PURPOSE

1. The purpose of this report is to provide a position paper on Ayrshire Doctors on Call (ADOC) and to inform the Primary Care and Out of Hours (OOH) financial savings.

2. This paper sets out ADOC’s:
   - background and the context of wider changes underway through integration and the urgent care transformation
   - existing service challenges
   - financial position and cost pressures
   - risk relating to achieving savings

BACKGROUND

3. ADOC service model involves engaging GPs on a sessional basis and Advance Nurse Practitioners (ANPs) on a salaried basis to provide a full range of OOHs General Medical Services across three Primary Care Treatment Centres (PCTCs) and up to five mobile units. In the main, patients accessing NHS ADOC services are triaged by NHS 24 who will determine the urgency of the call and the most appropriate mode of service delivery based on an assessment of the patients’ needs. The service is demand lead and subject to rapid swings in demand requiring short term action. Workforce data which flattens off this activity can be misleading.

4. The GPs and ANPs undertake assessment, treatment, care and advice for patients and this can be delivered through a face-to-face consultation at one of three PCTCs or at home via one of the NHS ADOC cars. In addition to this, dedicated shifts are available to provide GP telephone advice. Further, a number of standby shifts are included in the rota to enable a dynamic and flexible response to increased demand and / or unforeseen circumstances.

5. Over the last year ADOC is having increasing difficulty in filling its clinical shifts. In previous years this has been commonplace during school holidays but at other times there has been little difficulty. Current challenges are leading to increasing apprehension that the service is becoming unsustainable. Urgent action is required but it needs to take place against a background of transformational change. An additional challenge is the financial imperative to reduce the deficit in Ayrshire’s health and social care budget.
The solution must ensure that a quality and safe OOH service is provided to public at all times including during the summer months when our clinicians take well deserved holidays with their families.

6. In 2012/13 NHS Ayrshire & Arran undertook a review of local OOH services. This considered the configuration and staffing of the services. The preferred option was model 1.3 below with the addition of moving to a more mix model with increased use of ANPs:

**Model 1.3: Status Quo – Pay Uplift and Weekend Rates**

Under this model NHS ADOC would continue to provide a full range of OOHs General Medical Services to the people of Ayrshire and Arran, by engaging GPs on a sessional basis.

These services would be provided from three Primary Care Treatment Centres (PCTCs) and up to five mobile units, with eight available during Public Holidays.

The fees payable to the GPs providing the service would be permanently enhanced for weekends, using the temporary uplift agreed for summer 2013 as a baseline.

In addition to this weekday sessional rates will be uplifted in line with Doctors’ and Dentists’ Remuneration Board (DDRB) recommendations, with the increase being calculated based on a backdated uplift to 2007. This increase would be phased in over three years, with agreement that DDRB uplifts would be applied annually to the uplifted weekday and weekend sessional payments from 2014/15.

7. In 2014 an appreciative enquiry was undertaken inviting GPs to help the service understand why they did not wish to work with ADOC over the summer. The GP response was excellent and positive actions resulted to address some of the issues raised e.g. longer consultation times, reviewing shift start and end times are just a few examples.

8. In addition, in response to the above option appraisal recommendation and appreciative enquiry, the weekend ADOC rates were permanently increased however the weekday sessional rates were not uplifted in line with DDRB recommendations which means in effect the rate of sessional pay weekday has been reducing and this issue has been raised as a concern by the GP Sub Committee and Local Medical Committee.

9. During 2015 a national review of urgent care OOH services, *Pulling together: transforming urgent care for the people of Scotland, 2015*, was commissioned in response to the position that OOH services are “fragile, not sustainable and will worsen, unless immediate and robust measures are taken to promote the recruitment and retention of sufficient numbers of GPs working in both daytime and OOH services”.

10. The same recommendation, for pay reviews in line with DDRB, was made in the 2015 national OOH review.
11. Nationally the demand for urgent care is growing, particularly for rapidly increasing numbers of frail older people with multiple long-term conditions and complex care needs. Currently the over 75 year age group and the under one year age group are high volume users of OOH services. Patients aged over 75 years presently represent 8% of the Scottish population and account for nearly 20% of patients treated. The over 75 age group is projected to increase by around 32% by the year 2024. This national position is reflected locally in Ayrshire and Arran.

12. *Pulling together: transforming urgent care for the people of Scotland* recommended the following, which is being progressed in Ayrshire and Arran through the Primary Care OOH Integration Programme:
   - The future model comprises OOH services delivering integrated care in a coordinated fashion requiring effective partnership working of multi-professional and multi-agency teams
   - OOH services should aim to point patients to the service most suited to deliver the needs of patients and carers, and minimise access barriers. That might be provided face-to-face or remotely by telephone call or video link.
   - Urgent Care Resource Hub consisting of a community health and social care co-ordination and dispatch centre where its function is to co-ordinate, mobilise and orchestrate the most appropriate care response.
   - Urgent Care Centres to deliver urgent care within local communities.

**EXISTING SERVICE CHALLENGES**

13. The Integration Joint Board will be aware of the changes being tested in OOH, funded by the Scottish Government. The aim is to test new integrated ways of working in order to respond more appropriately to individuals’ needs and growing demand for urgent care. These changes will not however respond to more pressing challenges of gaps in medical cover particularly over the summer and other holiday periods, budget deficit and requirement for cost savings.

**GP Workforce**

14. ADOC has employed ANPs for an extended period. The competencies and experience to operate in out of hours are specific and consequently ADOC has been developing this workforce. Once trained, however, the ANPs are very marketable and there has been a significant turnover with ANPs moving to work in other urgent care services or in GP practices. A new cohort has been recruited this autumn and the intention is to develop a larger number of Primary Care ANPs for Ayrshire and Arran through the ANP Academy.

15. Over several years the summer months of June, July and August, together with religious periods when it coincides, have been the most difficult period to effectively and safely cover the NHS ADOC clinical rota.

16. In previous years the ADOC administration staff constantly make pleading telephone calls supported by emails to all the local GPs and ADOC doctors to cover the vacant shifts. Their good will and effort has been pivotal in maintaining the service provision up to now, however this good will is all but exhausted and the doctors are avoiding their phone calls and emails. In
previous years various financial inducements have been provided to encourage up take of vacant shifts with a degree of success.

17. According to 2015 OOH GP Survey carried out ADOC is extremely dependent on a very few doctors to sustain the service and some of these doctors are working very long hours. This is a high risk position:

Total number of doctors contributing to ADOC is 177 doctors including trainees and 169 excluding trainees doctors of these:
- 4 doctors worked over 1000 hours per annum
- 10 doctors worked over 500 hours per annum
- 42 doctors worked between 200 – 499 hours per annum
- 113 doctors work less than 200 hours per annum

18. In addition, the number of doctors undertaking shifts per year is overall reducing with the exception of those working a small number of shifts. The 11-20 session bracket is a substantial reduction and impacts adversely on the service.

<table>
<thead>
<tr>
<th>Table 1: Number of GPs/Shifts per year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
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<tbody>
<tr>
<td>151+</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>9</td>
</tr>
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<td>41-50</td>
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<tr>
<td>01-10</td>
<td>73</td>
<td>70</td>
<td>73</td>
<td>84</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>187</td>
<td>192</td>
<td>180</td>
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</table>

19. During July and August 2016 the usual lack of GP cover was exacerbated by a number of ANPs resigning. Concern was raise that this would impact on the Emergency Departments with patients attending there instead if they could not get appointments through ADOC or had longer waits. As a consequence, and in order not to adversely impact on the Emergency Departments the weekend sessional rate of GP pay was applied to Friday evening rather than the usual working week rate. This increase in rates was in line with the recommendation of 2013 Option Appraisal and was sufficient to attract GPs. This action had to be repeated on the second Friday during the October half-term holiday.

20. It is very difficult to make a robust comparison of pay rates between Boards. Based on the information produced Ayrshire and Arran’s rates are competitive. The various shifts are paid at different rates by Boards. Information is collected on a regional basis but the comparison is not like for like as some Boards have salaried doctors but quote the hourly rate (excluding on costs), others provide additional payments in response to pressures which are not notified. In
addition, Greater Glasgow and Clyde, which competes for the same cohort of doctors as Ayrshire and Arran, provides holiday pay and covers doctors' indemnity, which can be expensive for individual doctors.

21. Work is underway to ensure that ADOC has the appropriate clinical resource over the winter period. As at 3 November 2016 there were 98 vacant clinical shifts in November and of these 18 are on a Friday evening. This is a concern moving into winter as the acute hospitals are already anticipating a challenge with the level of activity remaining high across the summer. Plans require to be enacted to respond to the gaps in rota over winter.

22. It is recognised that ADOC core clinical rota has essentially remained unchanged for many years and increased flexibility of working will be required moving forward. One of the tests of change which is being undertaken, as part of the OOH Urgent Care Programme, is local call triaging linked to alternative workforce. This will afford the opportunity to have a more holistic and coordinated approach in directing the public to the appropriate care pathway.

23. It is clear that in the medium to longer term there is a need to rethink and redefine the OOH service and align it with national service model. A paper has been provided previously to the Integration Joint Board setting out this direction. This being undertaken through the OOH Integration Programme, however change will be over a number of months and years in order to test and develop new ways of working, new workforce and new services and infrastructure. The national Urgent Care Fund provides an excellent opportunity to support this transition.

24. A survey is being undertaken currently to understand GPs reluctance to work in the OOH service. Possible reasons are:
   - A perception that the shifts are busier and more stressful than previously
   - A standard of completing full data on clinical findings, templates for ongoing audit and looking up medical history and anticipatory plans
   - Need for doctors to work flexibly due to vacant shifts and introduction of ANPs who require assistance at times
   - The increasing number of vacant shifts adds significantly to the workload of those working
   - National tax and superannuation changes
   - Increasing day time workload due to recruitment difficulty and patient need

**Demand and Capacity**

25. The national review report identified that as at 2015 there were 64, Primary Care Emergency Centres (PCECs) in Scotland. These are stand-alone units, most of which are co-located or in close proximity with Emergency Departments at Acute Hospitals and some are co-located with minor injury units/community hospitals. As noted above Ayrshire and Arran has three centres and provides some minor injury/ minor ailment care at Girvan Hospital and in Arran.

26. National activity data is provided in table 1 and 2 below. It should be noted that attendance is higher in more deprived populations with the top two most deprived, Scottish Index of Multiple Deprivation (SIMD), groups accounting for 48% of activity nationally:
Table 3: National OOH 2015 activity data by age group and type of consultation based on the last consultation recorded for the patient (PCEC / PCC is Primary Care Emergency Centre / Primary Care Centre):

![Chart showing activity data by age group and consultation type]  

Table 4: National and Ayrshire and Arran Activity 2015

<table>
<thead>
<tr>
<th>NHS Board of Treatment</th>
<th>Patients (cases)</th>
<th>Number and Percentage of Consultations</th>
<th>Percentage (based on Total Consultations)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate per 1,000 population¹</td>
<td>Total</td>
</tr>
<tr>
<td>NHS Scotland</td>
<td>432906</td>
<td>80.8</td>
<td>480391</td>
</tr>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>283911</td>
<td>76.3</td>
<td>30502</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>7533</td>
<td>65.1</td>
<td>14551</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>11354</td>
<td>79.7</td>
<td>12473</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>30321</td>
<td>82.6</td>
<td>32038</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>23552</td>
<td>77.7</td>
<td>25636</td>
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<td>NHS Grampian¹</td>
<td>47461</td>
<td>81.2</td>
<td>54960</td>
</tr>
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<td>NHS Greater Glasgow &amp; Clyde</td>
<td>116950</td>
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<td>136589</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>25669</td>
<td>81.0</td>
<td>27380</td>
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<td>NHS Lanarkshire²</td>
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<td>NHS Tayside</td>
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<td>51.3</td>
<td>43683</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>1473</td>
<td>54.1</td>
<td>1651</td>
</tr>
</tbody>
</table>

¹ Table includes estimated data for NHS Lanarkshire (12th August to 30th September) and NHS Grampian (5th to 11th August)
² Crude population rates are presented based on NHS Board of Residence populations
³ A patient (case) may have more than one consultation
27. The activity of ADOC shows around 400 – 500 contacts per week, Table 5.

Table 5: ADOC Activity, contacts per week

28. The quality of care provided by ADOC is reviewed against national clinical standards and triage times. This shows that the service has remained responsive. Table 6 and 7 shows the waiting times at the centres and achieving home visits assessed as a one hour timeframe. Table 7 shows the impact of vacant shifts on performance.
Table 6: Waiting Time at Primary Care Treatment Centre, target less than 35 minutes, 90% of the time.

Table 7: Home triage target of 1 hour met.
29. Consideration of ADOC activity over the summer months shows a reduction in activity of circa 20% as below. There is an opportunity to align the clinical resource more effectively with the seasonal activity.

**Table 5: Reduction in activity over summer**

![Bar chart showing percentage difference from yearly average for 2013-2015]

30. A more detailed analysis has been commissioned from NHS Ayrshire & Arran Information Services.

**Financial Position**

31. The total annual budget for ADOC for 2016/17 is £5,313,940. Of this budget £3,655,921 is related to medical sessions. The current projected overspend for ADOC services is £250k. The overspend in 2015/16 was £281k. There are several contributing factors to this overspend, some of which are recurring in nature. A pay and supplies bid has been submitted to NHS Ayrshire & Arran for 2017/18.

32. Firstly, in 2015/16 the pay and supplies bid process received an abatement of 28% on all uplifts. ADOC had two separate bids:

- Implications of the HMRC process and the transfer of ADOC GPs onto NHS Ayrshire & Arran payroll for tax and National Insurance purposes – this bid was for £200k and awarded at £144k
- Implication in the change in rates for Public Holidays – this bid was for £200k and awarded at £144k
33. The shortfall in the bid process was £112k, which has left ADOC in a worsening financial position as the costs have been realised.

34. Secondly, in preparing the 2016/17 pay budgets, it was identified that there were areas ADOC operational staffing budgets that were funded as less than or equal to fully rotational, but the nature of the service is that these posts are paid more akin to nights only. This has not been so obvious in previous years due to staff levels being under established, however as the headcount has increased to meet the increasing demands on the service, it has become more obvious that there is a need for the funding levels to be increased to reflect the nature of the enhancements being paid. This relates to ADOC operational team and ADOC drivers. This additional cost is £117.5k.

35. The Pay and Supplies bid recommends that the Board provide an uplift to resolve the two recurring issues of £229.5k which would address the overspend.

36. In addition, to covering the above under-funding the Board requires a cost releasing efficiency saving (CRES) of 5% against all budgets. For ADOC this equates to £265.7k. At the same time as outlined in paragraphs 8 and 21 above the weekday rate for ADOC has not been uplifted for inflation and this is now impacting on GPs working on Thursday and Friday evenings in particular. The cumulative loss in DDRB uplifts (which have not occurred since 2007) is 13.5% and a 13.15% uplift to doctor pay rate weekdays only Monday—Friday would cost annually £128k.

37. The service has proposed to support funding this uplift through a reduction in service over the summer, in line with reduced activity. It has been suggested that the following changes could be considered. The impact and saving from these require further quantification:

- June through to August reduce one evening mobile from four to three cars reductions of 60 mobile sessions over 12 weeks
- Potential reduction on Saturday and Sunday in static shifts by one evening shift at Ayr and one evening shift at Irvine from May to September removing four sessions per week for 21 weeks

38. As outlined elsewhere on this agenda there are proposals to balance the 2016/17 on a non-recurring basis. If the overspend and CRES saving was required in 2016/17 this is a saving of £515.7k and would focus mainly on the removal of medical sessions as other staff costs could not be saved without staff redeployment. The total annual budget on medical sessions is £3,655k. Hence the saving would equate to a significant reduction in service highlighting the need for redesign within available resource.

Risks

39. As outlined earlier there are significant gaps in the rota leading up from now until January with a pattern of gaps particularly on Thursday and Friday evening. Friday evening is one of the busiest nights of the week for the Emergency Departments. The types of gaps in rota identified will require closure of centres.
40. The Acute hospitals and clinical leads for emergency care express significant concern about centre closures as the expectation is that people who are unable to receive a service from ADOC will attend the Emergency Departments. During the summer urgent meetings were held with acute colleagues and the decision was taken to pay Friday evenings as part of the weekend. There will also be significant consequences for daytime primary care services with some patients seeking urgent appointments the following working day.

41. As part of any changes planned an assessment is required of what would be the safe minimum level of GP cover required to run the service.

42. The non recurring solution to 2016/17 pressures has been required as alternative savings identified to address the overspend and CRES savings could not be safely instituted in 2016/17 as this would require significant reductions in home visits. Patients who receive home visits will be those who are most unwell and at risk of deteriorating very quickly. As identified in the activity data they are likely to be either older people or young children. Consequently there would be an unacceptable risk of a person coming to significant harm.

43. It is not envisaged that it would be prudent to reduce ADOC services over the winter.

FINANCIAL IMPLICATIONS

44. This paper sets out the financial position, the challenge of achieving a balanced budget and risks related to cost savings as well as the transformation agenda for urgent out of hours care.

HUMAN RESOURCE IMPLICATIONS

45. The transformation of urgent out of hours care will require new multi-disciplinary ways of working. Achieving a balanced budget and CRES would require a reduction in sessional and salaried staff.

LEGAL IMPLICATIONS

46. There are no legal implications arising from the report.

COMMUNITY PLANNING IMPLICATIONS

47. A reduction in service provision would require consultation and engagement.

EQUALITY IMPLICATIONS

48. A reduction in service provision would require an equality impact assessment will be undertaken.
RECOMMENDATIONS

49. The Integration Joint Board is requested to consider the following recommendations:

   i) Continue with transformational change with the eventual aim of reducing the number of doctors on shift with the remaining clinical interventions provided by other health care professionals who have relevant skills and training including independent prescribing;

   ii) Continue with service integration in order to achieve that people are provided with the right care from the right health, social care professional or third sector;

   iii) Continue to move to a skill mix with a higher proportion of ANPs;

   iv) As part of the redesign and within available resource, increase payment for weekdays in response to the 2013 option appraisal, possibly targeted at difficult to fill shifts;

   v) Review the mechanism of offering shifts to be more responsive and to reflect GPs who commit to the service on a regular basis and learn from the GP survey about what make the service attractive to work in;

   vi) Undertake a detailed review of capacity and demand to inform service configuration, including the testing the See and Treat / Local Urgent Care Centre in North Ayrshire and closer working with UHC Emergency Department;

   vii) Recognise the funding challenges of the existing service and the challenges and risks linked to achieving a balanced budget as well as cost efficiencies in 2016/17; and

   viii) To otherwise note the content of the report.

Pamela Milliken,
Head of Primary Care and Out of Hours Community Response Services
11 November 2016