Primary care out-of-hours services

AUDIT SCOTLAND

Prepared for the Auditor General for Scotland
August 2007

Auditor General for Scotland

The Auditor General for Scotland is the Parliament's watchdog for ensuring propriety and value for money in the spending of public funds.

He is responsible for investigating whether public spending bodies achieve the best possible value for money and adhere to the highest standards of financial management.

He is independent and not subject to the control of any member of the Scottish Executive or the Parliament.

The Auditor General is responsible for securing the audit of the Scottish Executive and most other public sector bodies except local authorities and fire and police boards.

The following bodies fall within the remit of the Auditor General:

- directorates of the Scottish Executive eg, the Health Directorates
- executive agencies eg, the Prison Service, Historic Scotland
- NHS boards
- further education colleges
- Scottish Water
- NDPBs and others eg, Scottish Enterprise.

Acknowledgements
Audit Scotland would like to thank the members of the study advisory group for their input and advice throughout the study (Appendix 1). We are grateful to the managers and staff within the NHS boards we visited as part of the review, to the GPs who took part in the national survey and to the users of out-of-hours services who took part in our telephone interviews.

Claire Sweeney, Catherine Vallely, Carolyn Smith and Tricia Meldrum produced this report, under the general direction of Barbara Hurst.

Contents

Part 1. Summary

NHS boards have sustained out-of-hours services for patients and most patients are satisfied with the service, but current models will need to change to deliver in the longer term.

Background

1. For most people contact with the NHS begins and ends in primary care, mainly during the working day.[1,2] People also contact primary care services during weekday evenings, weekends, bank and public holidays – known as out-of-hours care.[3] Every year there are over a million contacts with primary care out-of-hours services across Scotland, and the cost to NHS boards of providing these services in 2005/06 was £67.68 million.[4] The main users of primary care out-of-hours services are children, older people and people with long-term conditions, palliative care needs or mental health problems.[5]

2. The government, NHS managers and GPs across the UK considered that the pressure of the increasing on-call commitment outwith normal working hours deterred recruitment and retention in general practice and affected the sustainability of out-of-hours services. Increases in the demand for out-of-hours services also meant that the current service models could not be sustained. A new General Medical Services (nGMS) contract was introduced for GPs in April 2004 as part of a UK-wide move to reform pay and conditions across the NHS.[6] As part of this new contract GP practices can choose not to provide out-of-hours services for their patients. The opt-out was seen by the four UK health departments as central to agreeing the nGMS contract. By 31 December 2004, 95 per cent of GP practices in Scotland had decided not to deliver out-of-hours services and responsibility for delivering these services transferred to NHS boards.

3. One of the aims of the nGMS contract is to make it easier for the NHS to recruit and retain clinical professionals including nurses and GPs. The transfer of responsibility from GPs to NHS boards has led to changes in the way out-of-hours care is planned and provided. The main aims of these changes are to:

- improve access to and quality of out-of-hours care for patients, with patients receiving treatment from the most appropriate professional
- enable the NHS to better plan and manage out-of-hours services
- improve joint working and information sharing to deliver better patient care.[7]

4. NHS boards can deliver out-of-hours services to patients in two main ways under the new arrangements. They can directly employ GPs or other staff with extended roles (for example nurses); and they can pay other providers such as independent GPs (including those GPs now reproviding out-of-hours care) or locum agencies to help deliver services.[8]

5. Strong links to other clinical services are important to deliver high-quality out-of-hours primary care. This involves links to organisations such as NHS 24 and the ambulance service but also to other NHS board services, specifically unscheduled care services provided by hospital Accident and Emergency (A&E) departments.

6. Although changes under the nGMS contract are significant, this is only one of a series of large-scale changes affecting out-of-hours services. Other changes include the development of NHS 24, which now functions as the initial contact for patients requiring out-of-hours services across Scotland; and new contracts for consultants, nurses, allied health professionals, pharmacists and most other NHS staff.

Key messages

- As part of the nGMS contract over 95 per cent of GP practices have chosen to opt out of providing 24-hour care to their patients, with responsibility passing to NHS boards. This has been a major challenge for NHS boards but they have managed to sustain services for patients. The opt-out offers an opportunity for NHS boards to change the way services are delivered and to improve patient care, although this will take time to be used to its full potential.
- Most of the funding for new out-of-hours services comes from NHS boards' budgets. This has added to cost pressures for NHS boards, particularly in rural areas where they have had to meet a greater percentage of the costs. The cost to NHS boards in 2006/07 was approximately £67.93 million.
- The overall impact on patient care of GPs opting out of out-of-hours services is not clear as it has been introduced alongside other changes. Due to the lack of national data available it is difficult to assess whether patients are benefiting, however over 80 per cent of patients are satisfied with the service they received. GPs are positive about being able to opt out and 88 per cent of GPs are relieved to no longer have 24-hour responsibility for patients.

1 *Partnership for Care: Scotland's Health White Paper,* Scottish Executive, 2003.
2 *National Overview Out of Hours,* NHS Quality Improvement Scotland, October 2006.
3 The out-of-hours period is from 6.30pm to 8am on weekdays, the whole of weekends, bank and public holidays. Local arrangements may vary. The out-of-hours period may be categorised differently for non-primary care staff.
4 Audit Scotland data, 2007.
5 *Out-of-hours: mapping and supporting new roles for practitioners in unscheduled care,* NHS Education for Scotland, August 2004.
6 British Medical Association evidence to the House of Commons Health Select Committee's inquiry into the potential impact of the GP contract on the provision of out-of-hours services, June 2004 (www.bma.org.uk).
7 *Delivering the benefits of pay modernisation in the NHS in Scotland,* Health Department Letter (2005) 28, 1 July 2005 and *Implementing the new GMS contract in Scotland,* NHS Scotland, February 2004.
8 We refer to reprovision or reproviding to describe when a GP has opted out of providing out-of-hours care then provides some out-of-hours sessions back to an NHS board for a fee.

- Other services have helped NHS boards to take over responsibility for out-of-hours care, including NHS 24 and the Scottish Ambulance Service. Links with these services are continuing to develop but must be strengthened to support the delivery of high-quality patient care.

- Out-of-hours services are under continuing pressure as fewer GPs are reproviding services. New ways of working are required as there is a significant risk that current models of service delivery are not sustainable in the long term. The SEHD and NHS boards must adopt a much greater focus and commitment to investment in, and planning for, extended roles for health professionals and joint working.

About the study

7. In carrying out the study we:

- collected and analysed data on activity and cost from all NHS boards

- interviewed staff and reviewed relevant documents from the Scottish Executive Health Directorates (SEHD), the ambulance service, NHS 24 and a sample of six NHS boards (NHS Borders, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Highland, NHS Lanarkshire and NHS Shetland)

- conducted a telephone survey of 600 members of the public who had used out-of-hours services in the previous six months

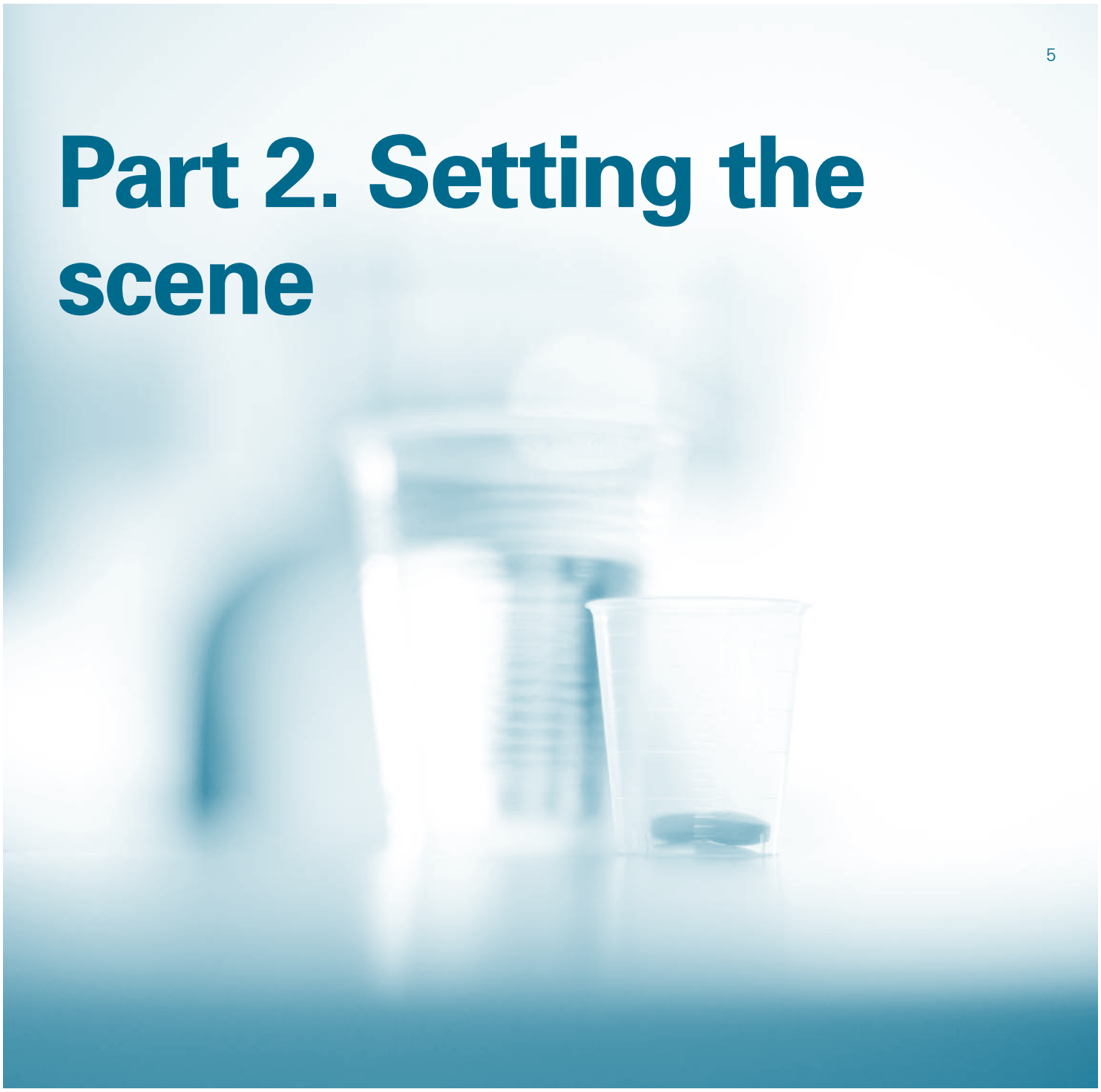
- surveyed all GPs in Scotland, seeking views on the impact of the new out-of-hours arrangements, with a 38 per cent response rate.

8. Our fieldwork was completed in 2006. We recognise that out-of-hours services are continuing to evolve and that this is an area where work is in progress. We reflect this in the main body of the report.

9. We make a number of recommendations in this report aimed at supporting the development of primary care out-of-hours services. NHS external auditors will monitor progress against our recommendations.

10. A separate document aimed at non-executive members of NHS boards accompanies our report. This document highlights issues arising from this report which will support non-executives in exercising their scrutiny role.

Part 2. Setting the scene



Taking over out-of-hours services has been a major challenge for NHS boards and their main focus so far has been on maintaining services for patients.

Key messages

- Taking over responsibility for out-of-hours services has been a challenge for NHS boards due to the timing and scale of the change and the additional costs involved. GPs voted in favour of the opt-out in 2003, and the nGMS contract was introduced in April 2004, although the transfer of out-of-hours responsibility did not have to be in place until 31 December 2004.
- NHS boards initially focused on the practicalities of taking over out-of-hours services, while maintaining services and minimising any effect on patients. The opt-out provides an opportunity to improve services so that the most appropriate person sees and treats a patient, but this has not been the main focus to date.

Significant changes have taken place in the delivery and management of out-of-hours services

11. There have been a number of changes to the way in which out-of-hours services are delivered, particularly since the implementation of the nGMS contract in April 2004 and the transfer of responsibility for out-of-hours care to NHS boards after December 2004. Exhibit 1 shows how primary care out-of-hours services have developed since 1948.

12. Before the introduction of the nGMS contract, GPs provided out-of-hours services in four main ways:

- GP practices joined together in an area to form a GP cooperative (most out-of-hours care was provided in this way)
- responsibility was transferred to a commercial deputising service
- GPs from several practices joined together to form extended rotas to cover the out-of-hours period
- out-of-hours cover remained the responsibility of individual practices (this model was common in rural or remote areas).

GP cooperatives covered around 75 per cent of patients in Scotland in the late 1990s, mainly in urban areas

13. GP out-of-hours cooperatives developed through the 1990s and had a significant impact on the delivery of out-of-hours care in urban and semi-rural Scotland. Understanding how these cooperatives developed highlights how the system for out-of-hours care was already changing and how the new arrangements are a continuation of these changes.

14. GPs owned and managed cooperatives, providing out-of-hours care for patients registered with a number of practices in an area. GPs participating in these cooperatives contributed to their running costs and may or may not have taken part in the out-of-hours rota. This means that under the cooperative system GPs were less likely to deliver out-of-hours care to their own patients than GPs who did not contribute to a cooperative.

15. GP cooperatives covered around 75 per cent of patients in Scotland in the late 1990s.[11] The size and organisational structures of cooperatives varied, and there were few formal relationships with other health and social services agencies.[12] They were less common in rural parts of Scotland because geography made them difficult to organise. A survey conducted in 1997/98 in Scotland demonstrated that while a cooperative in Greater Glasgow covered 98 per cent of the population, the population covered by a cooperative in Argyll and Clyde was only 61 per cent, in Lanarkshire 41 per cent and in Highland 27 per cent.[13]

16. Exhibit 2 (overleaf) shows a typical model of the various possible routes for a patient accessing out-of-hours services before the implementation of the nGMS contract.

There are now different ways of accessing out-of-hours services

17. Since the introduction of the nGMS contract and the ability of GP practices to opt out of providing out-of-hours care, an increasing range of practitioners are involved in providing these services, including GPs, nurses and pharmacists. Patients can now receive care in a number of settings including Primary Care Emergency Centres, GP surgeries and at home.

Ninety-five per cent of GP practices are no longer responsible for providing out-of-hours care to their patients, with responsibility passing to NHS boards

18. Ninety-five per cent of GP practices in Scotland have opted out of providing out-of-hours care (2,578 GPs opted out in 2003/04).[14] This is similar to England where 90 per cent of practices have opted out. By 31 December 2004, NHS boards had taken over responsibility for providing or securing the provision of out-of-hours care for their local population.

19. Under the terms of the new contract some practices cannot transfer responsibility for out-of-hours care, such as those in remote parts of Scotland where it is not possible to put in place sustainable alternative arrangements. There are a small

11 *GP Out-of-hours Services Working Group Report*, The Scottish Office, 1998.
12 *Evaluation of the introduction of NHS 24 in Scotland – final report*, David Heaney, Catherine O'Donnell, Anne Wood, Susan Myles, Joanne Abbotts, Gill Haddow, Iain Armstrong, Stephanie Hall and James Munro, December 2005.
13 *Evaluation of the introduction of NHS 24 in Scotland – final report*, David Heaney, Catherine O'Donnell, Anne Wood, Susan Myles, Joanne Abbotts, Gill Haddow, Iain Armstrong, Stephanie Hall and James Munro, December 2005.
14 Audit Scotland data, 2007.

Exhibit 1

Developments in primary care out-of-hours service delivery

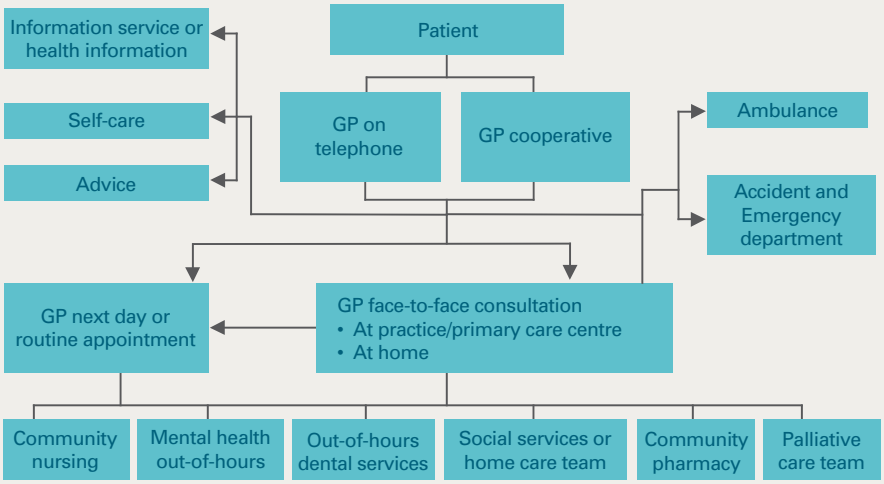
Year	Event
1948	GPs had a contractual agreement with the NHS to provide 24-hour general medical services.
1960s	Commercial deputising services (early cooperatives) covered parts of large UK cities. GPs paid these services to provide out-of-hours care on their behalf, but GPs retained the responsibility for 24-hour care for their patients.
1990	New GP contract introduced. This included a financial incentive to discourage use of commercial deputising services; a two-tiered fee for home visits during the night paid GPs more than their deputising service.
1995	A new agreement between the General Practitioners Committee of the British Medical Association (BMA) and UK government allowed GPs to transfer responsibility for night visits to another GP. GPs were allowed to delegate out-of-hours work to deputising or locum services but retained final responsibility for their patients. Payments were restructured and the Scottish Office Health Department created a development fund to cover the start up and running costs of new models of out-of-hours services such as GP cooperatives.
2000	*The NHS plan* announced UK-wide pay modernisation schemes, including the new consultant contact, nGMS contract and Agenda for Change.
2001	The Scottish Executive Health Department announced the creation of NHS 24 in *Our National Health; a plan for action, a plan for change*.[9]
2002	The NHS Confederation and the GP committee of the BMA started nGMS contract negotiations across the UK.
2002	NHS 24 launched in NHS Grampian.
2003	GP ballot for nGMS contract – 79 per cent voted in favour of the contract across the UK.
2004	April 2004 – nGMS contract implemented. GP practices have the right to transfer their responsibility for out-of-hours work with the consent of local NHS boards. Some practices are not able to transfer responsibility, such as remote practices.
2004	Implementation of two other major staff contracts: consultant contract and Agenda for Change. These contracts affect out-of-hours services: • out-of-hours work is clearly specified in the new consultant contract • Agenda for Change offers increased opportunities for extending the roles of some staff who deliver out-of-hours services, such as emergency care nurse practitioners.
2004	August 2004 – NHS Quality Improvement Scotland (NHS QIS) published standards for the provision of safe and effective primary medical services out-of-hours.[10]
2004	By 31 December 2004 – NHS boards took over full responsibility for ensuring effective out-of-hours services were in place where practices had opted out.
2004	NHS 24 operating across Scotland by the end of 2004.
2005	NHS 24 local satellite centres opened in NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Highland, NHS Lanarkshire and NHS Tayside.

Sources: *Out-of-hours Care in Remote And Rural Scotland: Identifying Sustainable Strategies For Change*, David Heaney and Stephanie Hall, June 2005 and Audit Scotland 2007.

9 *Our National Health. A plan for action, A plan for change,* Scottish Executive, 2001.
10 *The Provision of Safe and Effective Primary Medical Services Out-of-Hours,* NHS QIS, August 2004.

Exhibit 2

Typical model of out-of-hours care in Scotland before NHS 24 and the nGMS contract



Source: Audit Scotland 2007

number of practices which have decided not to opt out of providing out-of-hours care. Practices which have not opted out receive a locally agreed premium in recognition of their continued out-of-hours responsibility. The estimated population covered by these practices was 71,680 in 2005/06 (1.3 per cent of the total population).[15]

Over 1,400 GPs who opted out of providing out-of-hours care now reprovide sessions for a fee

20. There are two ways in which NHS boards can deliver out-of-hours services to their population:

- by contracting with a range of providers, including GPs[16 17]
- by directly employing staff (such as salaried GPs).

21. Out-of-hours services are currently largely delivered by GPs who chose to opt out but now provide some out-of-hours sessions back to an NHS board for a fee. We refer to this as reprovision. Based on data gathered during our fieldwork, in 2006/07 1,440 GPs who opted out now reprovide out-of-hours services to NHS boards. A further 89 GPs are directly employed by an NHS board and provide out-of-hours care as salaried GPs. Exhibit 3 shows the GP registered population, the number of GPs who have opted out across Scotland and the number of GPs who reprovided out-of-hours services in 2005/06. Parts 5 and 6 look in more detail at the new arrangements for delivering out-of-hours services.

GP practices opting out of out-of-hours care took place at the same time as rolling out NHS 24 and implementing other new pay contracts

22. Other initiatives were introduced at the same time as the nGMS contract was being developed and implemented and these affect the way primary care out-of-hours services are delivered. This includes the development of NHS 24, the introduction of new pay contracts for other NHS staff groups, the implementation of *Delivering for Health* and the creation of Community Health Partnerships (CHPs).[18] Although these initiatives are not the focus of this report, we refer to them where relevant.[19 20]

23. Other pay modernisation contracts also affect general medical services, including the new consultant contract, Agenda for Change and the new deal for junior doctors. Agenda for Change introduces a new pay system for non-medical NHS staff and has a major impact on how out-of-hours services develop as it affects the grading and pay for extended roles. We explore this issue further in Part 5.

24. As NHS boards assumed responsibility for out-of-hours services, their priority was to maintain delivery of this care. NHS boards have been successful in this despite the challenges presented by the majority of GP practices opting out of out-of-hours care.

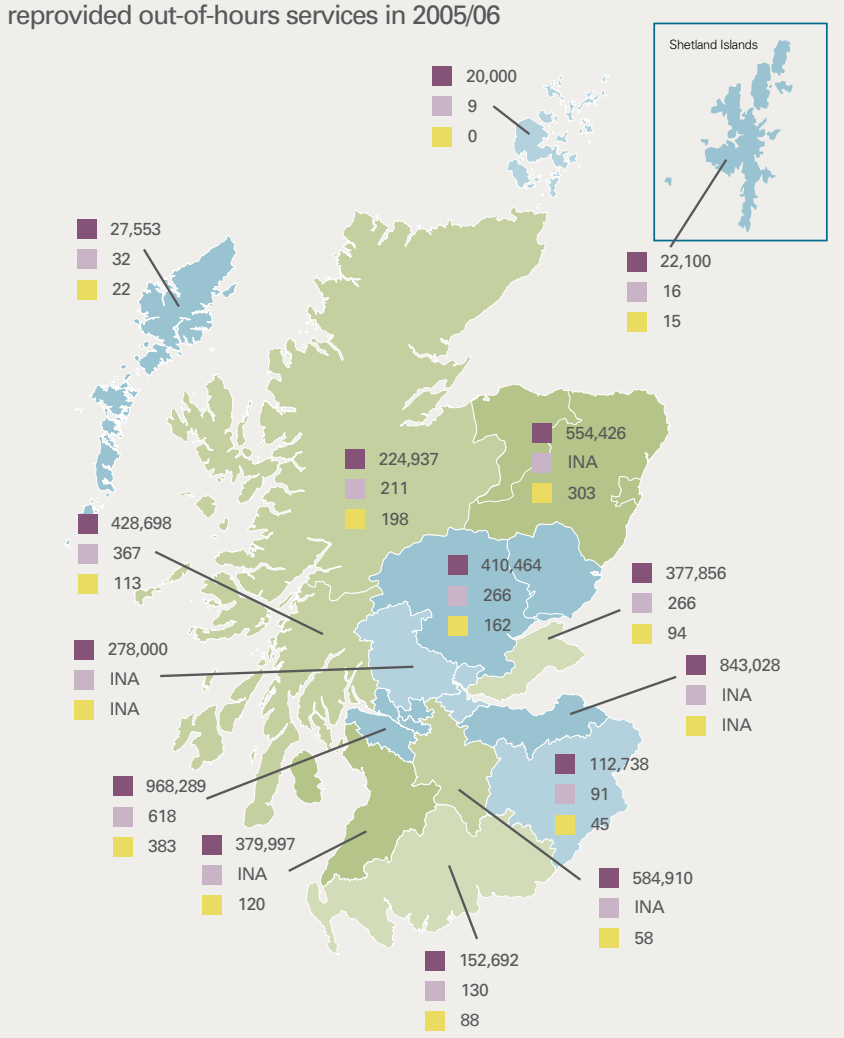
NHS 24 is now the first point of contact for most out-of-hours services

25. NHS 24 was established prior to the nGMS contract but was still being rolled out across Scotland as NHS boards were taking over responsibility for out-of-hours services. NHS 24 is now the first point of contact for most primary care out-of-hours services.

15 Audit Scotland data, 2007
16 General Medical Services contract, April 2004.
17 This includes GPs who opt out of providing out-of-hours care for their own practice population and then deliver some out-of-hours sessions back to an NHS board, referred to here as reprovision.
18 *Delivering for Health,* Scottish Executive, November 2005.
19 *Building a Health Service Fit for the Future – A National Framework for Service Change in the NHS in Scotland,* Scottish Executive, May 2005 (also known as the *Kerr report*).
20 *Delivering for Health,* Scottish Executive, November 2005.

Exhibit 3

Map of GP registered population and GPs who have opted out and reprovided out-of-hours services in 2005/06



Note: INA - Information not available.

Source: Audit Scotland 2007

People contact NHS 24 through one central telephone number to either receive advice over the telephone or be redirected to another service.

26. Exhibit 4 (overleaf) shows how patients access out-of-hours services under the new arrangements. People can access services such as A&E, ambulance, dental or palliative care directly during the out-of-hours period. Although it is not possible to give figures for how many patients directly access services in Scotland, as no data are collected, this is likely to be a small number.

NHS boards taking on responsibility for out-of-hours care at the same time as integrating with NHS 24 added to the pressures and risks associated with delivering these services

27. NHS 24 was initially designed to integrate with all GP out-of-hours cooperatives, A&E departments and with the ambulance service to provide a first point of access for patients requiring out-of-hours care. NHS 24 aims to play a key role in simplifying arrangements for the public to access a healthcare professional.[21]

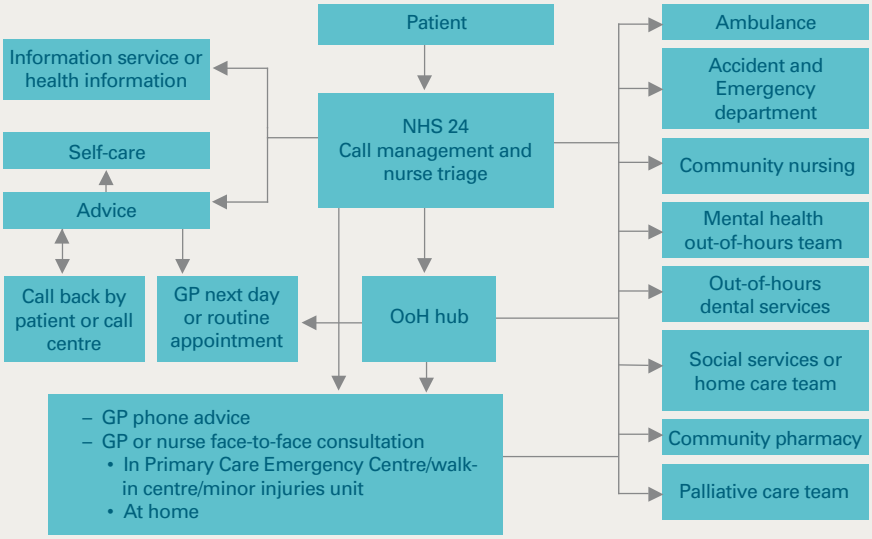
28. NHS 24 services were rolled out to many NHS board areas at the same time as NHS boards were taking over responsibility for GP out-of-hours. This has added to pressures and risks around out-of-hours services, and meant that NHS 24 was under pressure at the same time as GPs opted out. The work required to integrate services, IT and staff had to happen in a short timescale. NHS 24's original estimates were that 60 per cent of calls would be in the out-of-hours period. In practice, and with the changes to the GP contract, around 90 per cent of calls take place out-of-hours.[22] As there have been extensive reviews of the development and activity of NHS 24, we did not audit NHS 24 directly as part of this work but have drawn on existing evidence where relevant.[23 24]

29. The pressure and complexity of rolling out NHS 24 to all NHS board areas and integrating with each of those very different local services has proved challenging. This was the first time all out-of-hours contacts had been coordinated by one central organisation. A similar organisation operates in England, NHS Direct, although this service only acts as a first point of contact for a proportion of NHS trusts in England.

21 The three core services NHS 24 provides are: nurse-led consultation, aided and enhanced by clinical decision support software; referral where appropriate to a range of integrated and interfaced services; health information provided by Health Information Advisers.
22 *Annual Report 2004/2005,* NHS 24, 2005.
23 *Review of NHS 24,* NHS 24 Independent Review Team, September 2005.
24 *Evaluation of the introduction of NHS 24 in Scotland – final report,* David Heaney, Catherine O'Donnell, Anne Wood, Susan Myles, Joanne Abbotts, Gill Haddow, Iain Armstrong, Stephanie Hall and James Munro, December 2005.

Exhibit 4

Typical model of out-of-hours care in Scotland after the creation of NHS 24 and the implementation of the nGMS contract



Source: Audit Scotland 2007

Part 3. Planning for the new out-of-hours arrangements

As part of UK-wide negotiations GP practices opting out of primary out-of-hours care forego an average of £6,000 of their funding per GP.

Key messages

- It is not possible to do a like-for-like comparison of the cost of the out-of-hours service before and after opt-out as services delivered under the new system tend to be very different from what went before. However, the SEHD carried out some work to calculate what was paid under the previous system and assessed the possible implications of agreeing various levels of claw-back. This work showed that GP practices received an average of £12,000 for providing out-of-hours services.

- As part of UK-wide negotiations of the nGMS contract it was agreed that GP practices opting out of providing out-of-hours care forego an average of £6,000 of their funding each year per GP (known as the claw-back). The claw-back figure was a negotiating sum and not intended to be a precise reflection of the cost of providing out-of-hours services.

The new contract has changed how the NHS funds out-of-hours services

30. Prior to the introduction of the nGMS contract, out-of-hours care formed part of a range of services provided by GPs and costs were not collected or monitored separately. An annual out-of-hours allowance and specific payments relating to the number of out-of-hours call-outs formed part of wider payments to GPs. We cannot accurately report the cost of delivering out-of-hours services prior to the nGMS contract as the data held by the NHS give only a partial picture. The way services are delivered under the new system also tends to be different.

31. GP practices that opt out of providing out-of-hours services have their global sum payment reduced by six per cent.[25] This equates to about £6,000 each year per GP and is known as the claw-back. The six per cent was based on the Department of Health's (DoH) economic analysis of GP cooperatives in England and was a negotiating sum to encourage GPs to accept the nGMS contract.[26] The claw-back was not intended to cover the cost of reproviding the out-of-hours service.

32. NHS boards now receive a specific fund for primary care services: a general medical services allocation (which is not just for delivery of out-of-hours services). An out-of-hours development fund was paid each year from 1995/96 to 2005/06. NHS boards reported receiving a total of £8.9 million in 2005/06.[27] NHS boards have met the rest of the costs of out-of-hours services from their budgets.[28] (See Part 4)

The additional cost of the new out-of-hours service was £31 million in 2005/06

33. The SEHD carried out some work prior to agreeing the opt-out to understand what was paid for the previous service and to assess the potential impact of agreeing various levels of claw-back. Before implementing the opt-out two separate payments were paid to GPs to deliver out-of-hours services – night visit fees and a night visit allowance. These two payments cost £18.3 million in 2003/04. The SEHD knew that the new service would cost more than this as GPs had been supplementing the service. It was clear that many GPs would opt out of providing out-of-hours care, and NHS boards would have to buy back this GP work for a fee. There would also be new additional costs for administering the service by NHS boards, and other infrastructure costs.

34. We collected data from all NHS boards which show, compared with 2003/04, that the additional cost of the new service for 2005/06 was £31 million. There is no clear evidence to show how much the SEHD expected the additional cost to be.[29]

35. The work carried out by the SEHD to understand the cost of out-of-hours services in Scotland prior to agreeing the opt-out shows that the average cost of the previous service per GP practice was estimated as £12,000 in Scotland compared to £9,500 in England.

The SEHD worked closely with the NHS to implement the new out-of-hours arrangements but strategic guidance on some aspects could have been better

36. Most of the guidance provided to the NHS in Scotland on preparing for changes to out-of-hours services was guidance that was issued on a UK-wide basis. The SEHD and the Scottish General Practitioners Committee (SGPC) of the BMA also issued some jointly agreed guidance to the NHS in Scotland on implementing the changes. (Exhibit 5, overleaf)

37. In 2003, the SEHD established a National Reference Group to assess progress on implementing the nGMS contract. This group was made up of members from NHS boards, the ambulance service, NHS 24 and the SEHD. An out-of-hours operational sub-group of the National Reference Group focused on operational

25 This represents six per cent of a practice's global sum. The global sum provides for the delivery of essential and some specific additional services, staff costs and locum reimbursements. It is calculated on the basis of the needs of the population served by the practice regardless of the number of GPs in the practice.
26 The BMA reported that over 80 per cent of doctors would leave the NHS if negotiations were not successful, so there was pressure to reach an agreement.
27 NHS Shetland is not included as this information was not provided by the NHS board.
28 The SEHD allocates each NHS board a budget. Services to patients must be delivered within these funds.
29 Our calculations of additional cost are based on the SEHD assumptions of the cost of the previous system, specifically night visit allowances and payments, amounting to approximately £18 million.

issues and acted as a support and information network group for staff leading out-of-hours implementation in NHS boards.

38. In the sample of NHS boards where we did more detailed work, opinion was mixed on the usefulness of the central out-of-hours groups and the SEHD guidance. Some found the groups helpful in assisting with specific operational issues but others felt the groups were more of a forum for discussion and a clearer steer from the SEHD was needed. Given the pace and scale of changes which had to be implemented for out-of-hours services, these central groups tackled issues as they arose, and the SEHD could have done more to share good practice and encourage the transfer of learning to other areas.

39. There was a lack of central guidance from the SEHD on issues such as salary scales for salaried GPs, the range of pay rates for GPs and the development of extended roles for other staff. Although there were salaried GPs in the NHS prior to the nGMS contract this was the first time GPs could be salaried for out-of-hours. It would have been helpful to have arrangements in place to share this kind of information among NHS boards.

The lack of an indicative range of payments for GPs providing out-of-hours sessions has led to a lot of work for NHS boards to contain pay rates for this work

40. When GP practices initially opted out of providing out-of-hours services, there were often limited alternative arrangements. This meant that most NHS boards had little choice but to buy back the services of the GPs who had opted out under a separate arrangement. During UK-wide negotiation for the nGMS contract, government and employer representatives agreed not to set national GP rates or ranges for these rates, taking the view that setting a national rate could compromise local approaches to value for money. They felt that those NHS boards which could secure lower rates (such as urban NHS boards) would suffer, and there was a concern that a national rate would be toward the higher end of any payments that NHS boards could negotiate locally.[30]

41. Although it is impractical to agree a national flat rate for such work, given the regional variances in GP availability and activity, the SEHD could have done more to suggest a scale or range of rates to pay for these services. This has led to NHS boards facing challenges of changing services while taking part in lengthy local discussions over rates. This was particularly challenging in rural and remote areas where a limited number of GPs were available to reprovide out-of-hours sessions. By not setting out an indicative range of payments, market forces apply and NHS boards often have little control over rates particularly where there are few alternative service options available. Put simply, if a GP out-of-hours session cannot be filled the rate may need to be increased until someone is willing to cover it. In line with the National Audit Office (NAO) findings in England, our fieldwork interviews revealed concerns that NHS boards were subject to whatever rates GPs would take for working out-of-hours.[31]

Despite a lack of national data most NHS boards carried out detailed local planning prior to GP practices opting out of out-of-hours care, although planning for extended roles is not yet well enough developed

42. To assist local planning, all NHS boards carried out GP surveys to help understand how the service would operate when they took over responsibility. These local surveys showed that the majority of practices would opt-out. Although GPs in some areas indicated interest in participating in out-of-hours services in the future, the actual number was not known as this would depend on what fees were paid and how many other GPs were on the rota. NHS boards were therefore planning for the new service with some key unknowns and were aware of the risk that the fewer GPs available, or willing to fill out-of-hours rotas, then the greater the increase in costs.

43. All six sampled NHS boards carried out an analysis of the management information that was available from the previous out-of-hours services to help plan their new models of out-of-hours care.[32] Those NHS boards where out-of-hours services were covered by cooperatives had more information with which to plan and had less work to change services initially. They did however, carry out a lot of work to transfer cooperative staff onto NHS terms and conditions, such as drivers and administration staff. This was also at a time when Agenda for Change was reassessing the grade and pay for these staff.

44. NHS boards started from very different points depending on how coordinated the services were that they were taking over. However, all NHS boards lacked data on how the out-of-hours services worked with other services, such as A&E, as integration with other services tended to be weak under the previous system.

45. All sampled NHS boards monitored implementation and prepared a project plan setting out key actions and milestones to help manage the implementation of the new out-of-hours arrangements. Although NHS Shetland did not have a formal project plan in place, it regularly monitored progress with implementation. Sampled NHS boards carried out detailed financial planning based on an analysis of cost and activity data from the previous out-of-

30 Primary Care Out of Hours, Chief Executives Meeting, August 2005.
31 *The Provision of Out of Hours Care in England,* National Audit Office, May 2006.
32 NHS Borders, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Highland, NHS Lanarkshire and NHS Shetland.

Exhibit 5

Central guidance on implementing out-of-hours changes associated with nGMS contract

Date	Guidance	Notes
February/March 2003	New GMS contract 2003 *Investing in general practice*	The main contract document was sent to all GPs throughout the UK.
March 2003	Examples of innovative out-of-hours schemes	Innovative out-of-hours schemes as identified by NHS Confederation members, which were considered during the new GMS contract negotiations.
6 May 2003	New GMS contract 2003 *Investing in general practice* – supporting documentation	The second contract document sent to all GPs in the UK along with an additional information pack.
16 May 2003	New GMS contract 2003 *Investing in general practice* – Scottish Annex	This document covered Scottish aspects of the new GMS contract. It also included a glossary of terms and a detailed breakdown of the Scottish funding for the new GMS contract.
January 2004	New GMS contract – implementation schedule of key tasks, milestones and responsibilities	SEHD NHS circular PCA (M) (2004)
February 2004	Implementing the new GMS contract in Scotland	Guidance agreed jointly by the SEHD and the Scottish General Practitioners Committee of the British Medical Association.
March 2004	Standard General Medical Services Contract	NHS Circular introduced the General Medical Services Standard Contract for use in Scotland.
April 2004	**New GMS (nGMS) contract introduced**	
May 2004	General Medical Services Statement of Financial Entitlements (SFE) for 2004	
June 2004	Implementation of the new GMS contract work plan 2004/05	Issued by the UK National GMS Reference Group.
June 2004	Primary medical services – strategic tests workbook	nGMS implementation tool for NHS boards.
June 2004	Focus on out-of-hours	Guidance note produced by the General Practitioners Committee (GPC) to help GPs and Local Medical Committees with the out-of-hours arrangements under the new GMS contract.
August 2004	NHS QIS standards for the provision of safe and effective primary medical services out-of-hours	HDL(2004)41
November 2004	New GMS contract implementation schedule	
December 2004	**All NHS boards took over responsibility for out-of-hours services**	
Ongoing	Regular updates to nGMS contract document	

Source: Audit Scotland 2007

hours service, except NHS Shetland where overall financial planning was not robust due to several factors, including inadequate financial systems and poor data on the previous out-of-hours system.[33]

46. All sampled NHS boards carried out option appraisals and consulted with the local community. There is also evidence that planning involved all relevant stakeholders including the ambulance service, NHS 24 and NES.

Recommendations

The SEHD should:

- ensure that detailed national cost models based on accurate data are produced before implementing major schemes, and that these are used to inform negotiations and implementation
- provide timely and effective guidance when implementing major new schemes, identifying actions that NHS boards are required to take and monitoring their impact
- identify performance measures and baseline information against which benefits for patients and the NHS can be clearly measured before implementing major schemes.

33 The board's financial management system is not robust enough to support planning and delivery of services, as the ledger system is outdated and the board relies on a separate spreadsheet system to track out-of-hours expenditure.

Part 4. Cost and quality of out-of-hours services

Out-of-hours services cost an estimated £67.93 million in 2006/07. NHS boards have had to fund about half of the additional cost of the new out-of-hours service, and costs are higher in more remote or rural areas.

Key messages

- Under the new arrangements, out-of-hours services cost £35.03 million in 2004/05 (part-year costs), £67.68 million in 2005/06 and were projected to cost £67.93 million in 2006/07.
- The cost of providing out-of-hours primary care services varies across Scotland. The cost is directly linked to remoteness, with higher costs in more remote or rural areas. This is due to a range of factors such as sparse population and large geographical areas to cover.
- GPs who opt out but then decide to reprovide services to NHS boards are paid a fee. These fees are negotiated locally and vary among NHS boards and according to the time and type of day. For example, rates paid over Christmas are higher than standard weekly rates. The hourly rate paid to GPs to cover nights during the week ranges from £50 to £80.91 in the mainland boards.
- The claw-back from GP practices funded 30 per cent of the cost of the new service across Scotland in 2005/06. The rest mostly comes from NHS boards' budgets, contributing to cost pressures, and from an out-of-hours development fund, which was paid up to 2005/06. NHS boards covering more rural areas have had to find a greater percentage of the cost of the new service from their own budgets. For example, NHS Highland funded 80 per cent of the new service from its unified budget while NHS Greater Glasgow funded 26 per cent.

The cost to NHS boards in 2006/07 was approximately £67.93 million

47. The cost of out-of-hours services in Scotland from the time that NHS boards took over responsibility in 2004/05 up to 2006/07 is approximately £170.65 million (Exhibit 6).

48. The cost of out-of-hours services varies across Scotland and costs more to provide per head of GP registered population in more remote or rural areas (Exhibit 7). A fifth of

Exhibit 6

Cost of out-of-hours primary care services by NHS board, 2004/05 – 2006/07

	2004/05 Part-year costs since point of transfer £000	2005/06 Actual cost £000	2006/07 Projected cost £000	Total cost £000
Argyll and Bute	1,816	3,908	4,107	9,831
Clyde	1,980	4,202	4,318	10,500
NHS Ayrshire and Arran	3,916	4,325	4,522	12,763
NHS Borders	935	1,886	1,955	4,776
NHS Dumfries and Galloway	1,182	2,770	2,735	6,687
NHS Fife	2,593	3,758	3,862	10,213
NHS Forth Valley	2,160	3,853	4,031	10,044
NHS Highland	2,274	7,226	6,227	15,727
NHS Grampian	2,638	7,849	7,726	18,213
Greater Glasgow	4,905	7,366	7,390	19,661
NHS Lanarkshire	2,863	6,043	6,123	15,029
NHS Lothian	3,717	7,381	7,742	18,840
NHS Orkney*	INA	206	330	536
NHS Shetland**	280	357	333	970
NHS Tayside	3,056	5,522	5,567	14,145
NHS Western Isles	719	1,032	965	2,716
Totals	**35,034**	**67,684**	**67,933**	**170,651**

Note: Figures for Glasgow, Argyll and Bute and Clyde areas are shown separately due to the dissolution and mergers of the former NHS Argyll and Clyde Board. We have collected and shown data for these areas separately in order to track activity and costs over time.

* 2005/06 data for NHS Orkney are part-year. Opt-out occurred in November 2005. Out-of-hours care for almost 80% of the Islands' population is provided by GPs in practices that have not opted out.

** NHS Shetland was unable to seperately identify the full cost to the NHS board of providing primary care out-of-hours services, as most of this is delivered through the A&E service.

INA: Information not available

Source: Audit Scotland 2007

people in Scotland live in rural areas and a significant number in very remote areas.[34] Costs per head of population range from £7.61 for the Greater Glasgow area to £43.63 for the Argyll and Bute area. Costs in the Greater Glasgow area are lower due to a range of factors including the large and densely populated area covered by the NHS board. In contrast the Argyll and Bute area contains a number of small islands and a dispersed population, which make providing safe out-of-hours care in rural or remote areas challenging and more costly. This supports other work on the correlation of high costs of services and the rurality of NHS boards.[35]

49. Out-of-hours services also differ greatly in how they are delivered between rural or remote and more urban boards (Case study 1).

50 The largest proportion of the overall cost of the out-of-hours service is for the healthcare professionals providing care to patients, either through salaries or rates. GPs who reprovide out-of-hours sessions deliver the major part of the clinical work in the out-of-hours period. NHS boards may also use either locum or agency GPs or employ salaried GPs to deliver sessions, who are all paid differently.

51. Fees paid to GPs for reproviding out-of-hours services are negotiated locally and therefore vary across Scotland. This is due to local factors such as pre-existing arrangements and availability of GPs willing to provide the service. For example, rates in areas where there are more GPs willing or available to reprovide some sessions tend to be lower than in those areas where there are less GPs willing or available to reprovide.

52. We collected data on a range of payments for reprovision since the opt-out. These payments do not represent the total payment to GPs for reproviding out-of-hours work as some NHS boards make additional payments for on-call work in addition to the rates shown here.[36]

53. Exhibit 8 (page 20) shows the payments for one of the most frequent out-of-hours sessions – a weekday evening. This shows that the work put in by NHS boards in negotiating fees and sharing information among boards for this time period has successfully led to a common approach. Around £50 per hour is paid across most areas, ranging from £45 in NHS Forth Valley and NHS Greater Glasgow to £60 in NHS Western Isles. This is in line with the average rate for weekday evenings paid in England at £58.36 per hour.[37]

54. Payment rates for other times in the out-of-hours period are less consistent across Scotland. Exhibit 9 (page 21) shows that payments for a weekday overnight per hour varied from £50 in NHS Dumfries and Galloway and NHS Forth Valley to just over £80 in NHS Tayside, NHS Grampian, NHS Lanarkshire and NHS Western Isles in 2005/06. This variation reflects local market forces at work in determining GP fees.

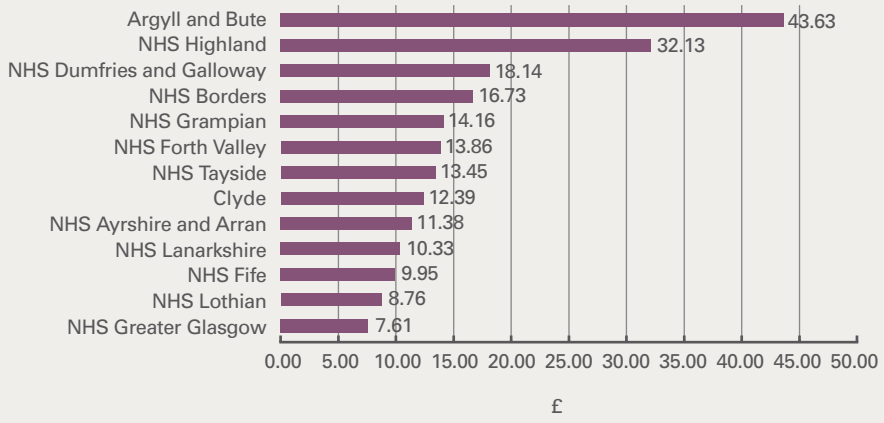
55. Payments at Christmas and New Year vary even more widely across Scotland, ranging from just under £81 per hour in NHS Tayside to £150 in NHS Highland and NHS Grampian in 2005/06.

On average NHS boards had to fund about half of the cost of the new out-of-hours service but rural NHS boards have had to fund more

56. Across Scotland in 2005/06 the claw-back funded 30 per cent of the cost of the new out-of-hours service, with 53 per cent of the funding coming from NHS boards' budgets (Exhibit 10, page 21).

Exhibit 7

Cost of primary care out-of-hours services per head of GP registered population, 2005/06



Note: NHS Shetland has been excluded as it is unable to seperately identify the full cost to the board of providing out-of-hours care as much of this is delivered through the A&E service.
NHS Orkney has been excluded as data for 2005/06 are part-year.
NHS Western Isles has been excluded as its data are not comparable with mainland NHS boards.

Source: Audit Scotland 2007

34 *Rural Scotland key factors 2005: People and communities, services and lifestyles, economy and enterprise*, Scottish Executive, September 2005.
35 *Scottish Economic Report,* Scottish Executive Health Department, 2004.
36 Sessional rates exclude superannuation contributions and where possible NHS boards have excluded national insurance contributions. Hourly rates are not directly comparable across Scotland for several reasons but they are useful to give a broad picture of differences across Scotland. Some NHS boards pay 'sessional rates' to GPs who may not be working through the out-of-hours period but instead are on-call or standby, while some other boards that have on-call or stand-by arrangements categorise these rates separately and pay much less. For example, NHS Borders pays a stand-by fee for 4 hours of £75. Some boards having difficulties covering out-of-hours sessions have also introduced other incentive schemes to encourage GPs back into the service but these incentive payments are over and above the basic sessional rates. For example, NHS Dumfries and Galloway has a bonus scheme.
37 *The Provision of Out of Hours Care in England,* National Audit Office, May 2006.

Case study 1

	NHS Greater Glasgow	NHS Highland
Previous out-of-hours service	NHS board area covered by a single cooperative	NHS board area covered by a variety of arrangements including cooperatives and single-handed GP practices
2003/04 population	968,890	220,071
Cost of previous out-of-hours service	Contribution by GPs (eg, to cooperatives) £4,523,000 Contribution by the NHS board £1,317,000 Total cost of previous system in 2003/04 £5,840,000	Contribution by the NHS board £351,000 Total cost of previous system unknown
New out-of-hours service	The NHS board has rolled over the previous cooperative arrangements, with some use of other healthcare professionals to deliver clinical sessions	A new out-of-hours service has been established. Other healthcare professionals are not yet used to deliver clinical sessions, but the board has employed some salaried GPs
2005/06 population	968,289	224,937
Percentage of GPs from opt-out practices now reproviding sessions 2005/06	61.8%	97.7%
Cost of new out-of-hours service 2005/06	£7,366,000	£7,226,000
Cost per head of GP registered population	£7.61	£32.13

Source: Audit Scotland 2007

57. The percentage of costs met from the claw-back to fund the new service varies across Scotland, although for rural NHS boards the pressure to fund the new service from the NHS board budget was far greater than for urban NHS boards (Exhibit 10, page 21). For example NHS Highland funded 80 per cent of the new service from its budget, while Greater Glasgow funded 26 per cent.

58. In 2006, the SEHD stopped the development fund for out-of-hours and included this money within the overall budget allocation to NHS boards. Exhibit 11 (page 22) shows that NHS boards expected to fund 63 per cent of the cost of the new service from their budgets in 2006/07. It also shows that the percentage of service costs met from the claw-back varies. Appendix 2 shows the figures used to compile Exhibits 10 (page 21) and 11 (page 22). The cost to NHS boards of delivering out-of-hours services has increased, with pressure being greater in the more rural areas.

NHS boards have largely met quality standards but there is scope to integrate out-of-hours services more effectively with wider NHS board systems

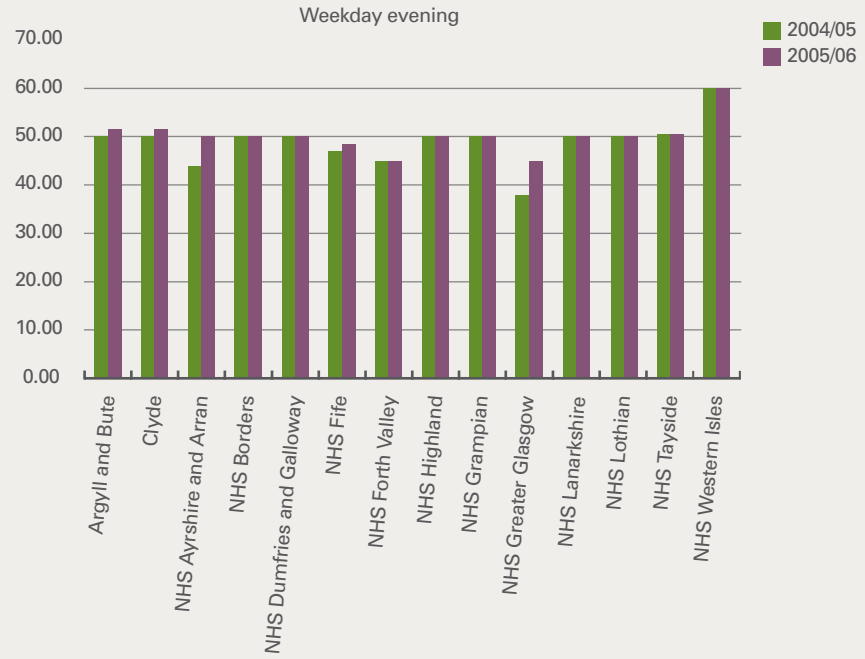
59. NHS QIS published a set of standards for primary medical services out-of-hours in August 2004.[38] All providers were required to comply with the standards from January 2005. Three standards relate to the provision of safe and effective out-of-hours services:

- access and availability at first point of contact

38 *The Provision of Safe and Effective Primary Medical Services Out-of-Hours,* NHS QIS, August 2004.

Exhibit 8

Hourly rates paid to GPs who have opted out of providing 24-hour out-of-hours care but have chosen to reprovide out-of-hours sessions on a weekday evening



Note: NHS Shetland's rate system is not comparable with other boards.
NHS Orkney was unable to provide the weekday evening hourly rate.

Source: Audit Scotland 2007

- safe and effective care
- audit, monitoring and reporting.

60. A review of NHS boards' performance showed that they are largely meeting the NHS QIS standards (Exhibit 12, page 22).[39 40]

61. NHS QIS identified some areas for development that NHS boards had to address by July 2007, summarised in Exhibit 13 (page 23). In its national report NHS QIS noted: "*Our review set out to find out whether NHSScotland is on track to provide safe and effective care out-of-hours and we were impressed by the progress that has been made in every NHS board and by the constructive and pragmatic approach that has been taken to implement the new out-of-hour services.*" [41]

62. Although the NHS QIS standards are a useful start in defining a minimum standard for all out-of-hours service providers, a system of clear performance indicators focused on patient out-of-hours care is not yet in place. The NHS QIS standards explore the processes and procedures underpinning the delivery of out-of-hours care rather than assess the quality of services provided to patients. National work, led by NHS 24, is beginning to develop national performance indicators, with pilot work underway to develop indicators for stroke services. The aim of these indicators is to assess services provided to patients across various in-hours and out-of-hours services. [42]

There is scope to improve contracts for out-of-hours services and to routinely consider value for money

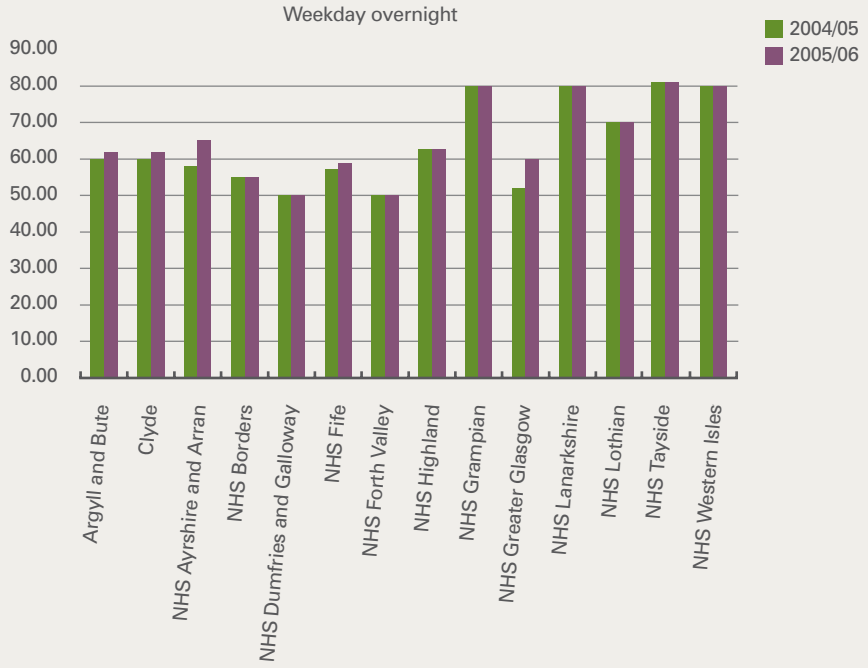
63. The new out-of-hours arrangements offer scope for clearer accountability arrangements as most out-of-hours services are now delivered by NHS boards and providers have to comply with NHS QIS out-of-hours standards. There are still a small number of practices in Scotland which have not opted out and are still responsible for delivery of 24-hour care to their patients.

64. NHS boards have been successful in sustaining out-of-hours services following the opt-out of GP practices, and are now starting to explore other routes of service delivery. Such as through contracts with partners, for example the ambulance service, an agency providing locum GP cover, or a neighbouring NHS board. To date, most of these contracts have not been reviewed for value for money.

39 Where boards were directly providing out-of-hours services themselves they were assessed by the NHS QIS review teams. Where NHS boards were contracting with another provider to deliver the service, the NHS board was responsible for carrying out the assessment, in line with the NHS QIS assessment process, and reporting back to NHS QIS.
40 All NHS boards were given a registration status which set out to what extent they had achieved the standards.
41 *National Overview; The Provision of Safe and Effective Primary Medical Services Out-of-Hours,* NHS QIS, October 2006.
42 'In-hours' refers to all services delivered in normal working hours, ie everything that is not delivered in the out-of-hours period.

Exhibit 9

Hourly rates paid to GPs who have opted out of providing 24-hour out-of-hours care but have chosen to reprovide out-of-hours sessions on a weekday overnight

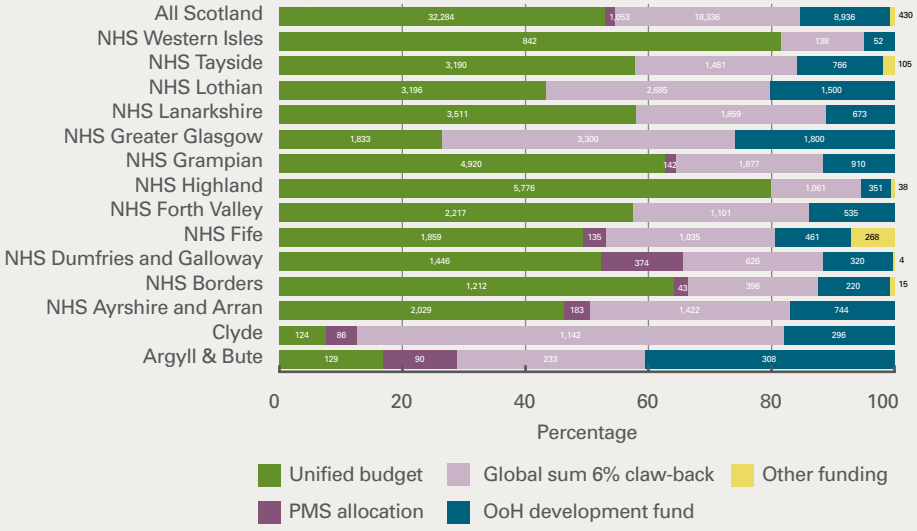


Note: NHS Shetland's rate system is not comparable with other boards. NHS Orkney was unable to provide the weekday overnight hourly rate.

Source: Audit Scotland 2007

Exhibit 10 [43]

Funding sources by NHS board 2005/06



Note: Funding for PMS practices in NHS Highland is included in unified budget figure as the out-of-hours element of this could not be separated out. NHS Shetland and NHS Orkney were able to provide information for 2005/06.

Source: Audit Scotland 2007

Recommendations

The SEHD should:

- work with the NHS to share data on costs associated with out-of-hours services including costs associated with different models of care, and to reflect the impact of rurality.

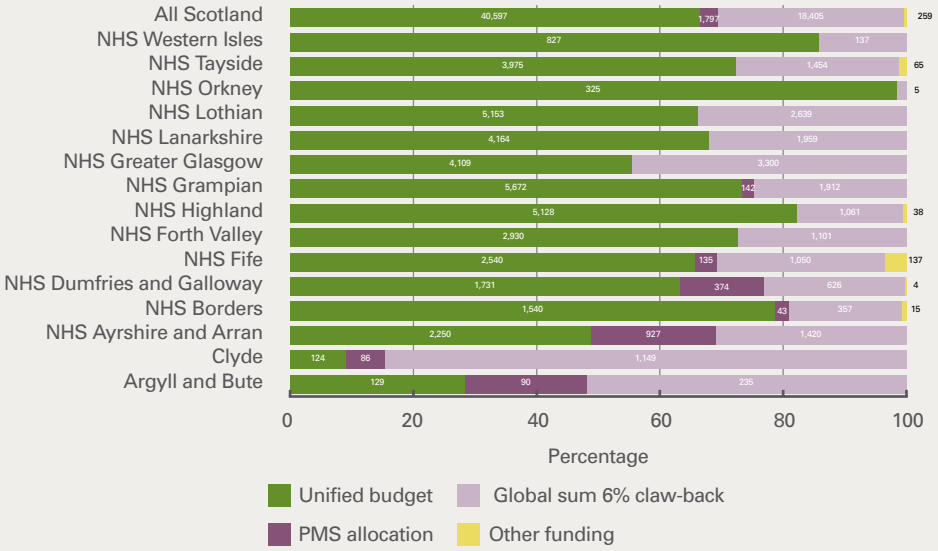
NHS boards should:

- share data on fees and payments to ensure value for money and monitor fee levels across Scotland
- monitor contracts with other service providers to ensure value for money.

43 The PMS allocation supports provides which have agreed Primary Medical Services (PMS) contracts with NHS boards. These contracts are locally negotiated and agreed annually between an NHS board and a GP practice. The PMS contract aims to provide primary care professionals with freedom to improve services to patients and shape services to meet the needs of the local population. The PMS contract aims to provide local flexibility with a simplified payment scheme.

Exhibit 11

Expected sources of funding for out-of-hours services by NHS board, 2006/07



Note: Funding for PMS practices in NHS Highland is included in the unified budget figure as the out-of-hours element of this could not be separated out. NHS Shetland was not able to provide information. From 2006/07, the out-of-hours development fund has been included in the overall budget allocation to NHS boards.

Source: Audit Scotland 2007

Exhibit 12

Compliance with NHS QIS standards for out-of-hours provision

Rating	NHS boards
Limited compliance	No NHS boards
Partial compliance	Two NHS boards: NHS Highland, NHS Orkney
Largely compliant	13 NHS boards: NHS Argyll and Clyde, NHS Ayrshire and Arran, NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Grampian, NHS Greater Glasgow, NHS Lanarkshire, NHS Lothian, NHS Shetland, NHS Tayside, NHS Western Isles
Fully compliant	No NHS boards

Source: *National Overview; The Provision of Safe and Effective Primary Medical Services Out-of-Hours*, NHS QIS, October 2006

Exhibit 13

Summary of NHS QIS review of performance against out-of-hours standards

Standard and criteria	Positive national findings	Areas for development
Access and availability at first point of contact	All NHS boards carry out needs assessments and base service delivery on the needs of the population There has been extensive consultation about the new out-of-hours services Access to translation services is generally good	NHS boards must: • find out about the needs of some ethnic minority groups and 'horizon scan' changing population demography, eg the rise in the elderly population • comply with the Disability Discrimination Act; this is largely due to old premises but progress is being made on this • improve access for patients with a sensory impairment, eg poor hearing or sight.
Safe and effective care	Evidence of partnership working in all NHS boards and progress with integrating services Verbal information about care or treatment is always given to patients All services have arrangements in place for receiving and communicating information to inform patients' ongoing care by the next working day NHS boards can demonstrate staff are trained and competent to work out-of-hours	• Some NHS boards face challenges integrating and sharing information with some services particularly local authorities, eg social services. • Written information is not always given to patients. • Consent is not always sought from patients to share information with other healthcare professionals. • All NHS boards have clinical governance committees but only one demonstrated that out-of-hours services are integrated into the NHS board-wide system. • All NHS boards have risk management systems in place but only four have implemented this system in out-of-hours services. Much work on this is under way. • Concerns expressed over induction into out-of-hours working environment and difficulties in accessing training carried out during the day. • All out-of-hours services adhered to their NHS board's standing financial instructions, but arrangements were not formalised in every NHS board.
Audit, monitoring and reporting	All NHS boards have systems in place to record and respond to comments, complaints and compliments but few showed action as a result	• No service has a full set of Key Performance Indicators in place although four are monitoring a limited set. • All NHS boards are at a very early stage of developing annual reports, but much work is already underway.

Source: *National Overview; The Provision of Safe and Effective Primary Medical Services Out-of-Hours*, NHS QIS, October 2006

Part 5. Impact of changes on the delivery of out-of-hours services

Most patients are satisfied with the service they receive out-of-hours, but national benchmarking and monitoring of performance needs to improve.

Key messages

- National benchmarking and monitoring of performance of out-of-hours services needs to be improved to give a clear view of the standard of services provided. There is no coherent national approach to monitoring the performance of out-of-hours services, although there is evidence of monitoring the process by which NHS boards are developing their out-of-hours systems. For example, NHS boards are monitored against NHS QIS standards for out-of-hours services. A national group involving NHS QIS, NHS 24 and NHS boards is currently developing national key performance indicators for primary care out-of-hours services.
- Only one in ten GPs (11 per cent) responding to our survey feel that patient care has improved under the new arrangements. Over half (52 per cent) feel that patient access and the availability of out-of-hours services have not improved. Our patient survey, however, shows that over 80 per cent of patients who have accessed out-of-hours services are satisfied with the service they received, and understand how to access services through NHS 24.
- Improving recruitment and retention of GPs were aims of the opt-out but, as the nGMS contract is with a practice rather than a GP, data on GP vacancies are no longer collected centrally. In 2006/07 the SEHD established an annual survey of GP practice staffing, including GP numbers, to measure changes in GP recruitment and retention, and to support workforce planning.
- Communication and sharing of patient information among the various providers of out-of-hours services could be better, for example NHS 24, the ambulance service, A&E and social services. However, the roll-out of the emergency care summary (ECS), which has made basic patient data available to health staff working out-of-hours, is a significant development since the opt-out.

The SEHD set out the initial benefits for out-of-hours care expected from the nGMS contract

65. The SEHD set out some wider benefits to patients, staff and the wider NHS that it expected from the nGMS contract. Some of these are related to out-of-hours services although these were not all specified until after the opt-out was in place. Exhibit 14 (overleaf) highlights the main expected benefits from the nGMS contract and, for out-of-hours, to what extent these have been achieved.

66. Some of the main anticipated benefits from the opt-out were to improve recruitment and retention of GPs. As the new GP contract is a practice-based contract there is no central requirement to collect data on numbers of GPs by NHS board or vacancies. Only four NHS boards across Scotland (NHS Fife, NHS Shetland, NHS Tayside and NHS Western Isles) were able to give us data on GP vacancies for 2005/06. Without this information it is impossible to say whether recruitment and retention of GPs have improved under the new out-of-hours arrangements. Also, the SEHD and NHS boards will not be able to carry out detailed workforce planning at national and local levels without this information. NHS boards are no longer required to submit data on numbers of other staff working in GP practices, further complicating workforce planning. To assist with this, the SEHD established an annual survey in 2006/07 to collect data on GP numbers and other practice staff.

Monitoring information for out-of-hours services is available locally at NHS board level but needs to be more developed at a national level

67. All NHS boards carry out some monitoring of out-of-hours services. All NHS boards make use of one of two data systems (Adastra or Taycare) which assist them in collecting and reporting on out-of-hours activity. Five of our six sample NHS boards have local performance indicators that they monitor and report regularly.[44] However, the extent to which NHS boards monitor out-of-hours activity varies across Scotland and the approach taken by each NHS board is different.

68. NHS 24 recommends that NHS boards monitor call response times for calls that NHS 24 has assessed and then passed on to NHS boards for action. Only six NHS boards reported that they monitor call response times, with three using NHS 24 recommended call response targets (the former NHS Argyll and Clyde, NHS Highland, NHS Lanarkshire) and three using their own local targets (NHS Lothian, NHS Orkney, NHS Tayside). Once a call is passed from NHS 24 to the NHS board a patient may require a home visit from a healthcare professional. Seven NHS boards are monitoring NHS 24 recommended home-visiting response times and were able to provide details of their performance against their targets (NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Fife, Greater Glasgow, NHS Lothian, NHS Shetland and NHS Tayside).

44 Only NHS Shetland had not agreed local performance indicators. However, due to the way the service is provided in Shetland local monitoring of A&E, where most of the primary care out-of-hours activity is handled, is appropriate.

Exhibit 14

Summary of benefits expected from the new out-of-hours care arrangements

Group	Expected benefits	Progress
Patients	Improved quality of out-of-hours care	NHS QIS standards are now in place and providers are mainly achieving these although these standards focus on process. National Key Performance Indicators for out-of-hours services are not yet developed although work is in progress.
	Reduction in waiting times to access out-of-hours care	This is not measured so it is not clear if this has been, or is in the process of being, addressed.
	Improved continuity of care through integrated out-of-hours and in-hours services	Progress being made although this varies depending on local circumstances.
	Improved information management and technology to ensure out-of-hours providers have access to patient medical history	Emergency Care Summary now rolled out.
Staff	More control over workload for some staff groups such as GPs	Better work-life balance for GPs – 73 per cent of respondents to our survey feel their work-life balance has improved.
	Improvements in quality of life for GPs (particularly rural GPs) through the ability to opt-out of providing 24-hour care	
	Ensuring that staff pay recognises care delivered out-of-hours	The new system now pays for out-of-hours work.
	Improved multi-disciplinary and inter-agency working and skill mix	There is evidence of some increased skill mix for out-of-hours services although more needs to be done.
Wider NHS	Improvements in recruitment and retention of key workforce groups including nurses, GPs, pharmacists, dentists and consultants	This is not measured for GPs or other practice staff therefore it is not possible to know if this is being achieved.
	NHS boards will have control of the budget for out-of-hours services in their areas and be in a better position to link budgeting processes with service and workforce planning	NHS boards are in a position to link budgeting with service and workforce planning, but other options for delivering the service have been limited to date, and workforce planning should be improved.
	Improved workforce planning and management, eg flexibility in the roles and use of NHS health care staff	Limitations as out-of-hours changes have taken place at the same time as NHS boards have been implementing Agenda for Change.

Sources: *Delivering the benefits of pay modernisation in the NHS in Scotland,* Health Department Letter (2005) 28, (1 July 2005) and *Implementing the new GMS contract in Scotland,* NHS Scotland, February 2004

69. There is no routine monitoring of how out-of-hours activity affects other services either at a local or national level. None of the six sample NHS boards routinely monitor referrals and activity between out-of-hours and social services and only one, NHS Lanarkshire, routinely monitors activity and referrals between out-of-hours services and A&E. This lack of monitoring will make planning for out-of-hours services and between different services less effective. In June 2007, the SEHD set up a steering group to review the changes in demand for unscheduled care services, including primary care out-of-hours services. Members include NHS boards, NHS 24 and the Scottish Ambulance Service.

70. There is no coherent national approach to monitoring the performance of out-of-hours services. However, there is evidence of monitoring the process by which NHS boards are developing their out-of-hours systems at a national level in three main ways:

- NHS QIS reviews NHS boards against its standards for out-of-hours services.[45]
- As part of monitoring the implementation of the nGMS

45 *The Provision of Safe and Effective Primary Medical Services Out-of-Hours,* NHS QIS, August 2004.

contract, the SEHD's pay modernisation team has asked NHS boards to assess themselves against ten strategic tests. One of these tests asks NHS boards to indicate to what extent they have reformed out-of-hours services.

- As the opt-out was introduced as part of the nGMS contract, the central monitoring of benefits of the main pay modernisation contracts makes reference to out-of-hours services, namely benefits realisation plans. These plans are now in their third annual revision and give examples of service initiatives. They do not act as a coherent monitoring tool to establish benchmarks for out-of-hours services.

The emergency care summary has now been rolled out and is used for 4.4 million patients across Scotland

71. The Emergency Care Summary Programme aims to provide essential patient information to out-of-hours services including NHS 24. The project is sponsored by the General Medical Services Information Management and Technology (IM&T) programme (part of the programme to implement the nGMS contract) and is a recognised component of NHSScotland's e-Health strategy. The project started in October 2003. The objectives of phase one of the project were to:

- provide a technically robust method of demonstrating the extraction of GP summary information from GP clinical systems into a 'store'
- establish a GP summary record and determine the frequency of updates for each element of the record
- share information and findings with the other UK nations.

72. Audit Scotland published a review of IM&T in November 2006 which sets out progress with the emergency care summary.[46] We concluded that the programme is well structured with clear governance arrangements for the overall programme, but that there is no business case for the programme or a defined set of anticipated benefits.

73. The emergency care summary was set up to support the changes to out-of-hours services which would take place following the GP opt-out. The summary gives healthcare professionals access to basic patient information such as current medication, allergies and demographic information. Information is copied from the GP patient record and updated twice a day if there are any changes. The system currently covers 4.4 million patients, whose GPs use the GPASS computer system. Work is underway to include the details of the remaining patients in Scotland whose GPs use different IT systems.

74. Currently the data can be accessed by staff at out-of-hours medical centres and NHS 24. A&E departments have access to these data but they are not all using it. In the future ambulance staff may be able to access these records. Patients are asked to give approval before anyone can access their information in this way.

Patients are generally satisfied with the out-of-hours service they receive

75. There have been changes in the care patients receive out-of-hours, specifically who provides the care and how patients are dealt with. There is scope for this to change further as services develop. Exhibit 15 (overleaf) shows a summary by NHS board of the care patients receive in the out-of-hours period.

76. We carried out telephone interviews with 600 members of the general public who had used out-of-hours services in the previous six months. Results from our patient survey are very positive with 85 per cent indicating that overall they were satisfied with the service they received. This included the manner in which staff dealt with them, information provided to them, the time they waited to speak to someone and the time spent treating the problem. Furthermore, overall satisfaction levels with each potential service used were very positive (eg, primary care treatment centre, NHS 24 or A&E).

77. In instances where further treatment was required after contacting NHS 24, a majority of respondents felt that they received treatment promptly – 62 per cent of those who received a home visit from a GP or another healthcare professional waited less than an hour; the average wait to be treated by a doctor or nurse at A&E was 43 minutes.

78. The small numbers of respondents who commented on the need for improvements to the out-of-hours service highlighted the need for a more speedy response in dealing with their health-related problem; that advice could be more thorough; or that they would like to have seen a doctor.

79. Patients travel either to a primary care treatment centre or to A&E to receive treatment out-of-hours. This was not raised as a concern by the majority of patients – 16 who had to attend A&E found difficulty in getting there, and only six had any difficulty in getting to the treatment centre.

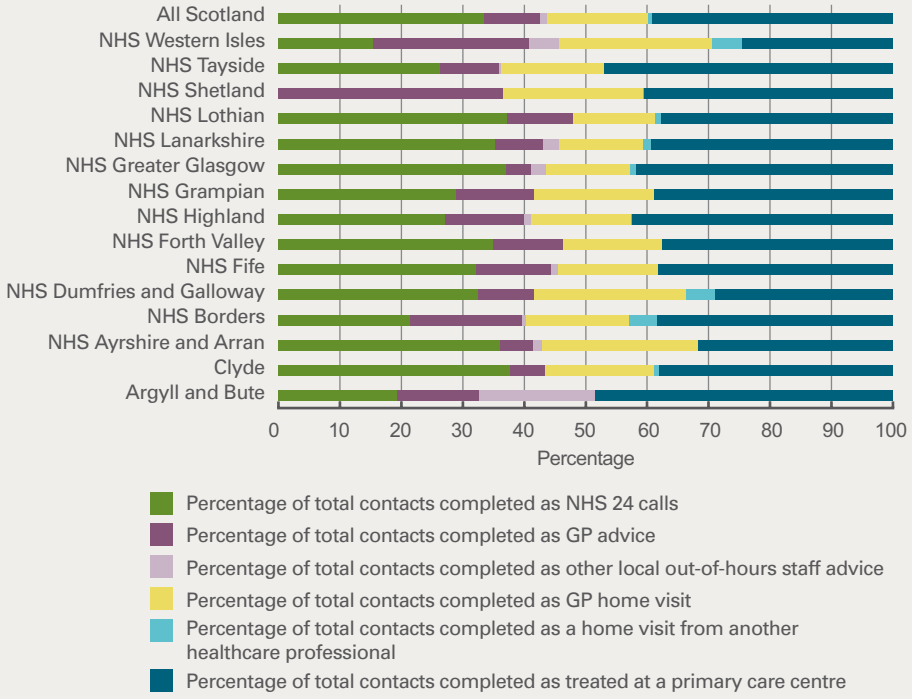
GPs are positive about the opt-out for themselves but do not feel the changes have improved care or access for patients

80. One of the main purposes of allowing GP practices to opt out of providing out-of-hours care was to give GPs more control over their work and improve working conditions. However, the benefit of opting out

46 *Informed to care*, Audit Scotland, November 2006.

Exhibit 15

Patient contact treatment outcomes 2005/06



Source: Audit Scotland 2007

will be less for those GPs who previously worked as part of an out-of-hours cooperative or engaged a deputising service.

81. GPs are generally positive about the ability to opt out of providing out-of-hours care. Eighty-eight per cent of GPs who replied to the survey said they are relieved that they no longer have 24-hour responsibility for patients, and 66 per cent feel that a career as a GP has become more attractive.

82. GPs do not feel the new arrangements have led to improvements for patients. Only 11 per cent of those who responded to our survey felt that patient care had improved under the new arrangements. A further 52 per cent felt that patient access and the availability of out-of-hours services had not improved.

Recommendation

The SEHD should:

- develop performance measures for out-of-hours services to support NHS boards to compare their out-of-hours services as they continue to develop them.

Part 6. Sustainability of the current service

There is a significant risk that current models of out-of-hours service delivery are unsustainable.

Key messages

- In areas with fewer GPs and a more dispersed population, GPs were less keen to reprovide out-of-hours services. NHS boards in these areas had to seek more innovative ways of sustaining these services, such as developing extended roles for nursing staff. In some particularly remote areas, such as parts of NHS Highland, some practices have not been able to transfer responsibility to their board as it is not possible to put in place an alternative service.

- The number of GPs from opt-out practices who then reprovided some level of out-of-hours care for a fee fell from 1,696 in 2004/05 to 1,440 by 2006/07. This makes it harder for NHS boards to fill out-of-hours GP rotas – five of the six sample NHS boards in our study reported difficulty in filling rotas. Increased practice income under the wider nGMS contract means that any financial incentive offered to GPs to carry out out-of-hours sessions is less attractive. Between 2003/04 and 2004/05, the average income of nGMS GPs in Scotland increased by 24.9 per cent to £82,696.

- The way in which services are delivered must change if out-of-hours services are to be sustained. NHS boards have been developing extended roles and involving a range of staff in delivering out-of-hours care, although progress is variable. There has been an increase in the use of salaried GPs from 61 in 2004/05 to 89 in 2006/07, but the use of staff with extended roles is more limited.

- The additional cost and time to train extended role practitioners to be able to pick up clinical sessions means that the costs of out-of-hours care are likely to rise in the short term.

There is a significant risk that current models of out-of-hours service delivery are unsustainable

83. The SEHD and NHS boards need to make a greater commitment to developing extended roles for nurses, paramedics and others to continue the development of skill mix in the out-of-hours period and in light of the fragility of relying on GP reprovision. For most NHS boards the number of GPs from opt-out practices who are reproviding out-of-hours services has remained relatively stable since the new contract was introduced. However, for three NHS boards, each with a large remote area to cover, there has been a significant reduction in the number of GPs providing this service (NHS Ayrshire and Arran, NHS Borders and NHS Dumfries and Galloway). At each of these NHS boards the number of GPs reproviding any out-of-hours sessions has almost halved. This may in part be due to a planned approach to reducing reliance on sessional GPs to reprovide out-of-hours work. For example, NHS Borders has moved quite quickly to a fully salaried GP rota for out-of-hours care because of the pressure on filling GP rotas (Case study 2).

Case study 2

NHS Borders did not manage to fill out-of-hours rotas in either 2004/05 or 2005/06. Sixty-four per cent of the total rota hours were filled in 2004/05, increasing to 98 per cent in 2005/06. This was due to more sessions being covered by salaried GPs. From April 2007 the service was operating a fully salaried GP service.

84. In 2004/05, 1,696 GPs from opt-out practices had reprovided some level of out-of-hours care for a fee. In 2006/07 this number had reduced to 1,440 (Exhibit 16). This affects some NHS boards more than others and makes it harder for them to fill out-of-hours GP rotas. Under the wider nGMS contract practice income has increased so there is less financial incentive to work out-of-hours. Between 2003/04 and 2004/05, the average income of nGMS GPs in Scotland increased by 24.9 per cent to £82,696.[47] [48]

85. Although the number of GPs willing to reprovide sessions has remained largely stable for some NHS boards, overall GPs tend to reprovide fewer sessions. This contributes to pressure in filling out-of-hours rotas. Exhibit 17 shows the frequency of GPs who have opted out of providing 24-hour care to their patients who then decide to deliver out-of-hours sessions for an NHS board.

86. NHS boards are already reporting difficulties in filling GP out-of-hours rotas, including five of the six sampled NHS boards.[49] If this pattern continues NHS boards will experience further difficulties in filling out-of-hours sessions and will need to find other solutions. Some NHS boards have also used agencies to supply GPs to deliver out-of-hours sessions although this is marginal in terms of both cost and activity (£1.09 million in 2005/06), and not all NHS boards have used agencies so far.

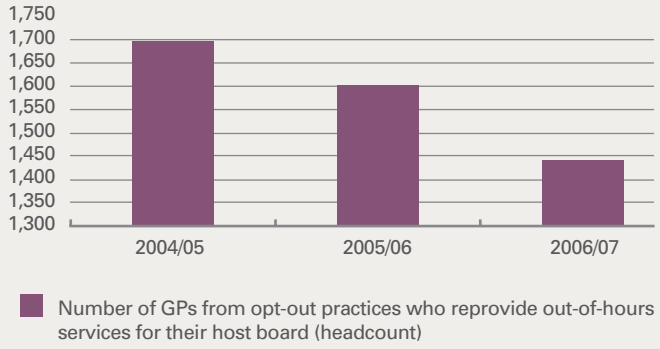
87. Since GPs are no longer required to deliver out-of-hours care, there is a risk that they will choose not to. This makes it difficult for NHS boards to plan how out-of-hours services might be delivered in the future.

47 *GP Earnings and Expenses,* NHS Information Centre, 16 July 2007.
48 GP income based on self-assessment income tax return to HM Revenue and Customs.
49 NHS Greater Glasgow and Clyde reported that it has successfully filled GP out-of-hours rotas.

Exhibit 16

Numbers of GPs reproviding out-of-hours sessions

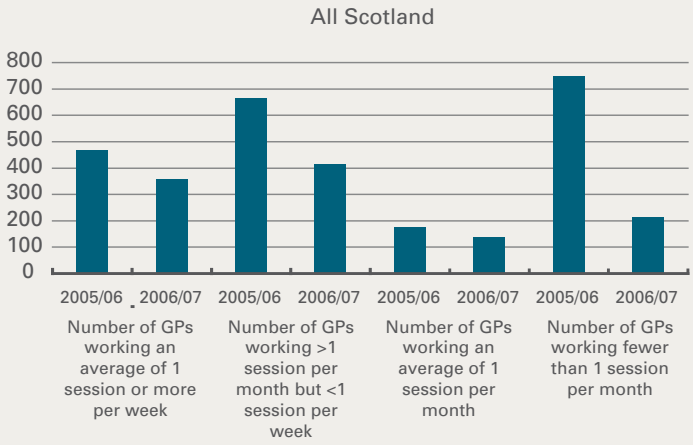
The numbers of GPs reproviding sessions has reduced over time



Source: Audit Scotland 2007

Exhibit 17

Reprovision rates of opt-out GPs across Scotland



Source: Audit Scotland 2007

NHS boards are developing new ways of delivering out-of-hours services but should do more to develop the skill mix

88. Out-of-hours services can best be provided by using an appropriate mix of clinical staff and providers. NHS boards employ salaried GPs to carry out some out-of-hours work, and all NHS boards have begun to develop extended roles for NHS staff so that staff such as paramedics and nurses can contribute to the effective care of patients in the out-of-hours period.

89. Exhibits 18 and 19 (overleaf) show the percentage of direct clinical activity delivered by GPs, NHS staff and locums in 2004/05 and 2005/06. Both charts show the variation in how services are delivered across Scotland. This is due to a number of distinctly local factors such as how services were configured prior to the opt-out, success in recruiting salaried GPs and the extent to which the NHS board has trained and employed nurses with extended roles. This situation has evolved because of what is available or possible locally, rather than any SEHD guidance on a preferred model or skill mix. The exhibits also show a small percentage of unfilled out-of-hours sessions in four NHS boards (NHS Borders, NHS Grampian, NHS Forth Valley and NHS Tayside). NHS boards have contingency plans to cover these hours by moving other staff working out-of-hours to cover sessions as required.

90. Exhibits 18 and 19 (overleaf) show that in 2004/05 there was relatively limited use of other staff to provide out-of-hours activity. The nGMS contract makes explicit provision for NHS boards to appoint salaried GPs for the out-of-hours period. NHS boards have taken different approaches to the use of salaried GPs, but across Scotland as a whole there is an increasing trend to employ salaried GPs. In 2006/07 there were 89 whole time equivalent (WTE) salaried GPs providing out-of-hours care employed across Scotland, a rise from 61 WTE in 2004/05.[50] [51]

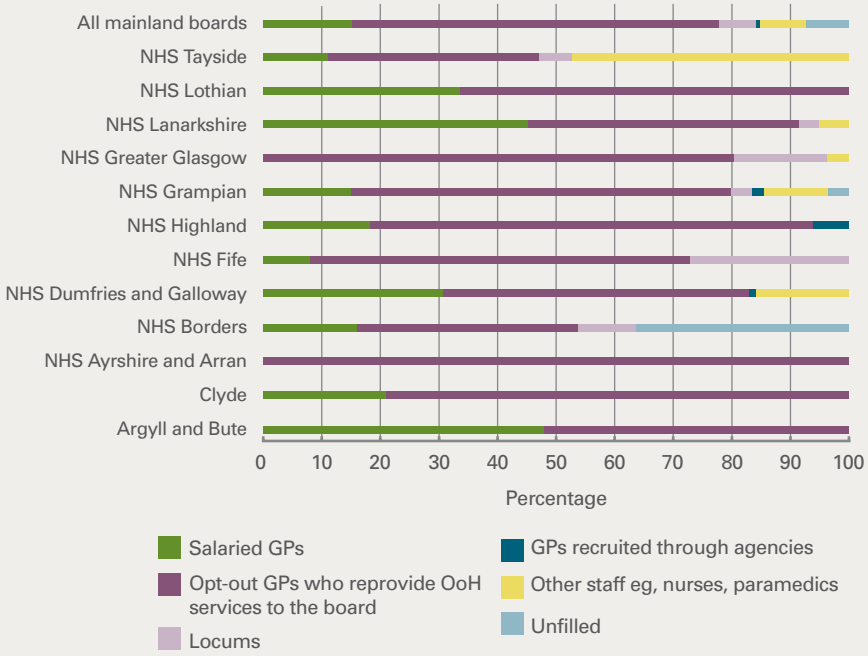
91. Most NHS boards have not yet used other healthcare professionals to cover out-of-hours work. For those boards which have started to use other healthcare professionals in this way, there was a small increase in the amount of work they did in 2005/06. More use has also been made of locum GPs.

92. There have been complications in moving forward with this skill mix approach to out-of-hours work. These options do not, in the short term, represent a cheaper way to

50 Workforce data, ISD, February 2006.
51 WTEs adjust headcount staff figures to take account of part-time staff.

Exhibit 18

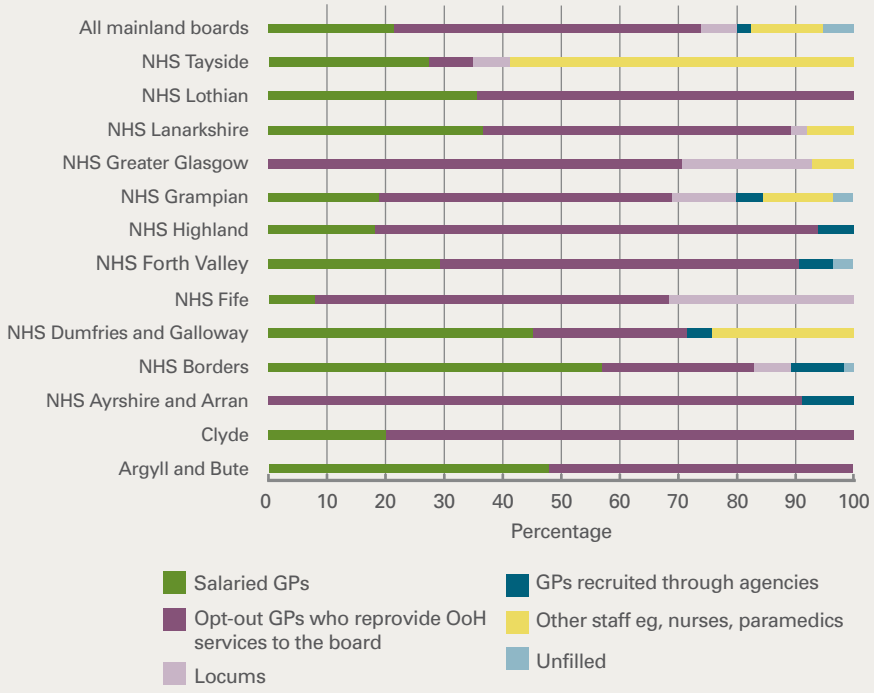
Percentage of out-of-hours work covered by GPs, other NHS staff and locums from point of transfer, 2004/05



Source: Audit Scotland 2007

Exhibit 19

Percentage of out-of-hours work covered by GPs, other NHS staff and locums 2005/06



Source: Audit Scotland 2007

deliver the service and it is costly to train and pay for staff working in these extended roles. It is not possible to replace a GP directly with another healthcare professional – using a greater skill mix is about making better use of the skills of healthcare professionals. However, one of the benefits of using other directly employed staff is that the NHS board will have more control and therefore be better able to plan and use resources as they are needed. Salaried GPs and nurses are tied in to the service and therefore offer a more predictable way of providing the service than GPs who currently reprovide some sessions but may decide not to in the future.

93. A further complication is in identifying the staff to carry out these roles. For example, some NHS boards have reported difficulties in recruiting salaried GPs. The implementation of Agenda for Change has also complicated the development of extended roles. Agenda for Change is one of the main strands of NHS pay modernisation, introducing new contracts for nursing, administration and other staff. The contract is still being implemented and all staff in these groups are having their jobs assessed and graded. This inevitably means a sense of uncertainty for staff potentially making them less likely to take on an extended role. Furthermore there have been differences in the way some extended roles have been graded either between professional groups (eg, paramedics and nurses) or in the grading that some extended roles have been given under Agenda for Change (ie, they are not paid much than a standard grade).

A greater focus on workforce planning, education and training is required

94. Although all NHS boards now have a workforce plan in place, the plans do not always provide details of numbers and types of staff required to deliver and develop the out-of-hours service. The number of

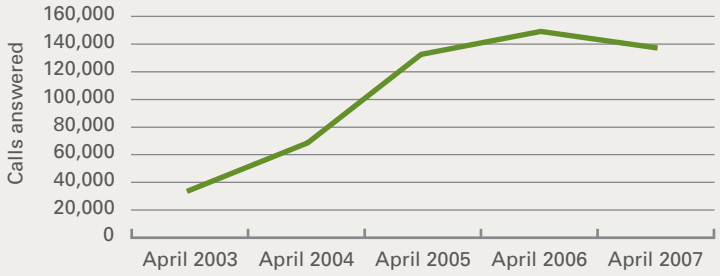
sessions delivered out-of-hours by GPs has reduced and NHS boards have reported pressures in filling GP rotas. In light of this, and the fact that GPs are no longer responsible for delivering this care, NHS boards need to be more proactive in planning how the service will be delivered. The SEHD should support this by developing a clear overall strategy for the continued development of out-of-hours services.

95. Although there are many training courses and schemes for training staff in skills necessary for out-of-hours work, there is scope for these to be better funded and coordinated. NES has led the creation of a new framework to support the development of new roles and skills that out-of-hours practitioners will need and has provided some funding to support this.[52] This is linked to a new integrated approach to workforce planning which aims to organise workforce planning around service themes set out in the *Kerr report*. This includes identifying numbers and types of staff required to deliver out-of-hours services, over a three, five and ten-year period and the actions required to meet any gaps identified. A group has been set up by the SEHD to share good practice and take a strategic approach to the development of extended roles for out-of-hours and they are expected to publish a report in late 2007.

New ways of working with NHS 24 and the ambulance service have helped NHS boards take responsibility for out-of-hours care

96. Although the cost of out-of-hours services delivered by NHS boards in 2006/07 was approximately £67.93 million, a range of other agencies support NHS boards in the delivery of out-of-hours care to their patients, most significantly NHS 24 and the ambulance service.

Exhibit 20
NHS 24 activity before and after nGMS opt-out

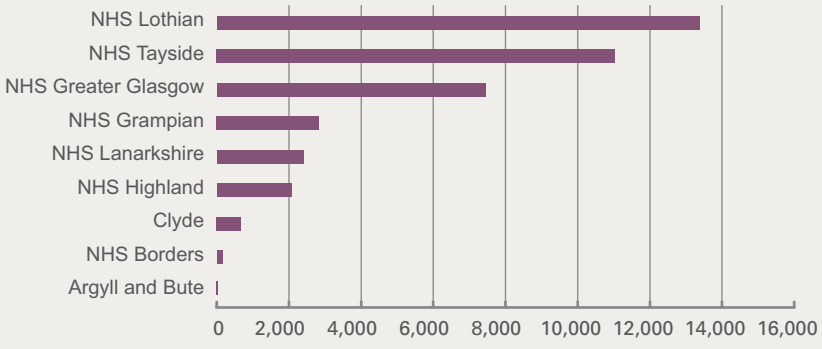


Source: NHS 24 performance reports

97 A review of NHS 24 carried out in 2005 found that 90 per cent of calls to NHS 24 take place in the out-of-hours period.[53] The cost of running NHS 24 was £42.6 million in 2004/05. Exhibit 20 highlights the increased activity of NHS 24, reflecting its changing role as it was rolled out across Scotland as the first point of contact for out-of-hours services.

98. There are times when NHS 24, under agreements with NHS boards, will transfer calls untriaged directly to local NHS boards to deal with. This is usually at times of peak out-of-hours activity (Exhibit 21).[54] Only four NHS boards do not take untriaged calls (NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Orkney and NHS Shetland).

Exhibit 21
Untriaged calls handled locally by NHS boards, 2005/06



Note: NHS Forth Valley, NHS Fife and NHS Western Isles have been excluded due to inaccuracies in or lack of data.
Source: Audit Scotland 2007

52 *Out-of-hours: mapping and supporting new roles for practitioners in unscheduled care,* NES, August 2004.
53 *Evaluation of the introduction of NHS 24 in Scotland - final report,* David Heaney, Catherine O'Donnell, Anne Wood, Susan Myles, Joanne Abbotts, Gill Haddow, Iain Armstrong, Stephanie Hall and James Munro, December 2005.
54 Untriaged calls are calls from patients who have not had their needs assessed or a decision made about any treatment required.

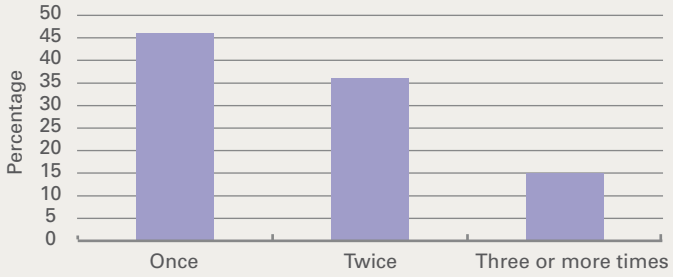
99. In addition to taking untriaged calls from NHS 24 many NHS boards re-triage some calls passed to them by NHS 24. This means that the patient is re-assessed by the NHS board after NHS 24 has already assessed the caller's needs. This could raise concerns that NHS 24 assessments are not always appropriate or that carrying out another assessment or triage delays patient treatment. The main reason NHS boards gave us for re-triaging calls is to ensure that they can best manage clinical priorities with available local resources when demand is high. Ten NHS boards re-triage calls that are passed on from NHS 24 but stated this happens occasionally or during peak periods of activity.[55] Exhibit 22 shows that over half of respondents to our survey had to explain their health-related problem more than once before receiving the care they required.

100. Exhibit 23 shows changes in activity of the ambulance service before and after the opt-out came into effect. The ambulance service is about to carry out more detailed work to understand the reasons behind the increases in its activity.

101. Changing the availability and location of out-of-hours services has a direct impact on the work of the ambulance service, such as how long it takes to transport a patient to hospital and where ambulance stations are located. While the Scottish Ambulance Service is continuing to work with individual NHS boards to contribute to local services, it is also analysing resource implications of changes to out-of-hours services.

Exhibit 22

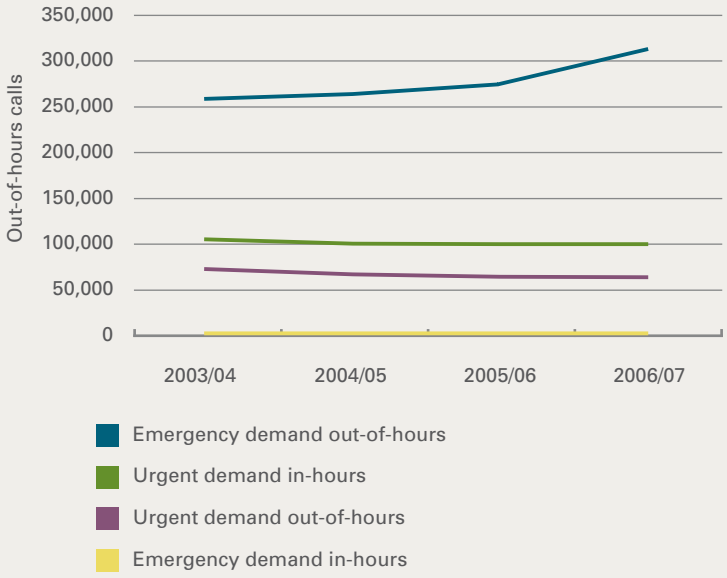
Number of times patients had to explain their health-related problem before speaking to the person who could deal with it



Source: Audit Scotland 2007

Exhibit 23

Scotiish Ambulance Service activity before and after nGMS opt-out



Source: Scottish Ambulance Service performance monitoring data

There is no evidence to suggest that the changes in how out-of-hours services are delivered has affected A&E activity

102. Changes in out-of-hours services have also led to changes for A&E services, and there is often a perception that A&E activity levels have increased as a direct result of the nGMS opt-out. For example, 48 per cent of respondents to our GP survey feel there has been an increase in attendances at A&E since the opt-out. However, there is little evidence at a national level that A&E

55 Boards which do re-triage calls once they have been passed to them from NHS 24 are: NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Highland, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Lothian and NHS Tayside.

activity has been affected directly by the opt-out. A&E activity was increasing before the opt-out and has continued to do so since.

103. ISD collects national data on A&E activity through its annual waiting times survey. It is not possible to use these data to show trends in activity over time as data were collected for different hospitals and over different time periods in 2003, 2004 and 2005.

There is now more demand for out-of-hours community pharmacy services

104. An internal report by the Scottish Pharmaceutical General Council (SPGC) shows that community pharmacists have seen an increase in demand for emergency supplies, particularly on a Saturday morning when GP surgeries are now closed, and also on public holidays.[56] The report shows that 35 per cent of all NHS 24 calls are pharmacy-related, which has an impact on the work of community pharmacists, and indicates that the pressure is greatest over the weekend and bank holidays.

Recommendations

The SEHD should:

- provide clarity about the way forward for primary care out-of-hours services, for example by investing in the development of extended roles for NHS staff to build on work carried out by NES and the SEHD strategy group
- review the impact of the changes to out-of-hours care on other services, specifically pharmacy, A&E and the ambulance service to inform planning around how out-of-hours services develop in the future
- ensure data are collected on a consistent basis to allow comparisons over time.

NHS boards should:

- continue to integrate primary care out-of-hours services with unscheduled care services, so that best use is made of available resources and patients can receive a more joined-up service
- monitor the implementation of extended roles for staff and GP reprovision rates to support accurate workforce planning for out-of-hours services and to inform service improvement.

56 Scottish Pharmaceutical General Council (SPGC) Performance Monitoring Survey, June 2005

Appendix 1.

Advisory group members

Member	Organisation
Dr Andrew Buist, GP and BMA representative	British Medical Association
Dr Angus Cameron, Medical Director	NHS Dumfries and Galloway
Dr George Crooks, Medical Director Clinical Director/Chief Operating Officer	Scottish Ambulance Service NHS 24
Douglas Griffin, Director of Finance	NHS Greater Glasgow and Clyde
Dr David Heaney, Associate Director, Centre for Rural Health	University of Aberdeen
Dr Una McLeod, GP and Senior Lecturer, Section of General Practice and Primary Care	University of Glasgow
Harry McQuillan, Chief Executive Officer	Scottish Pharmaceutical General Council
Dr Kate O'Donnell, Senior Lecturer in Primary Care Research and Development, General Practice and Primary Care	University of Glasgow
Dr Mike Sabin, Programme Director	NHS Education for Scotland
Dr Marion Storrie, Clinical Director, Lothian Unscheduled Care Service	NHS Lothian
John Turner, Director, Pay Modernisation Unit	Scottish Executive Health Directorates
Dr Steven Wilson, Performance Assessment Team Manager	NHS Quality Improvement Scotland

Appendix 2.

Funding by NHS board

	2005/06						2006/07				
	NHS board budget £000	PMS allocation £000	6% claw-back £000	Development fund £000	Other funding £000	Total £000	NHS board budget £000	PMS allocation £000	6% claw-back £000	Other funding £000	Total £000
Argyll and Bute	129	90	233	308	0	760	129	90	235	0	454
Clyde	124	86	1,142	296	0	1,648	124	86	1,149	0	1,359
NHS Ayrshire and Arran	2,029	183	1,422	744	0	4,378	2,250	927	1,420	0	4,597
NHS Borders	1,212	43	396	220	15	1,886	1,540	43	357	15	1,955
NHS Dumfries and Galloway	1,446	374	626	320	4	2,770	1,731	374	626	4	2,735
NHS Fife	1,859	135	1,035	461	268	3,758	2,540	135	1,050	137	3,862
NHS Forth Valley	2,217	0	1,101	535	0	3,853	2,930	0	1,101	0	4,031
NHS Highland	5,776	INA	1,061	351	38	7,226	5,128	INA	1,061	38	6,227
NHS Grampian	4,920	142	1,877	910	0	7,849	5,672	142	1,912	0	7,726
NHS Greater Glasgow	1,833	0	3,300	1,800	0	6,933	4,109	0	3,300	0	7,409
NHS Lanarkshire	3,511	0	1,859	673	0	6,043	4,164	0	1,959	0	6,123
NHS Lothian	3,196	0	2,685	1,500	0	7,381	5,153	0	2,639	0	7,792
NHS Orkney	INA	INA	INA	INA	INA	0	325	0	5	0	330
NHS Tayside	3,190	0	1,461	766	105	5,522	3,975	0	1,454	65	5,494
NHS Western Isles	842	0	138	52	0	1,032	827	0	137	0	964
All Scotland	**32,284**	**1,053**	**18,336**	**8,936**	**430**	**61,039**	**40,597**	**1,797**	**18,405**	**259**	**61,058**
Percentage of total	52.9%	1.7%	30.0%	14.6%	0.7%		66.5%	2.9%	30.1%	0.4%	

INA : Information not available

Note: Funding for PMS practices in NHS Highland is included in unified budget figure as the out-of-hours element of this could not be separated out. NHS Shetland was not able to provide information. NHS Orkney was not able to provide information for 2005/06.

Appendix 3.

NHS QIS standards

1(a): Accessibility and availability at first point of contact

1(a)1	Arrangements are in place to identify the needs of those potentially using these services.
1(a)2	Arrangements are in place to meet the needs of those potentially using these services.
1(a)3	Arrangements are in place for patients or their representatives to access care by telephone in the first instance.
1(a)4	Access to, and delivery of, services is not compromised by physical, language, cultural, social, economic and other barriers.

2(a): Safe and effective care – Healthcare governance

2(a)1	Patient Focus: Throughout the service, work is undertaken in partnership with individuals, communities and community planning partners in the design, development and review of services. The results of the work are acted upon and feedback is provided to all those involved.
2(a)2	Patient Focus: Information is made available by the provider for the patient and their representatives regarding any care or treatment given.
2(a)3	Clinical Governance: There are clear, cohesive plans across the service that direct and support policy development and service delivery both internally and through delivery partners.
2(a)4	Clinical Governance: Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised.
2(a)5	Clinical Governance: Providers of out-of-hours services have a system in place to report to NHS board clinical governance committees regularly.
2(a)6	Clinical Governance: Arrangements are in place to communicate, inform and cooperate with key professionals, external parties and voluntary agencies.
2(a)7	Staff Governance: Staff involved in out-of-hours care meet employment requirements, including qualifications.
2(a)8	Staff Governance: Staff are competent to perform their duties.

2(b): Safe and effective care – Clinical care

2(b)1	Procedures are in place to ensure quick and easy access to evidence-based clinical guidelines to support clinical decision-making.
2(b)2	Patients are assessed and responded to, based on clinical need and professional judgement.
2(b)3	The service has drugs which are in date and equipment which is regularly maintained.

Appendix 3.

NHS QIS standards (continued)

2(c): Safe and effective care – Information and communication

2(c)1	Systems are in place for the completion, use, storage and retrieval of records including compliance with the Data Protection Act, 1998.
2(c)2	Systems are in place for receiving and communicating information to inform patients' ongoing care, by the next working day.
2(c)3	Systems are in place to ensure that patients are aware of, and agree to, the sharing of information about them and their care with other healthcare professionals.

3(a): Audit, monitoring and reporting

3(a)1	A set of provider-specific key performance indicators (patient-focused public involvement, clinical and organisational) are in place.
3(a)2	Comments, complaints and compliments are recorded, regularly reviewed and action taken.
3(a)3	The service provider takes action to identify patient views and satisfaction levels.
3(a)4	A report on performance and services is published annually and is available to users of the service and those contracting services.

Appendix 4.

Self-assessment checklist for NHS boards

The checklist sets out some high-level statements about managing out-of-hours services based on issues raised in this report. NHS boards (with their Community Health Partnerships) should assess themselves against each of the statements and consider which statement most accurately reflects their current situation:

- not in place and action needed
- not in place but action in hand
- in place but needs improving
- in place and working well.

This approach will enable boards to identify what actions need to be taken forward.

Self-assessment of managing out-of-hours services

The last column in the checklist can be used to record sources of evidence, supplementary comments to support your assessment or to highlight areas of interest etc.

Issue	Assessment of current position					Comment to support or explain your statement
	No – action needed	No – but action in hand	Yes – in place but needs improving	Yes – in place and working well	Not applicable	
We share data on fees and payments with all other NHS boards in Scotland to ensure value for money and enable fee levels to be monitored across Scotland.						
We regularly review all contracts for out-of-hours services.						
We consider whether out-of-hours contracts represent value for money.						
We review both the activity provided and the cost of out-of-hours contracts.						
We are continuing to integrate primary care out-of-hours services with unscheduled care services, making best use of available resources.						
We are monitoring the implementation of extended roles for staff and GP reprovision rates to support accurate workforce planning for out-of-hours services and to inform service improvement.						

Self-assessment of managing out-of-hours services (continued)

The last column in the checklist can be used to record sources of evidence, supplementary comments to support your assessment or to highlight areas of interest etc.

Issue	Assessment of current position					Comment to support or explain your statement
	No – action needed	No – but action in hand	Yes – in place but needs improving	Yes – in place and working well	Not applicable	
We have detailed workforce plans in place for out-of-hours services, which set out the number and type of staff required to operate the service.						
We regularly monitor the impact of out-of hours services on other parts of the system such as A&E and community pharmacy.						
We monitor performance against NHS call-handling targets.						

Primary care out-of-hours services

If you require this publication in an alternative format and/or language, please contact us to discuss your needs.

You can also download this document at:
www.audit-scotland.gov.uk

Audit Scotland, 110 George Street, Edinburgh EH2 4LH
T: 0845 146 1010 F: 0845 146 1009
www.audit-scotland.gov.uk

ISBN 978 1 905634 68 2 AGS/2007/5