AGENDA ITEM NO: 15

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**12 June 2017**
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Subject:	**PROPOSED REVIEW OF PRIMARY CARE OUT OF HOURS**		

1.0 PURPOSE

1.1 This report informs the IJB of a proposed joint HSCP review of GP out of hours linked to the whole system review of out of hours services.

2.0 SUMMARY

2.1 The NHS Greater Glasgow and Clyde has developed proposals to redesign the Primary Care Out of Hours services in response to operational difficulties in providing the existing service, changing pattern of attendance and financial challenge. The six HSCP Chief Officers within the NHSGGC catchment commissioned a working group to scope options and make recommendations to the IJBs.

2.2 This paper highlights some of the work and the potential implications for Inverclyde of different options.

3.0 RECOMMENDATION

3.1 The Integration Joint Board is asked to note the content of this paper.

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4.0 BACKGROUND

4.1 In 2004, the General Medical Services (GMS) contract came into force. This gave General Practitioners (GPs) the opportunity to opt out of providing out of hours care for their patients. The GMS contract means that NHS Greater Glasgow & Clyde is responsible for ensuring all patients can access out of hours care. In the recently published National Out of Hours Review, out of hours care is defined as care to a patient which cannot wait until the GP surgery is open again. Access to the GP Out of Hours service was initially intended to be through NHS24, however, over time, a significant number of patients now walk into the GP Out of Hours service in most centres within NHSGGC. A notable exception to this pattern is seen in Inverclyde, with the highest percentage of NHS24 referrals and the lowest walk-in percentage (see table 1).

Attendances at Primary Care Out of Hours				
	NHS24	**Walk-in**	**Referred**	**Other**
Easterhouse	75%	23%	0%	2%
Greenock /IRH	**92%**	**6%**	**0%**	**2%**
Lomond /Vale	32%	51%	7%	10%
Renfrewshire /RAH	84%	9%	2%	5%
QEUH	71%	21%	6%	2%
Stobhill	63%	29%	1%	7%
Victoria	67%	27%	1%	5%

Table 1: Percentage attendances by referral route

4.2 The daily average activity for the Primary Care Out of Hours Centres is Shown in table 2. Inverclyde has the lowest attendances, possibly reflecting the low rate of unreferred "walk-ins".

	Gart-navel General	Easter-house	**Green-ock /IRH**	Lomond /Vale	Renfrew-shire /RAH	QEUH	Stobhill	Victoria
Monday	30	26	**11**	26	29	18	48	66
Tuesday	31	26	**12**	24	27	19	49	64
Wednesday	29	24	**10**	24	28	19	46	61
Thursday	29	23	**10**	23	27	19	43	61
Friday	33	26	**11**	25	28	20	47	65
Saturday	133	98	**47**	85	103	76	133	202
Sunday	132	97	**43**	84	103	77	133	197

Table 2: Daily average attendances

4.3 NHS Greater Glasgow and Clyde through Glasgow IJB have undertaken a review of the Out of Hours services in the context of the recently published National Review by Sir Lewis Ritchie, the Board's service and financial planning for 2016/17, and the above activity information.

4.4 Strategically, Integration Joint Boards are responsible for the planning and commissioning of safe and effective Out of Hours services. A joint group was established by the HSCP Chief Officers specifically to review the Social Emergency Service, GP Out of Hours and Mental Health.

4.5 This report describes the work to date, and the emerging recommendations from that work.

5.0 CURRENT SERVICE CONFIGURATION

5.1 The current GP Out of Hours services include the 8 centres described above, plus a number of pan-NHSGGC components:

- Home Visiting Service - this extends into Lanarkshire to cover Camglen, and into Highland to cover Helensburgh and the Lochside.
- Telephone advice service - this is provided from the Hub at Cardonald by the GP advisor who has a wide role in co-ordinating the service.
- A pre-prioritised call service to support NHS24 - this is provided from the Hub at Cardonald utilising GGC clinical workforce and funded by NHS 24.

5.2 The 8 Primary Care Centres are located geographically around the city to support access locally for patients. These centres see patients who are directed by NHS24, or self-present. Those centres that are adjacent to A&E departments will see those redirected by A&E. The service offers a patient transport service to and from these centres for patients who cannot afford public transport and do not have their own transport. This is intended to minimise the need for home visits. The service does not operate an appointment system and patients are directed by NHS24 to their nearest Primary Care Centre. For Inverclyde, our local services within the Greenock Health Centre up to midnight, when they transfer to the Inverclyde Royal Hospital.

6.0 CHALLENGES FOR THE SERVICE

6.1 Whilst there is some evidence of reducing demand for out of hours, overall the current service is under consistent pressure due to the increasing lack of availability of GPs willing to participate in the GP Out of Hours service. This is further exacerbated at holiday periods when there is a higher level of demand and call upon the same GPs to work extremely long hours.

6.2 The Home Visiting service is required to reach calls within the timeframe allocated by NHS24, i.e. within 1, 2 or 4 hours. Overall, it is usual for home visits to be achieved within 4 hours (usually 90% and above), however within these figures many of the 1 and 2 hour calls go out of time. The management team and Quality Assurance Group monitor these calls and there is concern that activity at weekends at times exceeds capacity.

7.0 ACTION TAKEN AND NEXT STEPS

7.1 NHSGGC has taken a series of actions to try to manage the issues of demand and capacity facing the GP Out of Hours Service. These include introduction of nurses into centres to reduce demand on medical staff; working with NHS24 to develop alternative pathways; and considering potential changes to the relationship between the Out of Hours service and hospital based service at IRH.

7.2 Whilst these actions have made some improvements there are a number of key strategic decisions to be made about the preferred future model of service. The Chief Officers Out of Hours Group has started from a position of looking at the number of Primary Care Centres from which the service is operational, and consider the potential to reduce these and the number of walk-in patients. This has led to the development of a number of options for consideration.

- Option 1 - sites co-located with the main Emergency Department or Receiving Units (i.e. 3 Primary Care Centres at the Glasgow Royal Infirmary, the Queen Elizabeth University Hospital and the Royal Alexandra Hospital);
- Option 2 – a mixture of acute and community sites linked to population centres;
- Option 3 – sites solely within communities (i.e. not in hospitals).

7.3 **Option 1 - Colocation with the main Emergency Department / Receiving Units**

Advantages

- Consolidates clinical staff on one site in each area which allows potential to redesign shift patterns and skill mix.
- Makes service less vulnerable if a clinician calls off at short notice.
- Potential to improve training environment for GP registrars.

Disadvantages

- Removes the Inverclyde service as well as other centres in areas with high levels of deprivation. This will reduce ease of access for vulnerable groups of patients.
- Reducing to 3 sites will make them high volume sites, particularly at weekends, which may make it even more difficult to attract GPs to work in such an environment.
- This will increase demand on patient transport, limiting any further opportunities to reduce the costs of the Patient Transport Service.
- There would be a potential increase in attendances to Emergency Departments, with patients preferring this to having to travel much further to a Primary Care Service.
- There will be challenges to accommodate large services each of the 3 sites.
- Resilience for service if Inverclyde GP choose not to participate.

7.4 **Option 2 – A mixture of acute and community, based on population centres.**

Advantages

- This could enable the development of an operating pattern with fewer sites mid-week, when current sites are less busy.
- There is potential to improve the training environment for GP registrars mid-week.
- There would be an opportunity to redesign shift patterns and skill mix mid-week.

Disadvantages

- Could potentially lead to increased attendances to Emergency Departments at a time when IJBs are expected to work to reduce unscheduled care in hospitals.
- Could cause confusion about what sites are able to deliver different levels of care (up to acute receiving and resuscitation).
- Reduces ease of access for people who stay in either rural areas or areas of high deprivation (such as Inverclyde).
- Potential increased patient transport requirement.

7.5 **Option 3 - entirely in community settings**

Advantages

- Frees up space on acute sites.
- Clearly differentiates GP and hospital services.
- Subject to sites selected, there could be a potential reduction in walk-ins (although this is less of an issue in Inverclyde).
- Consolidates clinical staff on one site in each area which allows potential to redesign shift patterns and skill mix.
- Makes the service less vulnerable if a clinician calls off at short notice.

Disadvantages

- Will require new locations to be found – Easterhouse is the only community site currently.
- There could be significant costs of moving (IT etc.).
- There could be significant workforce challenges depending on location and number of sites.
- Depending on the sites chosen, it could lead to people attending the local Emergency Department instead, leading to increases in unscheduled care.
- Removes the ability for the Emergency Departments to redirect primary care cases to primary care services.

8.0 CONCLUSION

8.1 This initial work, commissioned by the Chief Officers, has brought about considerable discussion, and agreement that the six Chief Officers should convene a half-day development session to consider the options in more detail. That session will also consider options to address the issue of lack of GP cover and the need to have a more systematic approach to help with future planning for an appropriate, modern and responsive service.

Once the options have been more carefully considered, an analysis and recommendation will be presented to a future Integration Joint Board meeting.

9.0 IMPLICATIONS

FINANCE

Up until 2015, Out of Hours GPs in the Greater Glasgow and Clyde service were independent contractors. In 2015, following a nationwide investigation into the way individual Boards paid out of hours GPs, HMRC implemented a ruling that GPs working in out of hours services required to be on the NHSSG payroll, rather than treated as independent contractors. The result of the changes to the tax treatment of GPs working in out of hours services for NHS GGC has incurred an additional cost of £2.5m per annum. This funding has been covered non-recurrently.

Rates of pay are increased at times of peak activity in Out of Hours namely Public Holidays and the Festive fortnight and this has also resulted in an unfunded cost pressure of c£500k. The service has constantly reviewed its costs and service delivery model and has made cost reducing efficiencies of £300k over the last 5 years.

It is important that we require NHSGGC to take contingency measures to manage pressures on GP Out of Hours services and budget as a whole.

9.1 **Financial Implications**:

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

9.2 There are no legal implications from this report

HUMAN RESOURCES

9.3 Human resource implications have still to be fully scoped from this report

EQUALITIES

9.4 Has an Equality Impact Assessment been carried out?

	YES.
X	NO – An Equality Impact Assessment will be undertaken by the working group to help finalise recommendations.

How does this report address our Equality Outcomes?

a) **People, including individuals from the protected characteristic groups, can access HSCP services.**

The impact will be considered once a redesign is complete.

b) **Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.**

The impact will be considered once a redesign is complete.

c) **People with protected characteristics feel safe within their communities.**

Not applicable.

d) **People with protected characteristics feel included in the planning and developing of services.**

The delivery of this outcome will depend on the consultation approach that is taken by the working group.

e) **HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.**

Not applicable.

f) **Opportunities to support Learning Disability service users experiencing gender based violence are maximised**.

Not applicable.

g) **Positive attitudes towards the resettled refugee community in Inverclyde are promoted.**

Not applicable.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

9.5 The impact will be considered once a redesign is complete.

NATIONAL WELLBEING OUTCOMES

9.6 How does this report support delivery of the National Wellbeing Outcomes?

a) **People are able to look after and improve their own health and wellbeing and live in good health for longer.**

Not applicable.

b) **People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**

Depending on the final model, there could be a negative impact on this outcome.

c) **People who use health and social care services have positive experiences of those services, and have their dignity respected.**

Whichever model is taken forward, it will need to consider patient experience and dignity.

d) **Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

Not directly reflected in the proposals.

e) **Health and social care services contribute to reducing health inequalities.**

Depending on the final model, there could be a negative impact on this outcome.

f) **People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.**

Not directly reflected in the proposals.

g) **People using health and social care services are safe from harm.**

Not directly reflected in the proposals.

h) **People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

Not directly reflected in the proposals.

i) **Resources are used effectively in the provision of Health and Social Care.**

The proposals are driven by a need to use resources more effectively.

10.0 CONSULTATION

10.1 A joint group has been established by the HSCP Chief Officers to review the provision of the full range of health and social care out of hours services.