

Key messages

Primary care out-of-hours services



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. 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.

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Executive and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.

Key messages

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 just over £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. 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 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 (eg, 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 the ambulance service and NHS 24 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.

The study

7. Audit Scotland has reviewed changes to the delivery of primary care out-of-hours services. We looked at national and local planning for out-of-hours care; how much it costs the NHS; and how the current delivery of out-of-hours services affects patients and GPs. 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.

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.

Key messages

1 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.

8. 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 to NHS boards did not have to be in place until 31 December 2004.⁹

9. 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.

2 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.

10. As part of UK-wide negotiations of the nGMS contract it was agreed that GP practices opting out of providing out-of-hours care would forgo an average of £6,000 of their funding each year per GP (known as the claw-back).¹⁰ The claw-back figure was a negotiating sum and was not intended to be a precise reflection of the cost of providing out-of-hours services.¹¹

11. 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.¹²

12. 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.

13. 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. *Exhibit 1* provides a breakdown of the costs for 2005/06 and 2006/07.

14. 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 (*Exhibit 2*). This is due to a range of factors such as sparse population and large geographical areas to cover.

15. GPs who opt out but then decided 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.¹³

16. 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 transferred responsibility to their board as it is not possible to put in place an alternative service.

3 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.

9 Not all practices were able to opt out, specifically those in remote or rural areas. In Scotland a small number of practices chose to retain out-of-hours responsibility.

10 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.

11 *The Provision of Out of Hours Care in England*, National Audit Office, May 2006.

12 Figures for Glasgow, Argyll and Bute and Clyde areas are shown separately throughout the report due to the dissolution and mergers of the former NHS Argyll and Clyde. We have collected and shown data for these areas separately to track activity and costs over time. This figure relates only to NHS Greater Glasgow area.

13 We have excluded island boards here as they tend to pay additional supplements or have local special arrangements which make comparisons difficult.

Exhibit 1

Cost of out-of-hours services, 2005/06 and 2006/07

	Cost (£ million) 2005/06	Projected cost (£ million) 2006/07
Salaried staff ^{14, 15} (including £11.2 million on salaried GPs in 2005/06 and £12.4 million in 2006/07. Other payments here are to managers, administration staff and nurses)	29.10	32.87
GPs reprovinding out-of-hours sessions	27.68	24.03
All service level agreements (including GP agency costs of £1.1 million in 2005/06)	3.74	3.57
Infrastructure costs (including capital costs, training and education)	4.46	4.80
Payments to opt in GPs to provide out-of-hours services	2.70	2.66
Total	67.68	67.93

Source: Audit Scotland 2007

17. GPs' ability to opt out of out-of-hours services has happened alongside other changes such as the roll-out of NHS 24 and the implementation of several large pay modernisation contracts. This makes it difficult to isolate the overall impact of the opt-out on out-of-hours services.

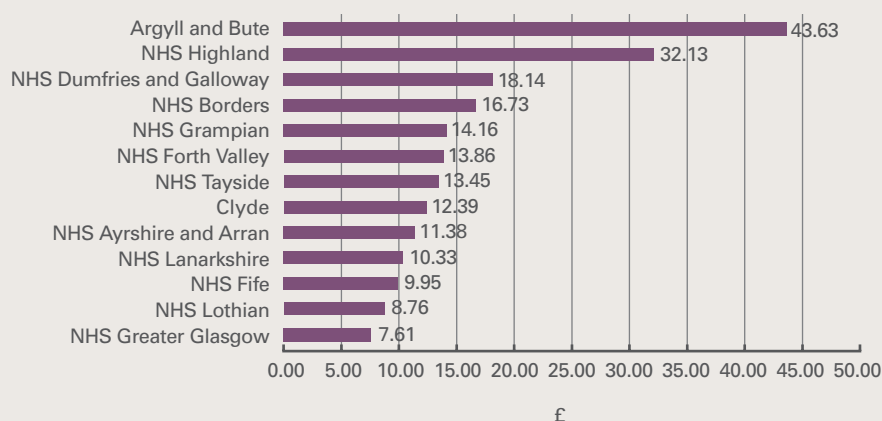
18. National benchmarking and monitoring of performance of out-of-hours services needs to be improved to give a clear view of the standard of services provided. There is no coherent national approach to monitoring the performance of out-of-hours services, although there is evidence of monitoring the process by which NHS boards are developing their out-of-hours systems. For example NHS boards are monitored against NHS Quality Improvement Scotland (NHS QIS) standards for out-of-hours services.¹⁶ A national group involving NHS QIS, NHS 24 and boards is currently developing national key performance indicators for primary care out-of-hours services.

19. 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.

20. Improving recruitment and retention of GPs was an aim of the opt-out but as the nGMS contract is with a practice rather than a GP, data on GP vacancies are no longer automatically collected centrally. This makes detailed workforce planning at national and local levels more

Exhibit 2

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



Note: This exhibit excludes NHS Orkney, NHS Shetland and NHS Western Isles.

Source: Audit Scotland 2007

¹⁴ These are staff who are employed directly by the NHS board and paid a salary.

¹⁵ Argyll and Bute and Clyde have not been able to separately identify salaried and sessional GP costs. Therefore these costs are included within the salaried staff costs. This amounts to around £1.8 million in both years for Argyll and Bute and around £4.1 million in both years for Clyde.

¹⁶ *Standards for the provision of safe and effective primary medical services out-of-hours*, NHS QIS, August 2004.

complicated. In 2006/07 the SEHD established a survey of GP practice staffing, including GP numbers, to measure changes in GP recruitment and retention and to support workforce planning.

4 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.

21. The creation of NHS 24 completely changed how patients access out-of-hours services. Ninety per cent of calls to NHS 24 take place out-of-hours and it is now the first point of contact for most primary care out-of-hours services in Scotland.

22. The impact of recent changes on other services such as the ambulance service and A&E is not clear due to a lack of routine information at local and national levels. None of the six sample NHS boards routinely monitors activity and referrals between out-of-hours and social services and only one, NHS Lanarkshire, routinely monitors activity and referrals between out-of-hours and A&E.

23. NHS boards have begun to integrate primary care out-of-hours services with unscheduled care services, for example, by co-locating their primary care out-of-hours service with A&E services and developing rotas and shared roles for staff to work across the two services. NHS boards are also beginning to integrate out-of-hours services with care provided during normal working hours ('in-hours' services), for example, all boards have systems to transfer patient information gathered in the out-of-hours period to in-hours GPs.¹⁷

But a variety of providers are now involved in out-of-hours care including NHS 24, the ambulance service, A&E and social services. Communication and sharing of patient information among these providers could be better. 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.

5 Out-of-hours services are under continuing pressure as fewer GPs are re-providing 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.

24. The number of GPs from opt-out practices who then re-provided 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 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.^{18, 19}

25. 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 ([Exhibit 3](#)).

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 exhibit shows a small amount of unfilled hours but NHS boards have contingency plans to cover these hours by moving other staff as required.

26. NHS Education Scotland (NES) is working with the NHS to support the development of extended roles for out-of-hours services. Although there are local initiatives supported by NES there is a need to improve local workforce planning and the development of extended roles.

27. 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.

Key recommendations

29. We have identified several key recommendations for the SEHD and NHS boards.

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

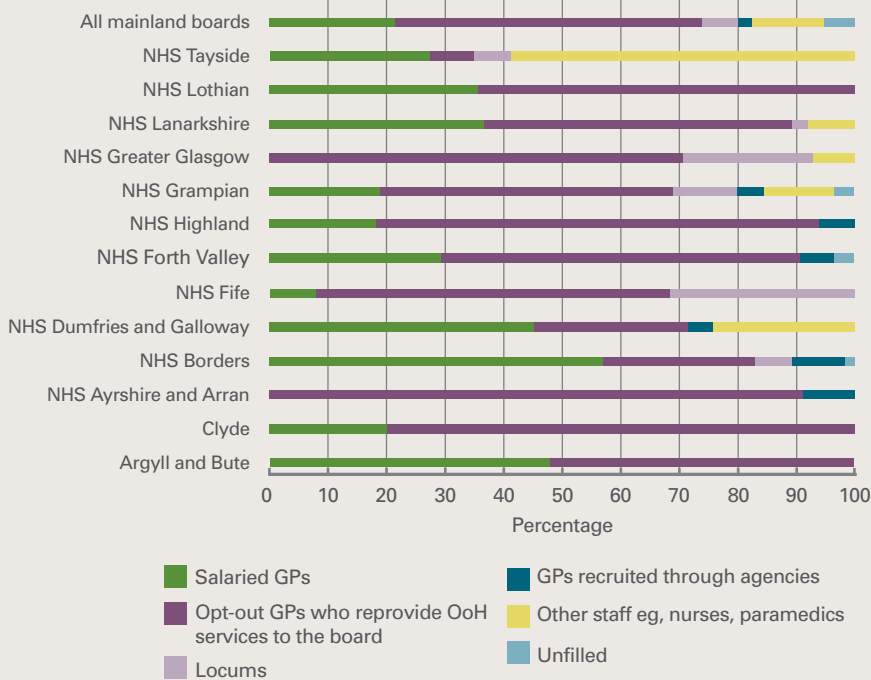
¹⁷ *National Overview; The Provision of Safe and Effective Primary Medical Services Out-of-Hours*, NHS QIS, October 2006.

¹⁸ *GP Earning and Expenses*, NHS Information Centre, 16 July 2007.

¹⁹ GP income based on self-assessment income tax return to HM Revenue and Customs.

Exhibit 3

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



Source: Audit Scotland 2007

- 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.
- 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.

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.

Primary care out-of-hours services

If you require this publication in an alternative format 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 998 1 905634 69 9 AGS/2007/5

This publication is printed on uncoated paper, made from 100% post consumer reclaimed material.