



House of Commons
Health Committee

GP Out-of-Hours Services

Fifth Report of Session 2003–04

Volume I



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Report, together with formal minutes

*Ordered by The House of Commons
to be printed 19 July 2004*

HC 697-I

Published on 6 August 2004
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

The Health Committee

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Footnotes

In the footnotes of this Report, references to oral evidence (contained in Volume II) are indicated by 'Q' followed by the question number. Written evidence is cited by reference to Volume II of this Report, in the form 'Ev' followed by page number, or by reference to numbered Appendices.

Contents

Report	<i>Page</i>
1 Introduction	3
2 Are PCTs ready to take on responsibility for GP out-of-hours services?	5
3 Opportunities	9
Skill mix	10
Different models of service provision	11
Quality	13
4 Risks	15
GP involvement	15
Skill mix	18
NHS Direct	20
Impact on other NHS services	24
Community hospitals	26
Financial pressures	28
Quality	32
5 Conclusion	34
Conclusions and recommendations	35
List of abbreviations	38
Formal minutes	39
Witnesses	40
List of written evidence	41
Reports from the Health Committee since 2001	42

1 Introduction

1. Every year, approximately nine million patients receive urgent primary care out of hours.¹ The ‘out-of-hours’ period, as it is now defined, accounts for two-thirds of every week.² Not only do GP out-of-hours services provide essential medical cover during the larger part of the week, they also act as a vital means of managing demand on the rest of the health service, since in the absence of accessible GP out-of-hours services, patients may seek care by attending the Accident and Emergency (A&E) Department of their local acute hospital, or by dialling 999. The National Association of GP Co-operatives (NAGPC) argued in evidence to us that “the numbers are such that a small percentage transfer from GP out-of-hours services to A&E would have a significant impact on A&E flows and therefore waiting times”.³

2. However, despite the indispensable round-the-clock provision they offer, GP out-of-hours services tend to be largely invisible, without high-profile political targets or initiatives to draw attention to their work. The lack of priority afforded to GP out-of-hours services was emphasised to us by the Rt Hon John Hutton MP, the Minister with responsibility for this area:

If you were to look critically at the development of out-of-hours, it is not an unreasonable conclusion to say that out-of-hours services, although there have been tremendous amounts of change in out-of-hours, has not had the same focus certainly in comparison to other parts of the health service.⁴

3. The changes to which the Minister referred include the move towards greater use of GP out-of-hours co-operatives during the mid 1990s. GPs currently have a responsibility to care for their patients 24 hours a day. Historically, if a patient who was registered with a GP required urgent medical care outside their GP’s surgery hours, that patient could expect out-of-hours care, either in the form of a telephone call or a home visit, from his or her GP. If GPs were single-handed they would provide all of their own out-of-hours cover, or, if they worked in a partnership, might provide cover in a rotation with their partners, or sometimes through an extended rotation with a couple of other local practices. Although there have long been alternatives to these intense working patterns, including commercial deputising services and GP co-operatives, according to the British Medical Association (BMA) it was not until the mid-1990s that there was a major trend towards care delivered by organisations above the level of the individual practice. This also led to a shift towards more premises-based care, where patients could be seen out of hours at a primary care centre rather than having a home visit.⁵ Department of Health figures show that at the beginning of 2004, approximately 70% of GPs had delegated the responsibility to a GP co-

1 Ev 58

2 Q17; the out-of-hours period is defined in the GP contract as from 6:30 pm to 8:00 am on weekdays, and also the whole of weekends, Bank holidays and public holidays (*Investing in General Practice; the new General Medical Services contract*, para 2.18).

3 Ev 12

4 Q141

5 Q5

operative, and around 25% to a commercial provider, leaving only 5% of GPs providing their own out-of-hours services.⁶

4. Following concerns raised by the Health Services Ombudsman, a review of arrangements for GP out-of-hours cover was commissioned by the Department of Health and published in October 2000 (the Carson Report). The report identified a future model of out-of-hours care in which Primary Care Trusts (PCTs) would develop an integrated network of unscheduled care provision, bringing together providers of out-of-hours services to work collaboratively with other health and social care providers such as A&E and ambulance services. The report identified the core quality standards to which all out-of-hours services should be delivered in the future.

5. In addition to questions being raised over the quality of out-of-hours provision, there was growing concern within the medical profession that the requirement to provide out-of-hours care was contributing to low morale amongst GPs, and that the existing default responsibility for all GPs to provide 24-hour care for their patients made general practice unattractive for many prospective and current GPs. The BMA's General Practitioners Committee's National Survey of GP Opinion in 2001 found that 83.8% of family doctors believed that it should be possible for individual doctors to choose whether to opt out of out-of-hours responsibility.⁷

6. Under the terms of the new General Medical Services (GMS) contract, which was agreed in 2003, GPs are now able to opt out of the obligation to provide out-of-hours care for their patients. Until 31 December 2004, GPs may opt out with the agreement of their PCT. After 1 January 2005, GPs will have a right to opt out in all but exceptional circumstances (including, for example, GPs working in remote and isolated areas). Where practices opt out, responsibility for securing out-of-hours services for their patients transfers to the PCT. In financial terms, providing 24-hour out-of-hours cover for all their patients will earn the average GP approximately £6,000 per year. This funding will default back to the PCT if GPs opt out. According to the BMA, approximately 90% of GPs are expected to opt out of providing out-of-hours services.⁸

7. Several of our witnesses have argued that the shift in responsibility for GP out-of-hours services from individual GPs to PCTs should not, if all goes to plan, impact upon patients at all. The greatest cultural shift for patients, they suggested, in fact occurred in the mid-1990s, when instead of being visited by their own GP, patients had to adapt to receiving out-of-hours care from a GP employed by a co-operative or commercial company who was probably unknown to them.⁹

8. However, adopting responsibility for commissioning and in some cases providing GP out-of-hours services is clearly a huge undertaking for PCTs, many of which are still relatively new organisations simultaneously grappling with numerous other changes in the NHS. We chose to undertake this brief inquiry to investigate how ready PCTs are for this new responsibility; whether opportunities to improve services are being exploited fully; and

6 Ev 58

7 Ev 1

8 Q61

9 Q7; Q147

whether risks to the delivery of a high quality GP out-of-hours service are being properly managed.

9. We launched this inquiry on 11 May 2004 with the following terms of reference:

The Committee will undertake a short inquiry into the potential impact of the GP contract on the provision of out-of-hours services. In particular, this will include consideration of:

- *The general readiness of PCTs to undertake their responsibilities with regard to out-of-hours services*
- *The role of GP co-operatives*
- *The role of NHS Direct*
- *The potential impact on other NHS services*
- *Potential financial implications*
- *Potential implications for quality of out-of-hours services*
- *Skill mix within out-of-hours services*
- *Arrangements for monitoring out-of-hours services*
- *Implications for urban and rural populations.*

10. During the course of this inquiry, we took oral evidence from: the Rt Hon John Hutton MP, Minister of State for Health, with officials from the Department of Health (the Department); the BMA; the NHS Alliance; the Royal College of General Practitioners; the NAGPC; the British Association for Emergency Medicine (BAEM); Primecare, a commercial out-of-hours provider; NHS Direct; West Hull PCT; and East Anglian Ambulance NHS Trust. In addition to our oral evidence, we also received over 30 written memoranda from NHS agencies, PCTs, ambulance trusts, patient groups, Royal Colleges, charities, medical advisory bodies, GP co-operatives, private GP out-of-hours service providers and individuals. We are extremely grateful to all those who supplied evidence to our inquiry. We are also particularly indebted to the NHS Alliance who at very short notice undertook a snapshot survey of their members' views on this issue. This is published in an anonymised version in Volume II. Before taking oral evidence we had a discussion about out-of-hours services with representatives from BMA Scotland, which proved a very informative introduction to the subject for us.

2 Are PCTs ready to take on responsibility for GP out-of-hours services?

11. According to the BMA, as many as 90% of GPs are expected to opt out of providing out-of-hours cover.¹⁰ As PCTs take over responsibility for providing GP out-of-hours

services, they have a number of options. These include: contracting with existing providers; inviting tenders from a range of providers, including commercial organisations; and seeking to arrange provision themselves, sometimes incorporating co-operatives into the PCT organisation. In some cases, PCTs are putting in place arrangements for the short term, pending further development of a wider model of unscheduled care provision.

12. The NHS Confederation is an independent membership body which is made up of the full range of NHS management across the UK. They also led the negotiations with the BMA for the new GMS contract on behalf of the UK Health Departments. In their written evidence, the NHS Confederation maintained that the “necessary structures and the support are available”, and was confident that “all primary care organisations in England, Scotland, Wales and Northern Ireland will secure a safe and effective service by the deadline of 1 January 2005”.¹¹ According to the Department’s figures, many PCTs have already taken on responsibility for GP out-of-hours services in advance of the 31 December opt-out. Approximately 10% of PCTs took over responsibility for out-of-hours services during April and May, 70% plan to do so between June and October, and the remaining 20% will do so in November and December. The Department argued that local health communities have been working on the development of out-of-hours services since the publication of the Carson Report in October 2000. The Department has also provided support for out-of-hours provision through a team of 14 regional co-ordinators who have detailed knowledge of the out-of-hours field, and who have been seconded to the Department from the NHS to provide support to PCTs and organised providers in the implementation of the recommendations of the Carson Report. The Department issued detailed guidance for PCTs in October 2003. It has also subsequently provided Strategic Health Authorities (SHAs) and PCTs with criteria which can be used for self-assessment of the readiness of PCTs and the robustness and sustainability of their plans.¹²

13. The Department met those SHAs and PCTs where the opt-out was planned for April or May, and the discussions, in the Department’s view, revealed a good state of preparedness, as well as highlighting a number of issues relating to readiness which have informed subsequent support to PCTs. The Department is now working with the 14 regional co-ordinators, SHAs and the Department’s Recovery and Support Unit to identify areas of concern and, where necessary, put in place appropriate actions to ensure an effective transition of responsibility.¹³

14. A sample of views from a survey of its members carried out by the NHS Alliance, which is a representational organisation for primary care and PCTs, provides a helpful snapshot of the mixed position in different parts of the country. Below are the views of a range of different members:

There’s the makings of some sensible changes, but there is still great risk and the PCTs do not seem to be aware quite how fragile the situation still is.

11 Appendix 18

12 Ev 60-61

13 Ev 60-61

I believe out of order there is the potential to produce chaos ... The local acute trust has severe financial pressures that have impacted on the PCTs and I feel that they are looking to save money on out-of-hours services. I do not think they realise what a big risk area out-of-hours services is if it goes wrong.

We have been extremely lucky in that we had a functioning GP co-operative in situ. This had been doing 7-11pm weekdays and weekends after 12.00 Saturdays for about seven years. It took over the overnight sessions in January 2002 and all out-of-hours including Saturday mornings in April 2004. We now cover the entire PCT population with calls triaged through NHS Direct and operate out of refurbished accommodation which we share with the Minor Injuries Unit, a nurse practitioner led service, at our local acute hospital. (The PCT used part of its 3 star bonus on this work.) We have been designated an Exemplar site. Plans are well advanced to further integrate the service with the District Nursing team and to enhance the service with the use of Nurse Practitioners and Emergency Care Practitioners. All the practices are enthusiastic about the levels of service which the co-operative provides, as are the patients, and there is a large pool of GPs willing to work the required number of shifts. Registrar out-of-hours training is incorporated into the process and supervised by the GP trainers on the rota. There is a real feeling of teamwork across the district.

Lots of niggles but I think they are gradually being ironed out and I am confident that on June 1st the PCT will be providing an out-of-hours service that is comparable to our well respected local co-op.

We are looking at a mutual organisation arising out of the present co-op. [We have a] ... small population of 400,000 so exploring risk sharing with [another locality] to give over 1,000,000 ... Task group making progress. Hoping to be sorted and responsibility transferred by October.

Progressing steadily. Hope to outsource rather than be run by the PCT. Local GP co-op bidding and probably the favourite. Aim will be to have more triage than currently. Hope to better integrate with district nurses and other teams in order to provide a more joined up service and have less attending Accident and Emergency (a big problem in our local area). There has been some piloting of nurse triage at the co-op already. In middle distance will need to work better with ambulance trust ... Hope to go live by 1st Oct or at latest 31st Oct.¹⁴

15. We received oral evidence from officials from two different localities, West Hull and East Anglia, both of which appeared to be well advanced in developing innovative solutions to providing GP out-of-hours services for their local populations. While we were

impressed with the work being done in these two areas, other evidence we have received does not give us confidence that the picture of PCT preparedness is uniform across the country. The NHS Confederation argued that “PCT readiness is not consistent across England”,¹⁵ and the RCGP supported this view, describing PCTs as “extremely variable” and expressing serious doubts about the readiness of PCTs to take on the provision of GP out-of-hours services:

From recent experience, most PCTs display a lack of understanding of out-of-hours services issues and, in general, are not in readiness for this responsibility. In particular, PCTs lack understanding of GP out-of-hours issues ... PCTs are also seen as reactive rather than proactive organisations thus far, that underestimate risks, true costs and practicalities of the out-of-hours issue. They also generally fail to have an appreciation of the good work done by GPs up to now.¹⁶

16. They also argued that few PCTs were working positively with GP co-operatives, often instead being adversarial and generating conflict.¹⁷ The RCGP went on to raise doubts about the quality of senior leadership within many PCTs, and suggested that “currently many junior managers and inexperienced Directors within PCTs are left to lead on this critical issue”.¹⁸ The BMA supported this argument, claiming that “some PCTs have delegated out-of-hours issues to managers who do not have the authority to make decisions, resulting in a disengagement of stakeholders, including local GPs”.¹⁹

17. This point was expanded upon in oral evidence by Dr Mark Reynolds for the NAGPC:

There have been people in the PCTs taking this job on with no experience really, thinking it is all going to be fine and reporting up the line that everything is fine; whereas in the other universe there are people doing the hard-edge of the provision, knocking up against financial constraints and misunderstandings and not confident in many areas that everything is fine.²⁰

18. When we asked the Minister whether he felt sufficient high-level management time was being invested by PCTs in GP out-of-hours services he told us that in his view “chief executives at PCT level” were “putting a huge amount of effort into this”.²¹

19. As well as developing a sound understanding of the realities of delivering GP out-of-hours services and investing this issue with sufficient priority, it is clearly also vital that PCTs are able to look at the bigger picture of service delivery across their areas. East Anglian Ambulance NHS Trust described how its six PCTs have worked together collaboratively in commissioning out-of-hours services. This has allowed economies of scale and co-terminosity with other health and social care providers, and eradicated many

15 Appendix 18

16 Ev 7

17 Ev 7

18 Ev 7

19 Ev 4

20 Q11

21 Q134

areas of duplication across PCT boundaries.²² However, both the BMA and the RCGP suggested that this has not happened in every locality, arguing that rather than delivering a cohesive approach to delivery of care for a whole city or area, many PCTs tend to act as single units, working in a diverse way.²³ This has meant, according to the BMA, that “some out-of-hours services have had to deal with multiple PCTs with inconsistent approaches”.²⁴ For the RCGP, this problem is underpinned by a lack of strategic capacity within SHAs, who in their view are not working proactively enough with PCTs to deliver whole area approaches.²⁵

20. Finally, the RCGP made the point that generally there has been little patient or user involvement in PCT discussions over out-of-hours services and, where it exists, it is often reactive.²⁶ Dr Mark McCartney, a Cornwall GP, also expressed his surprise at the lack of public consultation about the changes to the out-of-hours service brought about in the new GP contract.²⁷ We were very pleased to hear evidence from East Anglian Ambulance NHS Trust suggesting that they had taken steps to involve their local population, both through consultation with the local Patient Forum, and, more broadly, through the local Overview and Scrutiny Committee.²⁸

21. Our evidence suggests that while PCTs across the country are in varying states of readiness for taking on responsibility for providing GP out-of-hours services, forward planning is taking place and support systems are available. However, we were concerned at reports that this critical transition was in some circumstances being managed at too junior a level within PCTs, and also that some PCTs were failing to think about more integrated approaches within their wider local health economies. We urge the Department to consider these concerns raised in our evidence in their support and management of PCTs, and also to encourage, where possible, a greater degree of public consultation and involvement around the redesigning of GP out-of-hours services, as our evidence suggests that this has so far been largely lacking.

3 Opportunities

22. Although there were differences of opinion on many issues relating to GP out-of-hours services, our witnesses gave a clear and unanimous message that the handover of responsibility for GP out-of-hours services from GPs to PCTs represented an excellent opportunity to redesign out-of-hours provision for the better, designing services around patients and developing a new model of primary out-of-hours care that dovetailed with the wider economy of unscheduled care provision, including A&E departments, ambulance services, GP emergency clinics, Walk-In Centres, NHS Direct, and local authority social services provision.

22 Ev 42

23 Ev 7

24 Ev 4

25 Ev 7

26 Ev 7

27 Appendix 7

28 Q108

Skill mix

23. All of our evidence emphasised the crucial importance of skill mix in delivering high quality and cost-effective out-of-hours services. Use of ‘skill mix’ can involve both deploying different healthcare professionals, including nurses and paramedics, in delivering out-of-hours services, as well as retraining healthcare professionals for specific new professional roles, for example Emergency Care Practitioners. The NHS Confederation was clear that “the only way in which out-of-hours services can be re-provided effectively is by maximising the skills of the wider health team”. This, they argued, “involves engaging the full range of organisations involved in emergency care, with the emphasis on ensuring that patients see the most appropriate healthcare professional for their condition. Therefore, emergency care practitioners, paramedics, mental health professionals, nurses and others will have a vital role in an integrated out-of-hours service”. They went on to stress that workforce planning must focus, as a matter of urgency, on the training of first contact clinicians from a range of backgrounds, and that early investment must be made in this training.²⁹

24. In its written evidence, the Department highlighted several areas where innovative use of different skill mix was already being made:

- In Nottingham, the GP co-operative in collaboration with the local NHS Walk-in Centre has been developing the range of skills of nurses who now operate in an integrated clinical team in the out-of-hours primary care centre, offering high quality and appropriate clinical care and reducing the dependence on, and supporting, out-of-hours GPs.
- There is evidence from the Tees and Darlington PCT consortium of the benefits of skill mix, including positive feedback from the acute sector regarding the quality and the appropriateness of the referrals to the acute services from out-of-hours practitioners. A skill mix approach working collaboratively across this region should provide a quality responsive service for patients.
- In Exeter there is a round-the-clock nursing service which has been in operation for approximately one year. This is highly valued and works well together with the out-of-hours service. In Cornwall the out-of-hours mental health team are integrated and co-located with the out-of-hours provider which means that mental health patients calling the out-of-hours provider also have direct access to the appropriate professional.³⁰

25. The BMA agreed that skill mix was already being used in a number of creative ways. It gave the example of Derbyshire, where nurse practitioners based at local community hospitals are used in a triage role for out-of-hours care, with GPs available to see patients when required.³¹ This service operates in tandem with local paramedic services, and some local ambulance units are also located at the community hospitals.³²

29 Appendix 18

30 Ev 62-63

31 Triage is a system of classifying patients according to their clinical need to determine the most appropriate type and place of care.

32 Ev 2

26. East Anglian Ambulance NHS Trust has integrated a paramedic within its out-of-hours service for 18 months and reported “huge success” in this. It is also one of only a few national pilot sites training paramedics and nurses to become Emergency Care Practitioners. The intensive five-month training course that they undertake aims to develop in individuals the requisite skills in primary care, out-of-hours provision and single person ambulance response, and gives them extended knowledge of patient examination and assessment techniques. Once trained, they can also provide medication for patients using patient group directives.³³

27. The use of people from a wider variety of clinical backgrounds to provide out-of-hours care is important not merely to ensure that patients have access to the most appropriate health professional for their needs, whether this is a doctor, mental health nurse or social worker. The different use of skill mix also underscores the financial calculations upon which planning for GP out-of-hours services has been made. The NHS Confederation’s memorandum explains how cost calculations have been made in formulating the new arrangements:

The financial model of the out-of-hours change assumes that there are currently too many GPs providing out-of-hours and this is not cost efficient to the NHS ... the model assumes that the labour cost of the GP will double but that only half the number will be needed.³⁴

28. The anonymous survey of its members carried out by the NHS Alliance revealed similarly creative uses of different skill mix across the country:

*The new model of out-of-hours care makes much more extensive use of other healthcare professionals, particularly Minor Injury Unit nurses, Walk In Centre nurses and district nurses. We are also piloting paramedic involvement but without a definite commitment to use them as part of the service at this stage. These measures will reduce the numbers of GPs required to work out-of-hours thereby reducing the cost for the PCTs and the demands on GPs. Not all PCTs will have the full complement of nurses in place and trained by October.*³⁵

Different models of service provision

29. We have received evidence of a number of different, innovative models of service provision. We were impressed by the positive experiences in areas such as West Hull and East Anglia where GP out-of-hours services have been successfully integrated with ambulance services. We also took evidence from Primecare, England’s largest commercial provider of GP out-of-hours services, who were keen to adapt and respond to local needs.

30. The evidence we received from organisations developing new services demonstrated the crucial importance of building on existing local expertise by working collaboratively

33 Ev 41

34 Appendix 18

35 Appendix 22

with existing GP out-of-hours providers, with an example of this being provided by East Anglian Ambulance NHS Trust:

Within Norfolk, all six GP co-operatives collectively agreed to dissolve and worked with East Anglian Ambulance NHS Trust to amalgamate the current systems into the newly formed service called Anglian Medical Care. The service proposal that was put forward to the six PCTs was supported by all six GP co-operatives, the acute trusts and the Local Medical Committee. Each of the GP co-operatives was involved from the beginning and had input in the planning and the submission of the proposal.³⁶

31. However, this level of co-operation with existing GP out-of-hours services again does not seem to be uniform across the country. The evidence given by East Anglian Ambulance NHS Trust contrasts starkly with the reports made by North Yorkshire Emergency Doctors, a GP co-operative, who stated that two of the PCTs whose area they currently cover initially selected the local ambulance service as their preferred out-of-hours provider without even consulting them.³⁷

32. We are impressed with the potential of some models of GP out-of-hours service provision, including integration with ambulance services and creative use of skill mix. However, some of the models we have seen seem to be predicated on well developed collaborative working relationships with successful existing local out-of-hours service providers, and we urge the Department to encourage such collaborative working wherever possible.

33. In future, it is planned that NHS Direct will play an increasingly important role in the delivery of GP out-of-hours services. NHS Direct was first established as a stand-alone helpline, with calls to NHS Direct being answered by call-handlers who receive two weeks induction training, but are not clinically qualified. Calls are then returned by NHS Direct nurses who will give patients advice, which may include their administering self-treatment, making an appointment to see their GP, calling their GP out-of-hours service, going to their local A&E department, or, in emergencies, calling an ambulance.

34. The Carson report set out a central role for NHS Direct in the implementation of an integrated model of out-of-hours care. Under this model, patients accessing out-of-hours primary care would be transferred through a single telephone call to an assessment of clinical need conducted by NHS Direct. The patient or carer would either be given health information or advice on self-care or, where necessary, be referred to the point in the local network of out-of-hours care best able to meet that patient's needs.

35. The NHS Plan was published mid-way through the Carson review, and was informed by that report's preliminary findings. It included the aim that "by 2004 a single phone call to NHS Direct will be a one-stop gateway to out-of-hours healthcare, passing on calls, where necessary, to the appropriate GP co-operative or deputising service".³⁸ This aim was affirmed in the *Priorities and Planning Framework 2003/06, Improvement, expansion and*

36 Ev 42

37 Appendix 9

38 *The NHS Plan*, Department of Health, 2000; paragraph 12.4

reform: the next three years. Ed Lester, the Chief Executive of NHS Direct, explained to us that NHS Direct was currently able to provide two distinct ‘products’—call handling, and nurse triage. The key service models for NHS Direct are:

- Full clinical integration: calls are diverted from GP surgeries during out-of-hours to NHS Direct—providing single call access—where callers are assessed, given advice or information by NHS Direct and/or referred on as appropriate.
- Call handling only: calls are diverted from GP surgeries out-of-hours to NHS Direct—still providing single call access. Life-threatening emergencies are passed onto 999 and all other calls passed onto the out-of-hours provider. This may be particularly useful as an interim service until full clinical integration is achieved.
- Full clinical integration where staff are co-located with out-of-hours providers: this model is based on the full clinical integration model outlined above with the addition of nurses being co-located with out-of-hours providers. This is likely to be more expensive, although PCTs may be prepared to pay a premium to support this level of close working. In this model, nurses could be employed to carry out a dual role, providing telephone triage and face-to-face care.
- Nurse assessment only: in this model calls would be handled, and in the future possibly streamed, by an out-of-hours provider and only those calls that could benefit from nurse assessment would be passed onto NHS Direct. The out-of-hours provider would need to use the NHS Direct software to support call transfer, audit and support seamless single call access.³⁹

36. By December 2006, NHS Direct aim to be able to provide a clinically integrated out-of-hours service to 100% of the population, although local needs and choices will dictate which type of service is provided. The Department and NHS Direct confirmed in their memoranda that by December 2004 technical links will be in place to enable NHS Direct to transfer calls, where appropriate, to local GP out-of-hours services.⁴⁰ NHS Direct is currently working with the Department and SHAs to identify those areas that might benefit most from clinical integration with NHS Direct, to achieve early PCT-funded integration with the service by April 2005. NHS Direct will be able, if required, to take on the full role of accepting all calls to GP out-of-hours services by the end of 2006.

Quality

37. In its memorandum the Department pointed out that national quality standards for out-of-hours services now exist, and will apply to all providers of GP out-of-hours services:

The national quality standards are currently being reviewed to ensure that they take account of the changing realities of service provision, where a wider variety of organisations and health professionals will provide the service. Although the new standards will have a sharper focus on clinical outcomes and the audit of patient satisfaction, they will closely follow the existing standards for access and clinical

39 <http://www.dh.gov.uk/assetRoot/04/07/50/42/04075042.pdf>

40 Ev 62; Ev 45

assessment. These set out the maximum duration for episodes of care, including the maximum permissible times patients should wait for a telephone or face-to-face consultation.

The new standards will come into effect on 1 January 2005, and from this date all providers of out-of-hours services (including GP practices who choose not to opt out) will have to meet the quality standards as a contractual obligation.

The revised quality standards will include requirements that patients must be able to see a GP out-of-hours where necessary. Work is under way to frame a suitable standard through a small project team that consults with an expert reference group. The aim is to have a standard which requires PCTs to make arrangements for appropriate levels of GP cover, but without being prescriptive about what that level should be.⁴¹

38. The Department stated that it had made it clear to PCTs that they should have in place a contingency plan which could be put into immediate operation should an out-of-hours provider fail. They also argue that the greater role for PCTs in commissioning out-of-hours services should provide new opportunities to improve arrangements for the supply of medicines out of hours. The Carson Review recommended that, other than in exceptional circumstances, patients should be able to receive the medication they needed at the same time and in the same place as the out-of-hours consultation. A guide for PCTs and providers is in preparation and will be issued in Summer 2004, setting out approaches for PCTs to achieve this recommendation. The guide will include a new national formulary, which identifies those medicines which should be available to meet patients' urgent medical needs during the out-of-hours period.

39. The NHS Confederation suggested that the quality of the existing system was "variable", and pointed out that under the new system all providers, including those who continued to provide their own out-of-hours services, would be expected to meet the national standards.⁴²

40. We look forward to the publication of the guide for PCTs and providers to be issued in Summer 2004, and recommend that it makes mandatory scope for the provision of medication, where necessary, at the same time and place as out-of-hours consultation.

41 Ev 63

42 Appendix 18

4 Risks

41. Despite our witnesses' unanimous view that the handover of responsibility for GP out-of-hours services from individual GPs to PCTs represented a golden opportunity radically to improve services for patients, much of our evidence warned of numerous risks attached to the handover process which, if not properly managed, could destabilise the provision of GP out-of-hours services and also risk the loss of that crucial opportunity for improvement.

GP involvement

42. Currently, although individual GPs have the responsibility for providing out-of-hours care for their patients, in practice 70% of this is delivered by GP co-operatives.⁴³ As the term GP co-operative suggests, these not-for-profit organisations are funded and staffed by individual GPs and by GP practices in order to achieve economies of scale and relieve pressure on individual GPs. In their written evidence, the NHS Confederation painted an uncertain picture of the viability of traditional GP co-operatives in the future:

We see an important role for traditional co-operatives in the short term. In the longer term, the expansion of the primary and community sectors, the development of a multi-skilled workforce, the potential entry of new commercial providers and the opportunities for PCTs to provide services directly will result in traditional co-operatives having a diminishing hold on the market.⁴⁴

43. However, even with more effective use of skill mix it is clear that GPs will continue to play a crucial role in the delivery of GP out-of-hours services. Graham Rich, Chief Executive of West Hull PCT, estimated that in the long term at least 40% of the out-of-hours workforce would be doctors.⁴⁵ Until a stable state of skill mix has been established, even more reliance will be placed on GPs, and because of the long lead-in time for training new professionals and developing new services, in some areas the NHS is likely to remain dependent on the services of GP co-operatives.

44. Based on information gathered from SHAs, the Department has estimated that at least 50% of future provision will be delivered by the existing GP co-operatives.⁴⁶ But the NAGPC has delivered a stark and consistent warning, echoed in much of the evidence from local providers, that PCTs cannot and should not assume that GP co-operatives will continue to exist to provide services. Dr Mark Reynolds, in oral evidence to us, argued that:

The 24-hour responsibility has been the glue that has held those organisations together: one GP working on behalf of another. With the transfer of the

43 Ev 58

44 Appendix 18

45 Q127

46 Ev 61

responsibility to the PCTs, that glue has been removed and it essentially becomes voluntary whether GPs choose to take a turn in the out-of-hours' rota or not.⁴⁷

45. Initial soundings from the NAGPC suggested that 70% of GPs who currently provide out-of-hours services through GP co-operatives have indicated that they are willing to continue to work for their membership-based organization.⁴⁸ In the view of Dr John Chisholm, Chairman of the BMA's General Practitioners Committee, this was a rather optimistic estimate. He felt that soon only 40–50% of GPs would be willing to provide out-of-hours care through GP co-operatives.⁴⁹ Dr Reynolds went on to point out that in the long term, no level of commitment could be guaranteed:

No one can really tell how this will pan out a year into the contract, when actually GPs may decide in fact, "I don't want to earn £150 for working tonight, I would rather do some more insurance supports or fine-tune the practice to earn that money during the day".⁵⁰

46. These worries appear to exist at ground level as well. Dr Mark McCartney, a Cornwall GP, gave a pessimistic view, arguing that many co-operatives had already folded. While the remainder of GP co-operatives planned to evolve into new structures, Dr McCartney expressed "grave concerns about the financial viability of these new structures, particularly as they rely to a large extent on the goodwill of some GPs to continue working out-of-hours". He pointed out that where GP co-operatives did fold, this would mean "losing the experience and infrastructure that has evolved over the years".⁵¹

47. The survey of its members carried out by the NHS Alliance revealed a similar picture:

The main issue is likely to be availability of practitioners.

We know we will lose some GP workforce in October but hope that using Nurse Practitioners (as we already do) will enable us to sustain a service. However, a continuing service depends on the existing GP workforce (we know of no other large source of Primary Care trained doctors) and their continuance depends on working conditions (they aren't going to work out of hours if the conditions are onerous, most of them don't need the money) reasonable rates of pay (they already have fairly well paid day jobs) and continued goodwill and a sense of belonging and responsibility to the organisation and the population. The risks are that there will be a gradual and continued reduction in the number of GPs prepared to work for an out-of-hours service (that I feel is certain, it is the rate of loss that is uncertain) and that in order to maintain a workforce we will have to provide rates of pay that we cannot afford. In addition the European Working Time Directive will impact as, although at the moment medical staff can opt to work longer hours, we understand that there will be a

47 Q8

48 Q8

49 Q68

50 Q8

51 Appendix 7

duty on organisations not to knowingly employ staff who will be exceeding the working time directive by working for you.

Doctors are ... worried that as pay rates go up, the co-ops will try to compensate for this by increasing workloads to the extent that doing sessions becomes increasingly unpalatable ... The PCTs still seem to feel that they can run the out-of-hours services on the amount that was spent on out-of-hours previously—I think this is very unlikely. Also, until rates of pay are known, it is impossible to know whether or not GPs will sign up to do sessions— and unless rates of pay rise significantly, my informal soundings from colleagues suggests that many of them will not.

As the fruits of the new contract are delivered I have doubts about the number of GPs willing to work out of hours ... and this is in an area well served by GPs in the past.

48. The view on continued GP involvement in GP out-of-hours services is not uniformly negative. Although West Hull PCT reported “some concern” that in areas served solely by GP co-operatives, GPs may be less willing to undertake out-of-hours work when they no longer have the personal responsibility for the service, they told us that in their locality they had “not yet seen any threat of GPs not wanting to work for the service—in fact, it is increasing rather than decreasing”.⁵²

49. In the Minister’s view, there was unlikely to be an “exodus” of GPs working in out-of-hours services. In direct contrast to the BMA’s projection, Mr Hutton argued: “The evidence we are getting is that, although clearly GPs want to exercise—and most of them will—their right to opt out of out-of-hours services, large numbers of GPs will continue to want to provide out-of-hours services themselves, either on shifts or through their co-ops or whatever.” However, he conceded that “the issue about what happens if GPs suddenly decide that they do not want to provide out-of-hours services is a difficult question to deal with”. The Department has advised PCTs to ensure that they have three months’ worth of GP cover in place in any one period of time, so that if an “exodus” does occur they can manage that sensibly.⁵³

50. East Anglian Ambulance NHS Trust warned us that there could be a problem as the availability of the GP workforce remained “a significant unknown”.⁵⁴ They went on to argue that there were potential implications for the quality of the service if the local GP workforce chose to exploit their opt-out rights:

Alternative health professionals are required to maintain a service and there are insufficient trained personnel available to replace the GPs or change the skill mix to the levels required. Although the new service has plans to train and develop these

52 Ev 49; Q125

53 Q147

54 Press reports of overseas doctors being flown in to provide out-of-hours shifts in Norfolk have indicated some of the potential problems here. See *Times*, 6 July 2004. Such a practice is not uncommon.

new skills, it will take time and resources. If the quality of the out-of-hours service is poor, the impact could be huge.⁵⁵

51. According to the NAGPC, the next few months would be a critical time in determining how many GPs would continue to provide out-of-hours services:

There is also a highly uncertain few months ahead where, essentially, voluntary bodies and voluntary management teams are struggling to produce a service specification that matches the PCTs' financial constraints and to begin to think about inter-linkages with other services ... if they are not given the green light and an open door in localities, [GP co-operatives] have a choice to say, "It's not worth the hassle any more, we are going to pack up and go home".⁵⁶

52. Dr Reynolds ended on a more hopeful note, suggesting that "in the last month or two the culture on the PCT side has changed somewhat and the understanding of the difficulties of providing an out-of-hours service has increased". However, his evidence underlines the uncertainty PCTs face in this area, and the importance of PCTs working with GPs in the crucial months ahead to ensure they remain committed to providing GP out-of-hours services.

53. In our view, existing GPs, including those who work in co-operatives, will continue to form the backbone of future provision of out-of-hours services. They are also the NHS's main source of expertise in this complex area, and yet the availability of the GP workforce for out-of-hours cover still remains uncertain. It is therefore vital that they do not become disengaged from the process of redesigning GP out-of-hours services during this critical transition phase, and their expertise and local knowledge lost. We recommend that the Government should take all reasonable steps to encourage PCTs to work collaboratively with GPs, including those in co-operatives, and to encourage PCTs to provide the flexibility and support, as well as the financial incentives, necessary to retain a motivated GP workforce.

Skill mix

54. Imaginative use of skill mix in providing GP out-of-hours services should, in theory, reduce the cost of delivering GP out-of-hours services, as well as decreasing dependence on the GP workforce. However, it is clear from the evidence we have received that making use of a wider skill mix in out-of-hours services will not provide an overnight panacea. Although nurses and paramedics may have generic skills which can be transferred to delivering out-of-hours advice and care, this type of work requires a distinct set of skills, and the new workforce will have to be trained.

55. In their written evidence, the NHS Confederation argued that PCTs' renewing contracts with existing GP co-operatives was "clinically unnecessary, may be financially unviable and goes against the grain of systems integration".⁵⁷ However, Dr Reynolds, for the NAGPC, argued that this view was based on the uncertain assumption that other

55 Ev 43

56 Q18

57 Appendix 18

professionals working in the out-of-hours environment might be cheaper. Dr Reynolds disputed this, suggesting that “generally speaking other professionals work more slowly and you have to have more of them to replace the single general practitioner”.⁵⁸ This view was supported by other evidence: North Yorkshire Emergency Doctors, a GP co-operative, calculated that to replace their existing part-time GP workforce, they would need 70–75 nurse practitioners working a 37.5 hour week. However, there were only 12 nurses currently undergoing nurse practitioner training in their area, and even these were not specifically training in out-of-hours practice.⁵⁹

56. The RCGP questioned “whether an adequate workforce to provide effective skill-mix for out-of-hours cover can be found”.⁶⁰ Even East Anglian Ambulance NHS Trust, which appeared to be well advanced in terms of training and making use of skill mix in out-of-hours services, reported that “as a result of the extremely short lead-in time for this new service, there are a very limited number of trained alternative health professionals to integrate into the new out-of-hours service to reduce the burden on GPs, and fewer still anxious to work solely at night and weekends”.⁶¹ East Anglian Ambulance NHS Trust estimated it would take 3–4 years to train an adequate alternative workforce, although West Hull PCT felt this could be achieved in a shorter timeframe.⁶²

57. Members of the NHS Alliance expressed similar concerns about the lead-in time for new professionals:

[The] vast majority of GPs [are] opting out but do not want to provide services in the new era ... Sessional fees for GPs will not be raised sufficiently in the service specification to attract/retain a GP workforce in the interim before a multi-professional workforce can be developed ... Significant capacity issues in GP workforce to maintain/deliver out-of-hours in the new system.

58. In addition to concerns about capacity, the BMA sounded a further note of caution about the quality of care that could be provided by a different out-of-hours workforce. They warned that: “A greater use of skill mix in the out-of-hours period may generate inappropriate demand during regular surgery hours if skill mix is solely viewed as a cost cutting mechanism.”⁶³ The NAGPC agreed with this:

There is a regrettable tendency to regard doctors, nurses and paramedics as equivalent practitioners and this is hazardous since it may result in unrealistic and dangerous expectations of staff whose training and experience does not equip them for the responsibilities placed upon them. It takes a minimum of nine years of training before GPs are deemed capable of independent practice. This cannot be easily replaced by a 12-week course in emergency care.⁶⁴

58 Q 29

59 Appendix 19

60 Ev 7

61 Ev 41

62 Qq 129–130

63 Ev 2

64 Ev 13

59. The RCGP argued in oral evidence to us that there was “a general underestimate of the complexity of what goes on in an out-of-hours consultation”, and that these consultations in fact involve a “huge amount” of safety and risk management work. They stressed that the danger of using less skilled people was that this would result in more onward referral: “If you do substitute with the less experienced/less trained people, you are inevitably going to have less ability to absorb risk, uncertainty, and a more rapid default to, ‘You had better go to hospital’.”⁶⁵

60. Liverdoc, a GP co-operative based in Liverpool, stated that they used doctors rather than nurses to triage patients, and argued that there was “substantial evidence that triage by the most experienced clinician available is the most efficient use of resources”, and that it was a “false economy to use less experienced clinicians to triage, as they require more support and take much longer to reach decisions, which are less likely to be accurate.”⁶⁶

61. Because of the limited availability of other out-of-hours practitioners, but also because of the need to ensure patient safety and confidence, East Anglian Ambulance NHS Trust has decided that its new service will initially be GP dominant. This will be reduced over a period of about three years, once other health professionals are trained, developed and integrated, but the Trust were clear that the service would always still have GPs present to ensure safety and professional support to other healthcare professionals.⁶⁷

62. We strongly support the better use of skill mix to deliver out-of-hours care, not only for its potential to relieve pressure on GPs and deliver cost savings, but also, more importantly, for its potential to deliver a better quality of service to patients. However, out-of-hours care is a complex service to provide, and health professionals other than doctors will need appropriate training if they are to deliver it to a high standard. Our evidence suggests that those working in the NHS are well aware of the difficulties attendant upon recruiting and training this new workforce, and we urge the Government to ensure that PCT forward planning allows sufficient time for this to take place, and takes account of the view that triage by the most experienced clinician available, who may or may not be a doctor, is the most effective use of resources.

NHS Direct

63. While the potential for NHS Direct to form an integral part of the jigsaw of out-of-hours care provision is clear, and the NHS Confederation noted the clear advantages of a single telephone contact point for all out-of-hours medical advice and care, a number of reservations have been voiced in evidence to us both about the capacity of NHS Direct to deliver this, and about the quality of the service they will be able to provide.

64. Turning first to the issue of capacity, the NHS Confederation reported that “NHS Direct currently has capacity problems and it is unclear when key milestones will be delivered”.⁶⁸ The RCGP and the BMA supported this view, both expressing considerable

65 Q10

66 Appendix 10

67 Ev 41

68 Appendix 18

doubt about the ability of NHS Direct to cope with call volumes.⁶⁹ NHS Direct currently handles 550,000 calls a month, or 6.6 million calls a year. However, Professor David Haslam of the RCGP put this into context in oral evidence to us:

As far as I know NHS Direct currently deals with six million calls a year, which is very impressive. British general practice deals with one million calls a day.⁷⁰

65. This lack of capacity was reinforced by the written evidence we received from West Hull PCT:

The model of NHS Direct is clearly central to the concept of an integrated system of providers which patients can access through a single call. However, there have been concerns about the slow roll out of NHS Direct and concerns over the capacity of local branches to absorb the full range of out-of-hours calls, as opposed to solely the 0845 calls which are currently handled.⁷¹

66. East Anglian Ambulance NHS Trust expressed similar difficulties, stating that they had been unable to integrate services with NHS Direct due to insufficient capacity and growth within NHS Direct. According to the Trust, this had been “incredibly frustrating for all parties concerned as much willingness has been shown locally by NHS Direct but they have inadequate capacity to take on this busy additional service”.⁷²

67. The NHS Confederation suggested that the service offered by NHS Direct was “perceived to be expensive compared with alternatives”.⁷³ As a consequence of this, they argued, many PCTs were not taking account of NHS Direct in their re-provision plans. East Anglian Ambulance NHS Trust also pointed out that, because it is not up to capacity at this crucial time of changeover, NHS Direct may have missed an important window of opportunity:

The role of NHS Direct is clearly defined within the guidance as an integrated holistic service but will clearly not be up to capacity until 2006. By this time a high quality alternative solution will have to be in place and this is unlikely to be dismantled if performing well with good levels of user satisfaction.⁷⁴

68. Capacity problems can also impact upon quality. Liverdoc expressed a significant lack of confidence in NHS Direct, arguing that:

The service currently appears to have problems in meeting its own targets for response times, and we as an organisation would not wish to use NHS Direct in its

69 Ev 3; Ev 8

70 Q43

71 Ev 49

72 Ev 42

73 Appendix 18

74 Ev 42

current form to front our service, as it would lead to substantially worse outcomes for our target population.⁷⁵

69. NHS Direct told us that it was now taking steps to enable it to provide full clinical integration across the country, if required, by the end of 2006, and was meanwhile working with PCTs and SHAs to provide other solutions in the short term. By the middle of next year, they estimated that the establishment of a “virtual call centre” would enable them to increase their performance for nurses by about 15% and for call handlers by 25%.⁷⁶

70. However, in addition to concerns about capacity, our evidence has also raised the issue of demand management and referral rates. NHS Direct argued that the experience of the Exemplar Programme, where NHS Direct has been fronting all calls to out-of-hours services, had been positive, showing that:

The majority of schemes have been successful in meeting the needs of patients for safe and appropriate care and in delivering a substantial (between 25 and 40%) reduction in workload for the out-of-hours organisations with which NHS Direct has been linked.⁷⁷

71. However, this research does not appear to reflect the perceptions and experiences of others working in the field. Although it is clear that NHS Direct’s telephone advice service is well used and well liked by patients, there is little consensus as to its impact on other parts of the NHS. NHS Direct reported to us that it had “demonstrated its ability to reduce inappropriate demands on other clinical services” and cited a study by the National Audit Office published in 2000 which estimated that approximately half of NHS Direct’s running costs might be offset by savings to other services.⁷⁸

72. However, we received a large amount of anecdotal evidence based on clinicians’ experience of NHS Direct, suggesting that this service might actually be increasing rather than decreasing workload in other parts of the NHS. West Hull PCT argued that:

Whilst there is value in NHS Direct in reducing the number of contacts with clinicians, through the provision of telephone advice, there have been concerns that NHS Direct may be inflating the use of GP/A&E consultation facilities through adopting an over cautious approach to telephone advice, and that some “worried well” callers who would previously have self-cared, may be directed to GPs or A&E through precautionary rather than purely clinical need measures.⁷⁹

73. According to the Royal College of Paediatrics and Child Health, NHS Direct appeared to be referring more children to A&E departments than GPs had in the past. They also described reports of NHS Direct not returning calls, and families therefore taking children to A&E departments.⁸⁰ The RCGP maintained that there was very little evidence that NHS

75 Appendix 10

76 Q85

77 Ev 45

78 Ev 44

79 Ev 49

80 Appendix 17

Direct had changed consultation patterns either in general practice or in A&E departments:

It is an additional service and a very welcome one for people who are worried, but it does not seem to be reducing anything. That is not to denigrate it; it is just that if that is what it was intended to do, it is not doing it.⁸¹

74. These concerns, as articulated by Professor Haslam, do not necessarily detract from the usefulness of NHS Direct as a stand-alone helpline, providing an extra service. However, under the model of full clinical integration with out-of-hours services, such worries could translate into more serious issues in the delivery of out-of-hours care. Introducing a model whereby NHS Direct triage nurses act as a ‘filter’ to other parts of the NHS, including GP out-of-hours services, essentially introduces another barrier into the system. If triage nurses are themselves able successfully to handle a considerable number of calls which would otherwise have been handled by GPs, then this could provide a useful tool in limiting demand on other parts of the NHS. However, Dr Mark Reynolds, for the NAGPC, told us that while approximately 30% of calls to NHS Direct were completed by NHS Direct without further referral to another part of the health service, 70% were referred onwards.⁸² By contrast, Liverdoc, a GP co-operative, stated that their own onward referral rate was about 5%.⁸³

75. The implications of this are twofold. First, patients who are referred on to GP out-of-hours services will have experienced a delay, as the NAGPC argued: “The filter that NHS Direct puts in front of patients ringing for urgent calls out-of-hours only removes 30%, and delays perhaps 70%.”⁸⁴ There may also be further problems if other calls, which might otherwise have been completed by GPs, are instead referred directly to A&E departments, actually increasing demand elsewhere in the service.

76. Dr Reynolds made a useful comparison by stating that experienced, carefully trained nurses working alongside GPs in out-of-hours co-operatives, where they have access to either decision-support software or paper-based protocols, and have immediate recourse to a GP working in the room next to them or at the end of a phone, are able successfully to complete 60% of calls, referring only 40% on to other health services.⁸⁵ This suggests that the problems may not lie *per se* with the idea of nurse-led triage services, but perhaps pertain to the particular systems used by NHS Direct.

77. The NAGPC were not, however, opposed to the idea of integrating NHS Direct with GP out-of-hours services. They proposed an alternative model whereby, instead of NHS Direct nurses handling all calls made to out-of-hours services, initial assessments could be made by local call sorting systems, with calls then referred onwards either to an NHS Direct nurse, or to a GP out-of-hours service as appropriate. The NAGPC also argued for greater clinical freedom for NHS Direct nurses, suggesting that they should perhaps be

81 Q43

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83 Appendix 10

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recruited at a more senior level, and that the software used by NHS Direct should be radically changed to allow it to take more risks, with the proviso of suitable safety netting.⁸⁶

78. We accept the value of a single telephone access point for patients for all out-of-hours services. However, NHS Direct will have substantially to increase its capacity in order to cope with this burden. We remain concerned that full integration of NHS Direct and GP out-of-hours services could introduce unnecessary delay and increase referrals to other parts of the NHS. We recommend that alongside their work to develop capacity, NHS Direct should work collaboratively with others, including GPs, involved in delivering nurse telephone triage services for out-of-hours care to develop and refine their referral protocols to ensure this does not happen.

Impact on other NHS services

79. Our witnesses have repeatedly emphasised the importance of considering GP out-of-hours services as part of a whole network of ‘unscheduled’ or unplanned care. The NAGPC was clear that “demand which is not addressed in the out-of-hours service is likely to present elsewhere, especially to other direct access services such as A&E, Walk-In Centres and 999 services”. It went on to warn that “the numbers are such that a small percentage transfer from GP out-of-hours services to A&E would have a significant impact on A&E flows and therefore waiting times”.⁸⁷ However, according to the RCGP, “PCTs and local health economies are not working as cohesively as they could, with too much time and resource placed on A&E targets in isolation”.⁸⁸

80. The NHS Confederation argued that: “A&E centres are extremely nervous about the impact of the out-of-hours changes on them especially since they will also be meeting their waiting time targets and managing winter pressures.” According to the NHS Confederation, anecdotal evidence already exists to support these fears, suggesting increased attendance at A&E departments, especially on Saturdays when local surgeries are now closed, and ambulance service workloads increasing in areas where out-of-hours changes have already been implemented.⁸⁹ North Yorkshire Emergency Doctors estimated that in their area emergency services could have an additional 25,000 patients every month without an effective out-of-hours service.⁹⁰

81. The British Association of Emergency Medicine (BAEM) expressed similar worries in even stronger terms:

The British Association of Emergency Medicine has grave concerns about GP out-of-hours services. The impact on Emergency Departments could be very serious and may well affect us achieving our four hour target times unless the re-provision of out-of-hours services is handled swiftly. The view from our members across the country is that the provision of GP out-of-hours services is patchy and may be inadequate to cope with the numbers of primary care attenders. Many Departments,

86 Q43

87 Ev 12

88 Ev 8

89 Appendix 18

90 Appendix 9

including the one in which I work at Birmingham Heartlands Hospital, are seeing an increased number of attendances and the worry is that this is due to patients' perceptions that GP out-of-hours does not now occur, and that to obtain urgent healthcare, patients should visit the Emergency Department.⁹¹

82. According to the BAEM, in the last 12 months A&E attendances have increased by 13–15%, and in some hospitals by as much as 25%. Martin Shalley, for the BAEM, put this in the context of very modest rises of 1–2% for the previous three to four years, and concluded that patients were now confused about provision of GP out-of-hours services.⁹² The Department maintained that this was ascribable to the recent inclusion of Walk-In Centre and Minor Injury Unit attendances in these figures.⁹³

83. Mr Shalley pointed out that the out-of-hours period in fact represented two-thirds of the week, and expressed concern that “the default position will be that patients will come to emergency departments”. He went on to contend that increases in A&E attendances were very hard to reverse: “As yet, there has been no initiative, as has been shown, ever to decrease attendances at emergency departments.”⁹⁴ Mr Shalley argued strongly for a media campaign. This could let patients know what was available in terms of out-of-hours medical provision, how it could be accessed, whether through calling an out-of-hours service or attending A&E, and what patients could expect from different types of out-of-hours care provision.⁹⁵

84. In Norfolk, such a campaign is already taking place. East Anglian Ambulance NHS Trust felt that “communications with the public and professionals concerning the new service being offered” was “paramount to its success”.⁹⁶ According to the Trust this has been achieved through a communication strategy managed by a dedicated communications team. The two-phased approach began with a major launch, at the very beginning of the project, involving the issuing of patient leaflets and posters to surgeries, and a second phase in the lead up to implementation. As well as making information available in the expected places, such as surgeries and community hospitals, they also arranged leaflet drops in newspapers, paid for short radio advertisements, and made leaflets available in benefits offices, post offices and libraries.⁹⁷

85. Mr Shalley, along with several other witnesses, argued that categorising patient attendances at A&E as “inappropriate” was not a helpful way forward.⁹⁸ Instead services should be designed to provide seamless access to the most appropriate form of care no matter where a patient accessed services. Innovative examples of this include the co-location of GP services and A&E services, protocols to enable ambulance staff answering

91 Ev 23–24

92 Q17

93 Appendix 21

94 Q17

95 Q26

96 Ev 42

97 Q100

98 Q46

999 calls to take patients, where appropriate, to out-of-hours primary care centres, and the use of triage nurses to deal with less urgent calls that came through on 999.

86. GP out-of-hours services provide only one of many routes for people needing urgent care. Out-of-hours services are part of a larger network of ‘unscheduled’ care providers, which can include emergency ambulances and A&E departments, as well as GP emergency clinics run during the day. If one of these services is withdrawn or changed, or access becomes more difficult, demand for urgent care will simply increase in other parts of the system. It is not surprising, therefore, that A&E departments are anxious that changes in the provision of GP out-of-hours services may impact on already rising attendance rates.

87. We deplore the loss of GP Saturday morning surgeries which will limit access to their GP for many working people, and we recommend that PCTs should provide such clinics in primary care centres or co-located emergency departments.

88. Accessing healthcare outside normal working hours can currently involve negotiating a maze of different services and telephone numbers. We agree that in the long term, services should be designed around patients, taking account of where local patients are most likely to access healthcare. We are encouraged to see this already happening in certain places, through, for example, the co-location of primary care centres and A&E departments. However, we also believe that there is a place for patient information campaigns in order better to equip patients to play an active role in their own healthcare. Clear information should be available to everyone who needs it, setting out what local NHS services are available where, in order to help patients make informed choices on how to access out-of-hours healthcare. We recommend that the Government takes steps to ensure PCTs proactively provide information on NHS services to their local populations on a regular basis, paying particular attention to the need to keep people informed of any changes that may occur as a result of the handover of responsibility for out-of-hours care.

Community hospitals

89. Both the NAGPC and the BMA highlighted the specific issue of the impact of the transfer of responsibility for out-of-hours services upon the provision of care in community hospitals:

There is a particular issue with community hospitals which may rely on GP medical cover and if GP organisations are destabilised, the cover for community hospitals may disappear. This could result in the closure of community hospitals, or their downgrading to an equivalent to nursing homes. This would have a significant impact, especially in rural populations.⁹⁹

90. Although this is separate from their responsibility for GP out-of-hours services for their own patients, according to the BMA, traditionally—and particularly in rural areas—community hospital work has been part of the job of GP practices, and has been something that they have willingly accepted as part of their service to the community, even though for

a variety of historic reasons they have often been paid on quite a lowly-salaried rate. According to the BMA, the initial framework document setting out the parameters for the negotiation of the new GP contract suggested that the scope and responsibility for reviewing the remuneration structures for providing care in community hospitals would be considered by the negotiating parties. However, the BMA stated that to date the Department of Health in England had refused to undertake this work. This, they argued, could lead to significant problems:

The BMA believes it is essential that the negotiating parties urgently seek to agree at national level a national framework for GPs working in community hospitals with local flexibility to respond to the specific needs and circumstances of individual community hospitals. Otherwise, the impact on out-of-hours services will be two-fold. GPs will walk away from providing out-of-hours services in community hospitals if the rewards are not sufficient, given that they no longer will be obliged to provide out-of-hours primary medical services through their GMS or PMS contracts. Indeed, if they choose not to continue to provide out-of-hours services, it is likely they will cease all services to the community hospital as the current rewards are generally very poor, particularly compared to the new earning opportunities in the GMS and PMS contracts. Furthermore, if they do walk away this would seriously affect the opportunities available to PCTs in developing an out-of-hours service strategy, particularly in rural areas. Alternative provision will be more expensive than securing fairer rewards to retain GPs to provide the service.¹⁰⁰

91. The BMA maintained that because practices that serve community hospitals are now going to have the option of transferring their responsibility for out-of-hours general medical services to the local primary care organisation, there are now large numbers of practices that are thinking again about whether they wish to continue community hospital work at such low rates. They cited many reports from across the UK of practices giving notice to the community hospital of their intention to either cease any community hospital work or only provide in-hours community hospital work.¹⁰¹

92. The BMA told us that in Wales, the Government does seem to have got a grip on the urgency of the issue, and discussions are quite well advanced. Although these negotiations are not yet concluded, the BMA was heartened to see at least a willingness for the Government and the NHS Confederation and the Welsh General Practitioners' Committee to be in negotiation. However, in the view of the BMA, in England both the Department of Health and the NHS Confederation have been "disinclined" to engage in national negotiations. According to the BMA, the Department originally suggested that such negotiations could form part of the negotiations about staff and associate specialists. Those negotiations are about to begin, but the BMA expects they will take at least a couple of years to complete, by which time, in their view, "the community hospital problem may have got out of control". As well as the contribution they make to local communities, the BMA pointed out the valuable role community hospitals play in taking pressure off acute

100 Ev 3–4

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hospitals, and warned that unless the situation was resolved “we are going to see in some areas meltdown of the community hospital service”.¹⁰²

93. When we discussed this issue with the Minister he maintained that, although the BMA might have concerns about the rates at which GPs are remunerated for providing medical services to community hospitals, this was an entirely separate issue from out-of-hours provision and was being taken forward by the NHS Confederation.¹⁰³

94. Although providing services to community hospitals is a separate issue from GP out-of-hours services, it certainly seems possible from the evidence that we have heard that the handover of responsibility for GP out-of-hours services from GPs to PCTs will prompt some GPs to re-evaluate and perhaps to withdraw the services they currently provide to community hospitals, as part of their on-call duties. In our view it is regrettable that this vital subset of GPs’ work has not been addressed more swiftly, and we urge the Government to ensure that this is resolved as a matter of urgency to ensure that the extremely valuable service provided by community hospitals is not jeopardised.

Financial pressures

95. In oral evidence to us, the Minister made it clear that he was well aware of the potential impact of underinvestment in GP out-of-hours services on other parts of the health service:

It is a completely false economy for us to be prepared to sit back and see out-of-hours services and primary care not being properly resourced because ... the demand is there and it will show up somewhere in the Service.¹⁰⁴

96. However, another risk identified by many of our witnesses relates to the funding of new GP out-of-hours services. The funding changes surrounding out-of-hours provision were helpfully explained by the BMA in their written evidence:

Much GP out-of-hours work has been completed either at a discounted rate or for a notional charge and, with the use of locums, deputising services and the development of GP co-operatives, as well as private providers, it is impossible to identify the full market cost of the historic provision of this work.

As part of the new GMS contract negotiations the parties negotiated an opt-out cost of £6,000 per GP with an average practice weighted population. This value had to be acceptable to all GPs, to incentivise both those wishing to transfer responsibility and those wishing to retain responsibility. This value does not represent the true cost of service provision; instead this figure was negotiated as part of complex changes to the calculation of GP income.

However, given the traditional underfunding and undervaluing of these services, in many areas there may now be a considerable potential funding shortfall. PCTs will not be able simply to recommission the present medical model of services but will

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have to consider strategic and more integrated and creative solutions for service provision.¹⁰⁵

97. It is clear that the additional £6,000 per GP per annum that PCTs will retain if GPs opt out will not cover the cost of providing services to that GP's patients. While ultimately GP out-of-hours services may be delivered by a differently skilled workforce, training this workforce will incur start-up costs, and it is not possible to guarantee the level of cost savings that this workforce will ultimately deliver. East Anglian Ambulance NHS Trust argued that "the development of a comprehensive alternative healthcare professional workforce will take some years to achieve and will in itself be neither cheap nor easy to sustain in working anti-social hours patterns".¹⁰⁶

98. It is also clear that there will be heavy reliance on GPs in the short term, and that market forces may raise GPs' fees significantly, a problem which will be compounded by PCTs having to meet the extra costs of superannuation and National Insurance contributions. The NHS Confederation pointed out the uncertainty surrounding the potential impact of market forces on GPs hourly rates, especially in under-doctored areas.¹⁰⁷ Dr Graham Rich of West Hull PCT supported this view:

We have had some pressure on finances ... We have seen, I think, a nationwide increase in the rates that GPs wish to be paid for out-of-hours work. Under the old GP co-operative method, because they had a duty to provide out-of-hours care—part of being part of the co-operation was providing time into it—it was not done at a market rate. Now it is. They can choose whether to work or not and rates have gone up. I think that has happened across all different types of models that we have seen. We have had to find approximately £500,000 to meet our obligations under this new model.¹⁰⁸

99. Liverdoc provided us with estimates which already point to considerable cost escalation:

Independent medical practitioners locally can command remuneration of £60 per hour in normal hours, and we would therefore predict out-of-hours rates to settle at around £80–£100 per hour for evening and daytime weekend work, £100–£150 per hour for overnight work depending largely on work intensity, with 50–100% enhancement of these rates for Bank Holidays.¹⁰⁹

100. Dr Mark McCartney also argued that the European Working Time Directive would create even more cost pressures, as shift patterns would need to change to accommodate its requirements.¹¹⁰

105 Ev 2

106 Ev 43

107 Appendix 18

108 Q116

109 Appendix 10

110 Appendix 7

101. In its evidence, the Department listed several sources of funding for PCTs for the development of out-of-hours services, in addition to the £6,000 per GP recouped when GPs opt out. These included a ring-fenced out-of-hours development fund which is allocated annually to support the development of out-of-hours services and infrastructure, worth £92 million in 2004–05; an additional £28 million over two years to support those PCTs facing the biggest challenges in developing out-of-hours services; and some £30 million available in capital incentives, to reward PCTs for having robust arrangements in place for taking on their responsibilities for out-of-hours services.¹¹¹

102. However, several organisations have warned that even these extra payments may not fully cover the true costs of out-of-hours services. Although substantial resources have been made available to PCTs in order to re-provide out-of-hours services, the NHS Confederation’s initial estimates suggested that this was not enough to cover the cost of reconfiguring the entire system.¹¹² Kernowdoc, a GP co-operative which provides out-of-hours services for mainland Cornwall, estimated a financial gap of £5.3 million between what their service will cost, and the funding that will be available after 1 October 2004, when local PCTs have agreed GPs can opt out.¹¹³ They described this as a “significant shortfall”, even if some of the loss could be made up by skill mix changes. This level of shortfall does not seem to be restricted to Cornwall. North Yorkshire Emergency Doctors provided a similar estimate:

It is conservatively estimated that North Yorkshire Emergency Doctors’ costs in the future, given that GPs will have to be paid the market rate to work in the service, will be well in excess of £10 million. Even though the SHA has been given a small amount of additional rural funding (£1.1m of which our PCTs may see £700k) there remains a shortfall, in our area alone, of several million pounds. We understand that this situation is reflected nationally.¹¹⁴

103. Dr Mark Reynolds, for the NAGPC, told us that his organization estimated funding shortfalls for out-of-hours services of between £200,000 and £300,000 per PCT across the country.¹¹⁵ Dr Ruth Livingstone of the NHS Alliance reported research suggesting that considerable discrepancies in out-of-hours services were expected across the country:

Certainly putting in place alternative arrangements is going to by and large prove more expensive than the funding available to do it. Dr Chisholm talked about the £6,000 per GP, and then there is a top-up of about £3,000 per GP which would go into the new out-of-hours arrangement; but most of the new out-of-hours arrangements are going to cost more than that, so I think there is understandable concern. We have had responses which suggest anything between that we are going to break even within the budget we have, to we are going to have a £400,000 shortfall on out-of-hours alone.¹¹⁶

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112 Appendix 18

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114 Appendix 9

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104. Members of the NHS Alliance reported similar concerns:

Maintaining the current level of GP cover is extremely expensive. Every £10 per hour extra spent on GPs will cost the [local] scheme over £400,000. The fear is that market forces will substantially increase the acceptable hourly rate for GPs. Modelling GP costs on what we are informed is the mid range of acceptable hourly rates gives a potential shortfall of nearly £1m for 2004/5, which PCTs will have to find from very limited funds. This is after the out-of-hours Development fund has been nearly doubled, and GPs have given up the part year share of 6% of the global sum under the new contract. The PCT is looking at alternative skill mixes to ensure that this position does not deteriorate further in a full year of opt out. However, these will take time to secure.

Finance—we are struggling in the short-term despite the various non-recurring pump-priming resources announced, and will definitely struggle long-term, especially if the going rate for doctor time is higher than anticipated.

Despite “trimming” the service (including reducing the “red eye” shift to three mobile GPs for the whole county) there is still a funding gap of around £880k ... Quite rightly we have resisted pressure from the SHA to trim the service further to reduce the cost of the new service— any further changes could put patient care at increase risk.

Major issue on costs and affordability for the PCT ... PCTs will not be able to afford the true costs of out-of-hours if we are to retain/attract a viable workforce ... Worst case scenario of minimal GP input into out-of-hours with no other professionals to deliver is a reality, hence major impact on secondary care activity and also patients satisfaction (which is by and large currently very good).

We have a plan which is far too expensive but probably reflects market forces. We will need to modernise with skill mix issues in future but are concerned about knock on effects in emergency admissions.

The problem is finance. The PCT has as available out-of-hours funds approx £1.3 million. The service will cost about £2.2 million. Which if you are in this area is a huge problem because we are millions overspent anyway.

105. East Anglian Ambulance NHS Trust stated that “the amount of claw-back from the Global Sum has proven to be insufficient to provide a high quality service within Norfolk”.¹¹⁷ In oral evidence they told us that: “It has been very difficult, particularly for the

rural areas, and the PCTs did have quite a significant financial gap.”¹¹⁸ Similar concerns were expressed by West Hull PCT:

Evidence has shown that the true cost of providing an out-of-hours service is around £16k to £17k per year—a cost that was previously borne mainly by GPs themselves. The defund of GPs for out-of-hours opt out is much lower than the cost that GPs were previously incurring (unless they provided all their own cover) and PCTs will need to make up the difference from their main allocations.

It is likely that increased costs will be incurred as PCTs pursue service quality developments. Additionally, if PCTs need to fund local capacity in NHS Direct, there will be a potentially high demand on PCT financial resource, which will need to be managed within the context of competing priorities.¹¹⁹

106. When we put the issue of financial pressures to the Minister, he told us he was puzzled by the £200,000 per PCT figure provided by the NAGPC, arguing that this was the first time he had heard about this.¹²⁰ He then told us that “I think we have done our bit” by putting extra funding into the system.¹²¹

107. While we do not feel that we are in an appropriate position to make recommendations on the necessary funding levels for GP out-of-hours services and how this should sit with PCTs’ other spending priorities, it is clear from our evidence that there is anxiety in many quarters about securing adequate funding for GP out-of-hours services. Furthermore, with the true cost of GP out-of-hours services having been largely disguised until now by GPs’ previous practice, this is essentially a ‘new’ cost for the NHS, and one for which there are few precedents for commissioning or providing. In the light of this, we recommend that the Department monitor closely the financial arrangements for funding GP out-of-hours services. We will continue to investigate this in future years as part of our annual Public Expenditure Inquiry.

Quality

108. While there is no doubt that the opportunity exists to deliver better quality GP out-of-hours services for patients, and that new quality standards will be an important tool in achieving this, our evidence suggests that financial and capacity pressures may threaten PCTs’ ability to deliver high quality services.

109. The NAGPC argued that while most GP co-operatives currently provided higher standards than the national quality standards, which require, for example, that non-urgent calls are carried out within six hours, providers were likely to drop back to minimum standards if funding was tight.¹²² Kernowdoc stated that the financial concerns over possible funding shortfalls were causing PCTs in their area to consider reductions in service, which might result in reduced access for patients. Journey times for patients to

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reach an out-of-hours centre to see a health professional would be extended, and they anticipated that many patients would not be willing to make a longer journey, instead electing to call 999 to be taken to A&E. Kernowdoc warned that it was “very likely that reductions in service will seriously jeopardise the organisation’s ability to maintain our existing performance”.¹²³

110. Dr Reynolds of the NAGPC went on to argue that if financial pressures prevented GP co-operatives from delivering a high quality service, this could have a direct impact on whether or not GP co-operatives and the GPs who work for them continued to provide GP out-of-hours services. If GP co-operatives “are faced with a cash-strapped PCT that says there is only *X* amount to do it, and they know it is going to cost *Y* to do it, they have a choice of either diminishing the quality of the service to the patient or saying ‘No, we’re not going to play any more, because we know we can’t deliver a service for that much money’. It is a real problem”.¹²⁴

111. We support the introduction of quality standards for all providers of GP out-of-hours services, and we hope that these will be rigorously audited. Providers should also be encouraged, through incentives, to exceed quality standards and work towards continuous improvement. We are concerned by reports that financial pressures may adversely affect the quality of services some providers are able to offer, and we recommend that a broad-brush assessment against current quality standards is conducted prior to the handover of responsibility to PCTs, in order to provide a baseline against which performance under the new system can be measured.

123 Appendix 11

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5 Conclusion

112. It is inevitable in an inquiry such as this, where proposed changes directly impact on people's professional lives, that evidence will reflect professional standpoints, and may occasionally be distorted by vested interests. Equally, attempting to evaluate the likely impact of changes that have not yet taken place can only ever, at best, be an inexact science. We aim to keep a close watching brief on this area of the NHS as the new changes take effect over the coming months and years.

113. Despite these limitations, we feel that the evidence we have received has provided a valuable and largely balanced view of both the positive and negative aspects of the impact of the new GP contract on out-of-hours services. Our evidence has demonstrated that the transfer of responsibility for GP out-of-hours services to PCTs represents a tremendous opportunity to develop and redesign services in ways which can benefit patients, GPs and the wider NHS, an opportunity that those working in this area are, generally speaking, keen to embrace. However, crucial to managing this change in a way that builds upon rather than destabilises current provision of out-of-hours service is that PCTs maintain a keen awareness of the risks attached to the forthcoming changes and manage them accordingly. These risks include uncertainties surrounding the GP workforce, funding and the potential impact on other parts of the NHS. It is crucial that appropriate information on how best to access services is made available to patients, and that quality standards are rigorously monitored to ensure that patients continue to receive a high standard of service in the out-of-hours period.

Conclusions and recommendations

1. Our evidence suggests that while PCTs across the country are in varying states of readiness for taking on responsibility for providing GP out-of-hours services, forward planning is taking place and support systems are available. However, we were concerned at reports that this critical transition was in some circumstances being managed at too junior a level within PCTs, and also that some PCTs were failing to think about more integrated approaches within their wider local health economies. We urge the Department to consider these concerns raised in our evidence in their support and management of PCTs, and also to encourage, where possible, a greater degree of public consultation and involvement around the redesigning of GP out-of-hours services, as our evidence suggests that this has so far been largely lacking. (Paragraph 21)
2. We are impressed with the potential of some models of GP out-of-hours service provision, including integration with ambulance services and creative use of skill mix. However, some of the models we have seen seem to be predicated on well developed collaborative working relationships with successful existing local out-of-hours service providers, and we urge the Department to encourage such collaborative working wherever possible. (Paragraph 32)
3. We look forward to the publication of the guide for PCTs and providers to be issued in Summer 2004, and recommend that it makes mandatory scope for the provision of medication, where necessary, at the same time and place as out-of-hours consultation. (Paragraph 40)
4. In our view, existing GPs, including those who work in co-operatives, will continue to form the backbone of future provision of out-of-hours services. They are also the NHS's main source of expertise in this complex area, and yet the availability of the GP workforce for out-of-hours cover still remains uncertain. It is therefore vital that they do not become disengaged from the process of redesigning GP out-of-hours services during this critical transition phase, and their expertise and local knowledge lost. We recommend that the Government should take all reasonable steps to encourage PCTs to work collaboratively with GPs, including those in co-operatives, and to encourage PCTs to provide the flexibility and support, as well as the financial incentives, necessary to retain a motivated GP workforce. (Paragraph 53)
5. We strongly support the better use of skill mix to deliver out-of-hours care, not only for its potential to relieve pressure on GPs and deliver cost savings, but also, more importantly, for its potential to deliver a better quality of service to patients. However, out-of-hours care is a complex service to provide, and health professionals other than doctors will need appropriate training if they are to deliver it to a high standard. Our evidence suggests that those working in the NHS are well aware of the difficulties attendant upon recruiting and training this new workforce, and we urge the Government to ensure that PCT forward planning allows sufficient time for this to take place, and takes account of the view that triage by the most experienced

clinician available, who may or may not be a doctor, is the most effective use of resources. (Paragraph 62)

6. We accept the value of a single telephone access point for patients for all out-of-hours services. However, NHS Direct will have substantially to increase its capacity in order to cope with this burden. We remain concerned that full integration of NHS Direct and GP out-of-hours services could introduce unnecessary delay and increase referrals to other parts of the NHS. We recommend that alongside their work to develop capacity, NHS Direct should work collaboratively with others, including GPs, involved in delivering nurse telephone triage services for out-of-hours care to develop and refine their referral protocols to ensure this does not happen. (Paragraph 78)
7. GP out-of-hours services provide only one of many routes for people needing urgent care. Out-of-hours services are part of a larger network of 'unscheduled' care providers, which can include emergency ambulances and A&E departments, as well as GP emergency clinics run during the day. If one of these services is withdrawn or changed, or access becomes more difficult, demand for urgent care will simply increase in other parts of the system. It is not surprising, therefore, that A&E departments are anxious that changes in the provision of GP out-of-hours services may impact on already rising attendance rates. (Paragraph 86)
8. We deplore the loss of GP Saturday morning surgeries which will limit access to their GP for many working people, and we recommend that PCTs should provide such clinics in primary care centres or co-located emergency departments. (Paragraph 87)
9. Accessing healthcare outside normal working hours can currently involve negotiating a maze of different services and telephone numbers. We agree that in the long term, services should be designed around patients, taking account of where local patients are most likely to access healthcare. We are encouraged to see this already happening in certain places, through, for example, the co-location of primary care centres and A&E departments. However, we also believe that there is a place for patient information campaigns in order better to equip patients to play an active role in their own healthcare. Clear information should be available to everyone who needs it, setting out what local NHS services are available where, in order to help patients make informed choices on how to access out-of-hours healthcare. We recommend that the Government takes steps to ensure PCTs proactively provide information on NHS services to their local populations on a regular basis, paying particular attention to the need to keep people informed of any changes that may occur as a result of the handover of responsibility for out-of-hours care. (Paragraph 88)
10. Although providing services to community hospitals is a separate issue from GP out-of-hours services, it certainly seems possible from the evidence that we have heard that the handover of responsibility for GP out-of-hours services from GPs to PCTs will prompt some GPs to re-evaluate and perhaps to withdraw the services they currently provide to community hospitals, as part of their on-call duties. In our view it is regrettable that this vital subset of GPs' work has not been addressed more

swiftly, and we urge the Government to ensure that this is resolved as a matter of urgency to ensure that the extremely valuable service provided by community hospitals is not jeopardised. (Paragraph 94)

11. While we do not feel that we are in an appropriate position to make recommendations on the necessary funding levels for GP out-of-hours services and how this should sit with PCTs' other spending priorities, it is clear from our evidence that there is anxiety in many quarters about securing adequate funding for GP out-of-hours services. Furthermore, with the true cost of GP out-of-hours services having been largely disguised until now by GPs' previous practice, this is essentially a 'new' cost for the NHS, and one for which there are few precedents for commissioning or providing. In the light of this, we recommend that the Department monitor closely the financial arrangements for funding GP out-of-hours services. We will continue to investigate this in future years as part of our annual Public Expenditure Inquiry. (Paragraph 107)
12. We support the introduction of quality standards for all providers of GP out-of-hours services, and we hope that these will be rigorously audited. Providers should also be encouraged, through incentives, to exceed quality standards and work towards continuous improvement. We are concerned by reports that financial pressures may adversely affect the quality of services some providers are able to offer, and we recommend that a broad-brush assessment against current quality standards is conducted prior to the handover of responsibility to PCTs, in order to provide a baseline against which performance under the new system can be measured. (Paragraph 111)

List of abbreviations

A&E	Accident and Emergency
BAEM	British Association of Emergency Medicine
BMA	British Medical Association
ECP	Emergency Care Practitioner
GMS	General Medical Services
NAGPC	National Association of GP Co-operatives
PCT	Primary Care Trust
PMS	Personal Medical Services
RCGP	Royal College of General Practitioners
SHA	Strategic Health Authority

Formal minutes

Monday 19 July 2004

Members present:
Mr David Hinchliffe, in the Chair

Mr David Amess
John Austin
Mr Simon Burns
Jim Dowd

Mr Jon Owen Jones
Dr Doug Naysmith
Dr Richard Taylor

The Committee deliberated.

Draft Report (GP Out-of-Hours Services), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 113 read and agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Provisions of Standing Order No. 134 (Select Committee (Reports)) be applied to the Report.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman*).

[Adjourned till Thursday 9 September at 10.00 am

Witnesses

Thursday 24 June 2004

Page

Dr John Chisholm, Chairman, General Practitioners Committee, British Medical Association, **Dr Ruth Livingstone**, NHS Alliance, **Professor David Haslam**, Chairman of Council, Royal College of General Practitioners, **Dr Mark Reynolds**, Chairman, **Dr Mike Sadler**, Medical Director, Primecare, and **Mr Martin Shalley**, President, British Association for Emergency Medicine.

Ev 24

Thursday 8 July 2004

Dr Graham Rich, Chief Executive, West Hull NHS Primary Care Trust, **Ms Lyn Reynolds**, Primary Care Development Manager, East Anglian NHS Ambulance Trust and **Mr Ed Lester**, Chief Executive, NHS Direct.

Ev 51

Rt Hon John Hutton, a Member of the House, Minister of State for Health, **Professor David Colin-Thome**, National Director for Primary Care, and **Ms Margaret Edwards**, Director of Access, Health and Social Care Delivery Group, Department of Health.

Ev 65

List of written evidence

1	BMA (GP21)	Ev 1
2	NHS Alliance (GP26)	Ev 5
3	Royal College of General Practitioners (GP10)	Ev 7
4	National Association of GP Co-operatives (GP19)	Ev 9
5	Primecare (GP17)	Ev 18
6	East Anglican Ambulance NHS Trust (GP27)	Ev 27
7	NHS Direct (GP22)	Ev 43
8	West Hull NHS Primary Care Trust (GP30)	Ev 48
9	Department of Health (GP1)	Ev 58
10	National Patient Safety Agency (GP2)	Ev 75
11	Macmillan Cancer Relief (GP3)	Ev 78
12	Harmoni (GP4)	Ev 86
13	Dr Michael Colquhoun (GP5)	Ev 90
14	Ms Paula Hull (GP6)	Ev 90
15	English Community Care Association (GP7)	Ev 91
16	Dr Mark McCartney (GP8)	Ev 92
17	Royal College of Nursing (GP9)	Ev 95
18	North Yorkshire Emergency Doctors (GP11)	Ev 96
19	Liverdoc Ltd (GP12)	Ev 99
20	Kernowdoc (GP13)	Ev 102
21	OOH Foundation, Mutuo, Cobbets (GP14)	Ev 104
22	Councillor John Blacke (GP15)	Ev 108
23	Pharmaceutical Services Negotiating Committee (GP16)	Ev 112
24	Mr David Lloyd (GP18)	Ev 115
25	World Class International (GP20)	Ev 116
26	Royal College of Paediatrics and Child Health (GP23)	Ev 118
27	NHS Confederation (GP24)	Ev 119
28	PPI Forum for Staffordshire Moorlands NHS Trust(GP29)	Ev 123
29	Royal College of Pathologists (GP25)	Ev 124
30	Department of Health (GP1A)	Ev 128
31	NHS Alliance (GP26A)	Ev 130

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23
Fourth Report	Palliative Care	HC 454

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eighth Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)