Call for Evidence on Out of Hours Care Provision in Rural Areas

RCGP Scotland response 7th November 2009

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

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

Supporting GPs in Remote and Rural Areas

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

The aims of the RCGP Rural Forum are:

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

Membership of the Rural Forum is open to members across the UK. In **addition to the RCGP Scotland response we have attached a formal response from the RCGP Rural Forum as an appendix to this response document.** The RCGP Rural Forum response has drawn from the views of Scottish members of the RCGP Rural Forum.

RCGP Scotland also works directly to support its Scottish members in remote and rural areas through various events and initiatives. Currently Dr Susan Taylor acts as the Remote and Rural Lead on the RCGP Scotland Membership Liaison Group in order to inform work in relation to remote & rural activities through the development and facilitation of relevant programmes of work. Dr Susan Taylor is also the Chair of the Remote Practitioners Association of Scotland.

Response to the Call for Evidence

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

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

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

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

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

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

- Support local GP cooperatives to provide local and sustainable solutions. These should allow opt in/out of individual doctors, but seek to use local staff to provide a service with good continuity with daytime general practice.

- Over the last 8 years there have been so many options explored and for certain areas we come to the same conclusion that a motivated BASICS (The British Association for Immediate Care) trained GP is virtually impossible to replace.

- One option would be to adopt the Scandinavian model where small remote and rural practices would revert to being single-handed and the GP on-call 24/7.

- In Glenelg a GP needs to be part of the out of hours team 24/7, 365 days per year but I emphasise definitely needs to work as part of an evolving out of hours team.

- Giving contracts to local GPs to organise and subcontract to known local sessional doctors must be the way forward, perhaps operating as co-operatives. They would not be expected to provide all the service provision personally. However this would have to be done on a 3 or 5 year basis, so they could plan how to provide this cover e.g. by taking on extra doctors as partners/salaried or by using nurses for parts of the shifts.

- Incentivise the local GPs to deliver the service or support paramedics to act as the first line of response/assessment with GP to back up more centrally.

- If local GPs are prepared to cover larger localities during OOH (accepting busier OOH shifts with the advantage of less frequent OOH duties) then this can usually be done with the GP and a dual role driver/receptionist. Having nurses working alongside you is a luxury in rural OOH but not essential in my experience of OOH.

- Many years ago, the Highlands were given special provisions to ensure GPs in all communities. The community is reliant on the availability of adequate care for its survival. A group of other providers would be more expensive, difficult to coordinate (and look at the coordination problems we have already) and difficult to train, recruit and retain staff for (also demonstrated by existing difficulties). There are GPs already in rural areas and where possible they should be used to provide OOH services.

- I think that the most sustainable and cost-effective means of provision may vary according to population density and distribution of existing services, but central, protocol assisted nurse triage, supported by local General Practitioners with training and experience of unscheduled care works well. General Practitioners are trained at great expense to be good at assessing and managing risk. It is a waste of resources to have General Practitioners working in rural areas but not involved in OOH care. At present, many rural GPs do not provide OOH care, for a variety of reasons, and it is impossible and undesirable to have all rural GPs involved in OOH care, but steps should be taken to encourage more GPs to be involved.

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

As such, RCGP Scotland believes that the model for the most sustainable and cost effective way to provide OOH care in remote and rural areas of Scotland would utilise both the skill set and local knowledge of General Practitioners in order to maintain (as far as possible) good continuity of care for patients in these areas. Options would be dependant on local geography and service provision but examples provided above such as the Scandinavian model, locally run GP co-operatives or a BASICS trained GP as part of a response team would all be viable options in

certain areas. Some GPs felt that nurses and nurse practitioners have a viable role in their local areas, but some also felt that their areas did not require such provision and as such, this may need to be reviewed on a local level to ascertain effectiveness. Clearly a strong multi-disciplinary team approach is necessary with strong working relationship between all members of the team including the Scottish Ambulance Service and NHS24 but greater cost effectiveness can be achieved with the strong inclusion of General Practitioners with their own multi-disciplinary skill set to deal with or support a wide range of cases.

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

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

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

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

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

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

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

- While I believe that the current service, which uses local GPs, has very good standards of clinical safety and effectiveness, I do however have concerns about the lack of clinical governance support and structure. We rely on the use of informal systems within individual

practices, and are therefore missing the opportunity to learn as an OOH service from our strengths and weaknesses, and by not having a clinical governance mechanism specific to OOH, those clinical staff who are not also routinely employed in daytime general practice (all the nurses and some GPs) miss out on this essential learning activity. I do not think it is acceptable for any clinical service to function without clinical governance mechanisms in today's world, and OOH services should have this built in, and allowed for in all cost calculations.

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

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

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

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

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

- On the whole, in my experience, the current system provides high quality OOH care in most areas. Difficulties arise when ambulances are single-manned due to sickness absence or annual leave of crew, or when the nearest ambulance is engaged in another task. In such circumstances it is clearly especially vital that a GP is available to provide an additional emergency response in the community.

- There have been fairly serious concerns about locums employed for OOH cover on occasions. On one occasion we had to ask the OOH manager to tell the locum to stop working and take over ourselves as they were inadequately prepared and trained and had very poor English. On another occasion a complaint was made leading to a GMC referral on one of the locums. The locums sometimes come from other European countries and cannot speak or understand English very well and additionally do not have the breadth of training and experience of general practice in Britain let alone remote and rural areas. GP training

and GP work is not the same all over Europe and understanding and dealing with this is vital to prevent dangerous practice

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

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

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

Another safety issue for OOH in remote and rural areas is the danger of the roads, for both patients and healthcare providers. Provision of service on a local level lessens this risk by ensuring as far as possible that staff are familiar with the roads and difficult to find locations. For OOH healthcare providers there are specific risks which must be taken into account, for example deer jumping onto icy or windy roads in the path of the car, as well as lack of mobile reception.

The introduction of drivers, trained in basic life support to provide transport for OOH GPs and staff has been a major benefit, but it must be noted that drivers can cover over 300 miles during the course of three call outs often under the conditions listed above.

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

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

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

received from GPs in remote and rural areas, many of whom are directly involved in OOH care provision:

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

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

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

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

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

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

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

- In our area of Berwickshire the service is excellent.

- Good at the moment on the Isle of Lewis as it is quiet and there are few people. Services may be poor in the future when many extra tasks will be added.

- Access to OOH is reasonable in Gairloch as long as a GP remains in the area. There are no other supports for primary care such as A+E and there is limited support from services such as district nursing and psychiatry. The GP remains a vital piece of OOH care particularly with the distances involved. Availability is generally good; however integration of the new systems such as NHS24 and the increased use of the Scottish Ambulance Service need to be improved. This should then mean the service will be safe and effective.

- Currently the accessibility and availability of OOH care is satisfactory in most areas. If there were any reduction in GP cover then this would suffer considerably.

- Within my own area of Morvern, patients will easily be seen within 1 hr as long as they can get through to NHS24 and get the call correctly triaged, so the GP is always available, but NHS 24 systems can sometimes prove a barrier to accessibility.

- In Badenoch and Strathspey some elements of the care package are less accessible, e.g. patients can no longer speak directly to their own GP. But others elements are more accessible – many patients value the ability to obtain telephone advice from someone professional, but anonymous, without fear of 'disturbing' them. Most patients who are fit to do so, seem happy to attend the OOH centre, and are complimentary of the care that they receive there.

- There is a service in place in the east of Scotland but there is a question around the quality of this service and who is providing it e.g. is the patient being seen by a GP or under the 'see and treat' service.

- There is good accessibility and availability in Dunoon.

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

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

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

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

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

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

- NHS 24 usually links in well, although at times, the centralising of the telephone triage results in delays in access to medical care due to central high call volumes, even when the local service is quiet. The Scottish Ambulance Service also appears to use us appropriately, by

and large, and I feel that our support by receptionist and driver helps with both of these areas.

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

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

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

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

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

- Ambulance provision is patchy in the more remote areas, which means that savings cannot be made in reducing the number of GPs per geographical area as, if they need to transport a patient to secondary care, the area will be left without ambulance cover for many hours. We have also had repeated reports of single manning of ambulances, as a routine occurrence, not just an emergency cover situation. Better management with ambulance and GP cover

would greatly help. Attempts have been made to enlist nurses for shifts, but there are not enough suitably trained nurses living locally. Even with the best trained nurse, a doctor will still be required 50% of the time, and the nearest Primary Care Emergency Centre might be over 2 hours away with only a single doctor on duty there too, already covering a huge geographical area. NHS24 is usually much less useful in a rural area, as they can't possibly understand the local geography. The money used for the nurses here (who triage on average only 3 patients an hour) could be put into the GP system as detailed above. The use of a local 'Hub' is essential though, to keep track of the calls, addresses and the doctors.

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

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

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

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

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

involved. This change can probably only be achieved a high level as we have already discussed this problem and various incidents with the Scottish Ambulance Service and found their operations unchanged.

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

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

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

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

Response Summary

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

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

praised for increasing efficiency and safety for patients and healthcare professionals who may previously have worked alone in very remote areas.

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

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

Yours sincerely,

Dr. Kenneth Lawton

Chair

Appendix

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

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

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

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

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

We do not think it appropriate to generalise here. Clearly quality of service may vary in accordance with local circumstances and problems. Access to secondary care for example will vary according to locality and will largely be inversely proportional to the degree of remoteness.

Access to tertiary care such as emergency coronary angiography for example may simply not be available in the more remote areas. We believe that the Scottish Parliament and Health Boards should make every effort to improve resources for the service providers in any locality where there might be evidence of service failings or difficulties.

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

See responses to question 1 and 2.

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

Feedback from numerous doctors throughout rural Scotland suggests that there is variance in the standard of service provision. In some areas the service links seem to work well but in other areas particularly parts of the West Coast and Islands there appear to be problems as highlighted in our response to the Scottish Ambulance Service consultation. Concerns included issues around air ambulance versus terrestrial ambulance, inappropriate diversions, prioritisation and misconceptions about community hospitals being regarded as places of safety. This particular issue relates to when there is a call for urgent transfer from a community hospital for a patient in need of emergency treatments or investigations that cannot be provided by a Community Hospital. Even though a patient may be critically ill an ambulance (whether air or terrestrial) may be diverted to a call to a patient whose need is less serious.

The consensus view is that this sort of problem is less likely to occur where there is locally centralised co-ordination and links between NHS24, out-of-hours providers and ambulance services so that communication between staff with **clinical experience** and local knowledge can lead to more efficient call handling and prioritisation. We understand that this is increasingly being recognised and that control of out-of hours calls are already being handled in a single control room in Glasgow for example. Many rural and remote general practitioners have regular BASICS training and I understand that areas where the Scottish Ambulance Service engages with, and works with such doctors, patients value that service.

Dr Malcolm Ward
Chair of the RCGP UK Rural Forum