction and Background

The magnitude of change, possibly the biggest in care provision since the inception of the NHS in 1948 coupled with the short timescale to redesign out of hours (OOHs) provision was a daunting prospect for most Boards in 2004.

Prior to this and during the 1990s, delivery of OOHs general medical services was transformed in most of Scotland by the introduction of OOHs co-operatives. Such innovations, however, seldom occurred in rural areas. Geography, weather, transport infrastructure, population distribution and structure, along with recruitment and retention of health personnel all conspired to make it more challenging for remote and rural GP practices to work in co-operatives.

The new 2004 General Medical Services (GMS) contract gave General Practitioners (GPs) the option of opting out of providing OOHs care. This brought about a major re-design of OOHs services and permitted the perceived hurdles, i.e. recruitment and retention, to fundamentally change in remote and rural areas.

Existing structures were to some degree shaped by the local geography in remote and rural areas. In most of the rural areas, it was the commitment to being on-call rather than the actual workload that was burdensome. The OOHs commitment prior to the introduction of the 2004 contract had a significant impact on the working and personal lives of GPs.

In Tayside, prior to the new contract changes, substantial change had already happened in less remote areas (Strathmore area in Perth & Kinross, covering sparsely populated Glens) where the introduction of a co-operative had considerably improved the working lives of GPs. Other, seemingly minor advances, such as an increase in mobile phone coverage had generally helped to relieve the burden of OOHs work.

Given all of this, the culture change for the majority of patients in Tayside had already taken place prior to 2004 and there has been a general acceptance of seeing a health professional rather than the patient’s own GP.

The patient population, however, in the more remote areas is sparsely distributed, and is often skewed towards the elderly. In some places there is also a fluctuation in patient numbers at certain times of the year due to temporary residents. All of these population characteristics can influence patient culture which can also be shaped by the previous GP services prior to the new GP contract.
Research by Heaney and Hall (2005) found that people in the more remote and rural areas are accustomed to a personal relationship and this continues to influence their expectations and attitudes towards provision of care during the OOHs period.

It is with this background that the following response has been prepared:

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

   In larger urban areas e.g. in Tayside’s case, Perth and Dundee, organising OOHs provision is relatively simple as economies of scale come into play. In these larger more densely populated areas multi disciplinary teams work well and small numbers of GPs and OOHs nurses provide a cost effective service.

   Once population density drops less demand makes multidisciplinary teams less cost effective, each GP home visit takes more time and the distances involved often dictate the positioning of Primary Care Emergency Centres (PCECs) and Minor Injury and Illness Units (MIIUs). One crucial factor is the ability to respond to a home visit within one hour.

   Sustainability is dependent on these factors and the differentiation between access to a GP/health care professional during the OOHs period and an emergency response is poorly understood by the public. Emergency care has not changed with the implementation of the new GP contract; however there has been a blurring of responsibility and patient expectation since 2004.

   Ownership by rural communities of the new models of care is crucial to sustainability and is dependent on successful community engagement. Examples of community engagement within Tayside are listed below.

   **Angus**

   Angus Community Health Partnership (CHP) have worked in partnership with the Scottish Ambulance Service (SAS) and the local communities to devise what is now known as the Angus See and Treat Service, which was launched in June 2007. This takes the place of the Montrose, Brechin and Forfar MIIUs after 10.00pm every night, through to 8.00am next morning and responds to direct calls to the SAS for Category B and C calls thus allowing our rural SAS capacity to concentrate on Category A calls.

   93% of patients referred to See and Treat are treated in situ with no need for onward care. Through interface with Community Nursing and local GP practices via the Taycare computer reporting system patients can receive follow up or additional monitoring if required.

   The See and Treat Team has had particular success with the older age groups and young children and we have seen a marked reduction in transfer to Ninewells A&E and acute admission. We still have work to do with the
younger and youth age groups however many of them may access A&E in Dundee as they are in the vicinity on a night-out.

The team travel across Angus in a SAS Rapid Response Vehicle and are deployed either by NHS Tayside OOHs hub or by the Emergency Medical Dispatch Centres of SAS. A more recent introduction which we are trialling is direct referral from NHS 24 local hub and this is working well. The average response time is 28 minutes. In some instances Category A SAS calls can be revised and are redirected to the See and Treat team. When the SAS team identify that a more local response may be more appropriate the team will visit wherever the patient may be i.e. home, care home, street, hotel etc.

Clinical safety and clinical effectiveness are paramount to all health care provision within Angus and the staff working on the See and Treat service overnight have all undergone additional training in Minor injuries, Minor illness and Emergency Care of the Child courses to enable them to work as autonomous practitioners within the service. The nurses are all part of the Angus MIIU staff, who rotate on to the See and Treat service from the units where they work as autonomous practitioners on a day to day basis. Some of them have completed the Non Medical Prescribing Certificate, whilst others use the Patient Group Directives (PGDs) which are used within the OOHs service and the Minor Injury units across Tayside.

Nurses work to MIIU protocols and guidance for minor injury and illness presentations, taking into consideration best practice, the guidelines and protocols are regularly reviewed as they are also used in the MIIUs. Nurses rotate in to the MIIUs regularly to ensure that they maintain their clinical knowledge and skills as well as to access any further training or updates.

The paramedics also have additional training as well as being fully qualified paramedics, some of them have undertaken Minor Injuries and Illness courses to assist them in this role.

Although the current model of OOHs health care provision in Angus is in its infancy it has been extremely well received by the public, who following public consultation were keen for it to begin and the subsequent patient satisfaction surveys have all been very positive.

Perth and Kinross

In the Rannoch and Tummel area during August and September 2008, Perth & Kinross CHP undertook a series of community engagement events to consider the issue of community resilience around healthcare. The conclusion from the process was that the overriding concern of the community was in relation to emergency response. A number of options to improve emergency response were presented to the community in October 2008.

NHS Tayside Board agreed to establish a local reference group to secure a model of emergency response and to financially support the measures in collaboration with the SAS.
During 2009, the reference group has met seven times and has initiated a number of developments, including:

1. Establishment of a Community First Responders Scheme, which is supported by NHS Tayside and run by the SAS and now delivers to the people of Kinloch Rannoch an additional emergency response over and above the current arrangements for OOHs. There are six volunteers who have started the service (commenced in August), which will continue to be developed by the SAS, and there have been five responses made by the scheme since its inception.

2. During the in hours period, the Aberfeldy and Kinloch Rannoch Medical Practice now respond to emergencies with advance trained GPs equipped with emergency kit bags and connected via a vehicle location system to ambulance paramedic response.

With regard to Kinloch Rannoch the position of NHS Tayside can be summarised as follows:

- Appropriate standards of care either in or out of hours have always been and will continue to be the priority.
- The current provision of GP OOHs cover to Kinloch Rannoch is within a framework that meets and exceeds the legal, regulatory and inspectorate requirements and standards and has neither employed OOHs locum GPs from abroad nor employed GPs engaged by independent contracted companies.
- Evidence continues to demonstrate that requests for GP response in the Kinloch Rannoch area in the OOHs period average two per month, and that these requests are routinely met within the required timescales.
- We believe that the issue in Kinloch Rannoch is the community’s concern around providing an emergency response - this is very different from providing GP services OOHs.
- That additional emergency response service based in the heart of the community is now available through the Community First Responders Scheme, and is additional to the current OOHs GP provision which will continue to respond to non-emergency situations.
- The Community First Responder Scheme ensures the patient has rapid access to a specially-trained individual with life-saving skills putting an emergency response which is safe, sustainable and economically supportable, right into the heart of the community until a paramedic reaches them.
- We believe we have given all members of the Kinloch Rannoch community, both those who are involved in the Community Council and the many others who live in the wider community, the opportunity to put their views forward and we have listened.
Current services available in northwest Perthshire:

- OOHs GP with driver and vehicle based at Aberfeldy Community Hospital to respond to home visits.
- Rapid Response Unit (RRU) comprising paramedic single manned vehicle, based at Aberfeldy Community Hospital to augment the double-crewed Paramedic Ambulance emergency response team based at the new Pitlochry Integrated Care Centre.
- Primary Care Emergency Centre (PCEC) now co-located within the Accident and Emergency Department at Perth Royal Infirmary.
- OOHs GP with driver and vehicle based at the PCEC to respond to home visits.
- A district nurse evening and overnight service based in the localities during the evening and operating from Perth overnight, further augments OOHs services.
- Nurse-led, extended hours MIIUs based at Crieff, Pitlochry and Blairgowrie Community Hospitals (now with tele-medicine link to OOHs GP clinical decision support).
- In addition, the Community First Responders Scheme, which is supported by NHS Tayside and run by the SAS, now delivers to the people of Kinloch Rannoch an additional emergency response over and above the current arrangements for OOHs. There are six volunteers who have started the service (commenced in August) and this will continue to be developed by the SAS.

Kinloch Rannoch Activity in 2008

- Home visits = 16
- Minor Injury and Illness Unit attendances = 26
- Attended Primary Care Emergency Centre in Perth = 0
- Telephone advice by GP = 7

999 Ambulance Calls

- In 2007 – 36 calls to Scottish Ambulance Service
- In 2008 – 28 calls to Scottish Ambulance Service

Consistently averaging approximately three calls per month.

On 26 October 2009, the Cabinet Secretary for Health and Wellbeing launched the Emergency and Urgent Response to Remote & Rural Communities Strategic Options Framework (SOF). This framework comprehensively addresses all aspects of Emergency & Urgent Response and is designed as a tool to be used by the SAS, in partnership with NHS Boards, CHPs and local communities, to establish, over time a response appropriate to local circumstances.

It is the “response appropriate to local circumstances” that is key to any service provision with sustainability and cost effectiveness crucial factors.
Quality Improvement Scotland (QIS) have a key role to play as does the local community in collaboration with relevant Health Boards and the SAS.

It is imperative that true cognisance of existing provision in its entirety also needs to be taken on board prior to forming opinions on both sustainability and cost effectiveness. Any proposals should meet:

- Enhancing community resilience in a remote and rural community.
- Strengthening social capital and community capacity.
- Addressing the requirements of the Remote and Rural Healthcare Strategy.
- Compliance with NHS QIS Standards.
- Progress towards the implementation of the Hierarchy of Care model through strengthening services in local communities.
- Improving local access to emergency response.

There are clear opportunities to consider an appropriate ‘tiered’ response utilising a mixed economy of statutory bodies. However current structures such as health and SAS, can constrain change in the short to medium term and a more cohesive approach to delivering health care in rural areas could add to sustainability and cost effectiveness and ultimately improve care delivered to patients.

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

Board OOHs services were set up and intended to provide access to healthcare professionals in situations where the patient’s clinical condition is such that it cannot wait until the next day. Through the redesign process there is more standardisation but a less personal OOHs service although it is more open to measurement against quality standards.

QIS are clear on their role in terms of clinical safety and effectiveness across the whole of Scotland. Each Health Board has been subject to external scrutiny and Tayside has reached level 4 Provider status which means that the service has achieved full compliance against QIS standards.

Through QIS standards various key performance indicators (KPIs) were developed:

a) Time stratifications (ensuring patients are seen within designated times)
b) Special notes (where patient information is shared via registered GP practice with OOHs services).

Patient feedback on service delivery is a crucial factor when measuring clinical safety and effectiveness and it is equally important that feedback from patients is used to further develop services.

It is worthy of note that in rural areas where feedback has been gathered from patients that have used the service (exit survey) this has in the main been
positive. This is opposed to members of the public, who have never used services and who have expressed concern around distances that would have to be travelled, possible loss of GPs, safety and home visits.

The SOF, previously mentioned, also clarifies the statutory responsibility and role of both the SAS and Territorial Boards as well as a set of specific standards for emergency and urgent response for use in remote and rural communities. The services provided are usually more fully and openly monitored, to more explicit standards, than previous arrangements. The standards set by NHS QIS are comparable with emergency medicine and day time GMS services.

All of the above applies to rural as well as urban areas. However, more ‘joined up’ thinking may be required on the part of NHS QIS as NHS Boards should not be examined or scrutinised in isolation with regard to quality and clinical effectiveness in rural areas.

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

Accessibility and availability depend on many variables and the communities perception of this. Factors include degrees of remoteness, population and population spread, previous and current data around utilisation of OOHs services, in hours provision and the need for a clear distinction between accessing a GP in an OOHs situation and accessing an emergency response in an OOHs situation. Clarity is required and it needs to be understood that “availability of OOHs care in rural areas” does not imply access to a GP; it means access to the most appropriate response.

One of the keys to success in relation to accessibility is provision of patient transport and this has helped particularly in rural areas. There is however no provision of NHS transport to daytime GP services, and given this there are significant differences between the indications for day time and OOHs services:

- night time cases are for treatment that cannot wait till the following day;
- patients will usually have chosen their GP surgery for ease of access; the OOHs centre may be quite a bit further away for some patients;
- availability of public transport drops in the evening and even more so at night.

Patients continue to raise NHS 24 as an accessibility issue even although there has been a positive and noticeable difference in ‘call back’ times. In some rural areas it is perceived that NHS 24 triage is less effective than triage by GPs who know their patients. The understanding by NHS 24 of remote and rural areas has improved and they now have a reasonable knowledge base of local areas.

There is widespread concern about the accessibility of the ambulance service in rural areas with slow response times reported and backup ambulances
stationed outwith the area. There were ongoing issues about accessibility to the ambulance service prior to the development of OOHs services in 2004. In this context, there were also fears expressed by SAS on increasing pressure on the already strained ambulance service stemming partly from NHS 24 and partly from the OOHs service. In some areas however, there are more responses than just an ambulance i.e. Rapid Response Paramedic and the back up if necessary of the Air Ambulance service. A balance needs to be gained as a current challenge for SAS personnel can be skills attrition and lack of job satisfaction due to low activity.

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

Generally the links with both SAS and NHS 24 have considerably improved since 2004. However, due to the nature and challenges of remote and rural planning there is a greater need for multi-agency working from the outset and collegiate networks will assist this. The need is not only for ambulance access but significant consideration needs to be given to both Air Ambulance and Emergency Medical Retrieval Service. The launch of the SOF (in terms of Emergency and Urgent Response) clearly identifies the strategic responsibilities of the SAS which is further reinforced within the Memorandum of Understanding relating to Roles and Responsibilities Associated with Emergency and Urgent Response Services.

In the absence of the aforementioned SOF, strategic roles and responsibilities were less clear and therefore appropriate “ownership” of issues could be challenging.

In rural areas a more ‘joined up’ approach is essential to provide a unified approach to care. Working with SAS allows better ‘cover’ of rural areas and can help the boards deal with workforce issues such as European Working Time Directive, recruitment and retention. Whilst we have always worked closely with NHS 24 there is still room for closer working.

Mr Sandy Watson
Chairman
NHS Tayside
5 November 2009
Inquiry into out-of-hours Health Care Provision in Rural Areas

NHS Borders

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

The most sustainable and cost effective way of providing an adequate out-of-hours service in rural areas is by using a combination of suitably qualified salaried GP’s and nurses/AHPs who have extended their scope of practice educationally and practically in the assessment, diagnosis and treatment of patients in the rural locality. The Borders model is an example of this with further benefits possible from greater use of paramedic practitioners, using ‘See and Treat’ methodology. In addition, the minor ailments service from community pharmacies can reduce unnecessary travel and provide a good service in the rural locality.

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

Clinical safety is paramount and is enhanced by the appropriate training and development of staff working within the rural locality, ensuring that practice is competency-based and appropriate to the needs of the population. Enhanced multidisciplinary working will ensure that cohorts of patients, such as palliative patients, receive joined-up care appropriate to an individual’s needs.

The educational needs of rural GPs differ from those of urban and as such the use of Rural Networks for learning are valuable. Nursing staff are used in greater numbers in rural areas and the current training pathways are effective.

New technology such as telemedicine could play a greater role in areas that are rural but not remote.

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

The Borders model offers effective and safe cover across a large geographical area, taking account of activity prediction tools to make most appropriate and cost effective use of medical and nursing resources.

The service is locally focused and tailored to the needs of the rural population where possible, such as ensuring adequate GP cover around the wide geographical area of the Borders until 23.00 when it is busier than our overnight shift.
Patients are able to access the service through NHS 24 or can self present at treatment rooms/minor injury units across the region. Good networking across the service between primary, secondary and tertiary care offers a comprehensive service to the population.

There is no doubt that travelling can be inconvenient for patients at night but we have to match resources with clinical need. Visits to the patient home are done when appropriate. Use of increase-skilled nurses also ensures that patients who cannot travel are seen as soon as possible.

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

Existing out-of-hours services, NHS24 and SAS work well together but there is room for a more cohesive approach.

NHS 24 is fundamentally linked to the service here in Borders, with examples of good collaborative working. In keeping with health boards across Scotland, a local NHS 24 service has been established and is based adjacent to the Borders out-of-hours hub.

The leads of the out-of-hours services and NHS24 feed into the National Out-Of-Hours Operation group. The management of chronic illness out-of-hours could be more integrated with NHS24 by appropriate information sharing via local MCN leads and the patients' GP.

The closer links with NHS24 and SAS in Cardonald makes for better working and the redirection of calls to NHS24 to and from ambulance.

Links with the Scottish Ambulance Service have the potential for further development and could become more formalised. We have an Unscheduled Care meeting with SAS, and the Clinical Lead of the Borders Emergency Care Service liaises regularly with the local SAS lead on an ad hoc basis about specific issues.

Greater use of paramedic practitioners may limit unnecessary journeys to hospital especially for patients eligible for 'see and treat'.

Shona Cameron
Public Involvement and Communications Manager
NHS Borders
6 November 2009
Inquiry into out-of-hours Health Care Provision in Rural Areas

Scottish Ambulance Service

The Scottish Ambulance Service welcomes the opportunity to contribute to this inquiry into out-of-hours provision in rural areas. In specifically addressing the four questions;

1) The Scottish Ambulance Service would advocate a collective, collaborative NHS response to delivery of out-of-hours provision. This could make use of existing GP, nurse, paramedic and other clinical resources in rural areas and explore opportunities for enhancing skills and sharing resources to ensure efficiency and cost-effectiveness.

The work of the Remote and Rural Implementation Group in developing seven distinct models of care for remote and rural communities could also inform the development of tailored local solutions and brings together the full range of service providers in these areas.

It is essential, however, that the right mix of skills and resources is available in all areas and there is improved co-ordination of these resources to be both effective and appropriate but also cost effective.

Increased use of technology to facilitate this co-ordination could be better exploited, for example, use of Scottish Ambulance Service Emergency Medical Dispatch Centres to track and dispatch all mobile resources could be explored. Likewise, increased levels of decision-support using telemedicine and access to national clinical support could be further developed and available out-of-hours.

It is also essential that the skills of staff providing out-of-hours care in remote and rural communities are maintained and skills atrophy due to low levels of demand is avoided. We believe this only strengthens the argument for shared delivery models and skills transfer through joint working.

The Scottish Ambulance Service has already developed effective models in some areas, including paramedic practitioners and community paramedics who have a range of enhanced skills, increasing levels of treatment and discharge at scene, direct referral to primary and secondary care, and working as part of the out-of-hours team alongside NHS colleagues.

A key factor will be ensuring that available funding is distributed to the most appropriate providers of the service. The Scottish Ambulance Service has seen a significant growth in 999 activity in the out of hours periods since the changes to OOH provision were made.
2) The decision-making around the appropriateness of referral route and outcomes for patients is inconsistent which generates waste in the NHS when patients are inappropriately referred or duplication of effort. This impacts on the patient experience.

Access to GPs is inconsistent and the Ambulance Service has experienced significant uplifts in demand following the change to the out-of-hours provision. In many areas, GPs no longer undertake home visits and the Ambulance Service is often asked to attend these patients, generally resulting in an unnecessary trip to hospital and the possibility of an unnecessary and costly admission.

In many areas, the Ambulance Service is filling 'gaps' in provision and this impacts on our ability to respond to emergencies.

3) Provision is inconsistent and there are gaps in provision across Scotland. This impacts on SAS and NHS24 which are often the default for patients looking for care out-of-hours. Access to services is unclear for patients and this is generating duplication and confusion resulting in patients being 'bounced' between NHS agencies or an inappropriate level of care and response.

The Scottish Ambulance Service has recently undertaken extensive consultation with patients, public and partners around the issue of access to care and has been commissioned by Scottish Government to work with NHS24 and other out-of-hours providers to develop a consistent triage and assessment tool which appropriately assesses clinical need and ensure that appropriate referral pathways are in place.

This consultation has clarified that there is a lack of awareness about which Service to access, that patients are confused about the most appropriate route to care and, that particularly in remote and rural communities, the traditional role and expectation on GPs as the first point of contact remains.

4) NHS24 and SAS have greatly enhanced levels of joint working and both agencies have seen corresponding increases in demand levels following changes to the out-of-hours contract. The nature of telephone triage is to be necessarily risk averse and where this is the primary means of responding to demand out-of-hours, this does result in some inappropriate use of emergency resources, which may have been better dealt with following face to face contact with a GP.

SAS works closely with NHS24, not least in co-locating call taking and triage facilities. As previously stated, SAS and NHS24 have been jointly commissioned to work with out-of-hours providers and others to develop a common triage and assessment tool which will address some of the difficulties currently experienced.
SAS has developed models working alongside out-of-hours providers and these have generated significant reductions, in some cases as great as 70%, in unnecessary attendances at A&E. SAS is committed to continuing to expand and develop appropriate models of response and develop the range of conditions which can be treated at home.

There is evidence to suggest that the public and patients are confused about accessing care. There is also some evidence that accessing care and advice out-of-hours is more convenient for patients and we would support further research or exploration as to how the public access services in Scotland.

SAS has been actively involved in the 'Know Who to Turn To' awareness campaign with NHS Grampian and we recognise the benefits of this work in clarifying how patients access care and we are committed to continuing to support this type of activity more widely in recognition of the changing behaviour of patients.

Summary

In conclusion, our view is that there are inconsistencies in the type and level of out-of-hours services across Scotland, resulting in SAS filling a 'gap' in provision.

We are committed to working with providers to develop an integrated and appropriate response and to simplifying the access and referral processes for patients.

Fundamental to sustaining out-of-hours provision and ensuring cost-effectiveness will be a review of the effectiveness of current delivery, ensuring the 'gap' is fully recognised and that any funding allocated to the provision of out-of-hours services is realigned towards greater integration and demonstrable service delivery.

Pauline Howie  
Chief Executive  
Scottish Ambulance Service  
6 November 2009
Inquiry into out-of-hours Health Care Provision in Rural Areas

NHS 24

Background

In submitting evidence to the Health & Sport Committee on behalf of NHS 24, it is important firstly to reflect on the reasons behind the major redesign of GP Out of Hours Services in late 2004. The need for service redesign in the Out of Hours period was brought about by the implementation of the nationally negotiated and agreed UK wide new general medical services contract. The contract allowed GPs to give up their individual responsibility for the provision of 24 hour primary care to patients on their personal list, and for GP practices to choose to deliver services during a defined in hours period. As a result, the responsibility for the provision of Out of Hours services, in the evenings, overnight and at weekends for nearly all patients in Scotland became the responsibility of Territorial Health Boards. The principle rationale for this change was to address the increasing challenges around the recruitment and retention of medical practitioners in general practice, a problem that was a concern in remote and rural areas. One of the key factors that made general practice less attractive to young doctors and motivated senior practitioners to reduce their commitment or to leave the profession was the burden of on-call and out of hours working. Some of this burden had been alleviated in many parts of Scotland through the formation of GP co-operatives and collaborative working between general practitioners and practices; however this option was unavailable to a significant number of rural and remote practitioners due to the practicalities and organisational challenges of this type of service model. One success of the new GMS contract has been the positive effect it has had in both the recruitment and retention of general practitioners and in particular the ability to recruit to rural practices covered by the new General Medical Services contract.

NHS 24 Role

The core role of NHS 24 across Scotland is to provide comprehensive telephone answering, clinical assessment, triage and advice to patients when they call the service, primarily during the out of hours period. When NHS 24 determines that a patient requires to be seen by a local clinician, it directs patients to services that are available in their own locality. The types of services both in terms of breadth and responsiveness varies across Health Boards and localities, an issue that is particularly noticeable in remote and rural areas of Scotland.

In 2008/09 NHS 24 received approximately 1.5 million calls. Of these, over 40% did not require any GP Out of Hours action – these patient dispositions included for example self-care advice, direct to hospital, or referral to other clinicians such as dentist, pharmacist or district nurse.
NHS 24 – Knowledge Management System

To ensure that NHS 24 provides a high quality service to all patients across Scotland, including remote and rural areas, NHS 24 has made significant investment in a state of the art Knowledge Management System. This system, supported by a dedicated team, ensures that up to date information on all health services in a locality including location, opening times and services offered are available real-time to all NHS 24 frontline staff. For example, should a person in a rural part of Scotland contact NHS 24 seeking information on the closest available pharmacy, the Knowledge Management System will identify the closest pharmacies that are open, calculating road mileage from the patients home to the pharmacy location. NHS 24 operates a robust system of review, in partnership with Territorial Health Boards, to ensure that all the information about local health services on the Knowledge Management System are regularly updated and modified when necessary.

NHS 24 – Local Services

To further support safe and effective service provision across Scotland, NHS 24 has a network of local centres covering every mainland Territorial Health Board across Scotland. This means that in addition to the main centres in Clydebank, Cardonald (Glasgow), South Queensferry and Aberdeen, NHS 24 has local centres in Dundee (Wallacetown Health Centre), Melrose (Borders General Hospital), Dumfries (Dumfries and Galloway Royal Infirmary), East Kilbride (Hairmyres Hospital), Kilmarnock (Crosshouse Hospital), Inverness (Raigmore Hospital), Falkirk (Falkirk Royal Infirmary), and Glenrothes (Saltire Centre). NHS 24 is at an advanced stage of development for a local service presence in Orkney (Kirkwall) and discussions are also underway with Shetland and the Western Isles to secure an NHS 24 presence in those communities. The major benefit to patients and NHS 24 of this business model is to access local clinicians to work within the NHS 24 service, support community resilience, raise the local profile of NHS 24 and provide local knowledge and expertise when dealing with patients. The telephony system in NHS 24 is configured to direct patients from that locality to clinicians based in the area for further assessment, with the opportunity to redirect that call to the first available clinician should the clinical priority of the caller warrant a rapid consultation.

NHS 24 - Health Boards Partnership

NHS 24 is an integral part of the NHS in Scotland, and works in close partnership with all Territorial Health Boards, recognising that most Health Boards in Scotland include populations living in remote or rural areas. NHS 24 has close operational ties, and plans and delivers services in close liaison with Territorial Health Boards and with the Scottish Ambulance Service.

NHS 24 has over the past years, worked with local Health Boards to engage with local communities by for example; holding meetings, particularly in rural
areas to raise the profile of NHS 24 and to explain how to access the service and the range of services that are available.

NHS 24 also works closely with communities and voluntary organisations from across Scotland. The NHS 24 Public Patient Forum (PPF) includes patient representatives from several remote and rural areas of Scotland.

Summary

- NHS 24 works in close partnership with Health Boards across Scotland and recognises the particular challenge that Territorial Health Boards have in the design and delivery in GP Out of Hours services, particularly in remote and rural areas.
- NHS 24 can only come to dispositions for patients that reflect services deployed on the ground by Territorial Health Boards in a patients locality.
- NHS 24 has developed a dispersed service model to ensure a NHS 24 local presence in every mainland Territorial Health Board with plans to extend the network to the Island Board areas.
- NHS 24 telephony configuration attempts to direct patients requiring clinical assessment to staff based within their locality in the first instance, networking nationally based on the patients clinical priority and need.
- NHS 24 has undertaken significant investment in a Knowledge Management System that provides NHS 24 frontline staff with up to date and accurate information on the availability of health services in any locality across Scotland.
- NHS 24 monitors the effectiveness and safety of its services on a daily basis to ensure equity of access and responsiveness.
- Territorial Health Boards are responsible for the configuration of local services available in remote and rural areas.

NHS 24 would be pleased, at the Committee's request, to provide further information in relation to any aspect of NHS 24 services. NHS 24 would also like to extend an invitation to Committee Members to visit a NHS 24 centre to see NHS 24 services working at first hand.

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NHS 24
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