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TRANSCRIPT OF "FILE ON 4"- OUT OF HOURS GPS

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ACTUALITY OF PHONE CALL

RECEPTIONIST: How can I help you, sure?

MAN: Well, they've been trying to get in touch with somebody all day long …

RECEPTIONIST: Uh huh.

MAN: Now we are getting very very anxious about it.

HILL: One man's frustration turns to anger after hours of waiting for a doctor to visit his dying mother-in-law.

MAN: I think this is absolutely diabolical …

RECEPTIONIST: Okay sir.

MAN: And I want something done immediately.

HILL: That recording – made in December – is a symptom of the difficulty which many people are experiencing in getting a doctor to visit out of hours. Last year GPs' contracts were changed, allowing them to opt out of evening and weekend shifts. Providing cover is now the responsibility of Primary Care Trusts.
File on 4 has investigated the effect this is having on patients. We've obtained new evidence that doctors in many parts of the country are failing to get to very ill patients in time. And many out-of-hours services have told us they're facing cut-backs because their budgets simply don't balance.

SIGNATURE TUNE

ACTUALITY OF HOME VISIT

VIJAYA: It's the doctor.

VOICE OVER INTERCOM: Okay. [DOOR BUZZES OPEN]

VIJAYA: Now, what can I do for you?

WOMAN: I get up and walk just to the door …

VIJAYA: Yes …

HILL: It's the start of Dr Vipran Vijaya's night shift in Birmingham, and his first call is to an elderly woman with heart problems and breathing difficulties.

VIJAYA: I'm just going to check your blood pressure now, all right?

WOMAN: Uh huh.

VIJAYA: Okay now, what I want you to do, can you stand up for me?

HILL: Dr Vijaya is a GP, but this isn't one of his patients. He's working for the private company Prime Care, which provides out-of-hours cover for the city. Last April, doctors like him were able to opt out of their responsibility to provide night time and weekend visits for their patients. It was part of the new contract GPs had negotiated with the government.

WOMAN: Okay.

VIJAYA: All right?

WOMAN: All right, thank you. [DOOR SHUTS]

HILL: So now, when he does a shift for Prime Care, Dr Vijaya gets paid extra, but he has cover a wider area.

VIJAYA: There can be days when you can be very busy, sometimes the weekend.

HILL: And what happens if you get too many calls to do?

VIJAYA: If we get too many calls, it depends on how busy you are yourself. If you are able to actually complete those calls, that's all well. If not, then it will normally be passed on to another clinician, if they are able to help you. Or, if there's going to be a delay, then usually we ring them up and tell them there will be a delay with the visit, so they can make a decision on whether they want to go to the hospital or wait for the doctor to visit.

HILL: Overall responsibility for out-of-hours cover now rests with Primary Care Trusts. Many choose to use private companies like Prime Care, which has contracts with a tenth of all the PCTs in England. Some patients have already noticed a difference.

ACTUALITY WITH DUCKS

MANS: Come along, come on, come along!

HILL: Rosemary Mans keeps prize-winning ducks at her home near Hereford. Her family roots and traditions are very much in the Herefordshire soil and its rural way of life. At Christmas, her 84 year old mother Dorothy developed a serious chest infection. The family called Prime Care on the morning of December 28th.

MANS: She'd become very delirious and tired, exhausted, had a problem breathing and we decided to call for the doctor. Our own GP wasn't on duty. She said that they were extremely busy, they'd had a lot of illness and that she was on the list and due for a visit, but they couldn't give a time at all.

HILL: We've had access to tape recordings of the various conversations the family had with Prime Care. The first was shortly before 11 in the morning and the calls continued throughout the day.

ACTUALITY OF CALLS

MANS: My name's Rosemary Mans. I rang earlier this morning, about 10.30 …

RECEPTIONIST: Yes?

MANS: A call about my mother-in-law that's poorly …

RECEPTIONIST: Okay, yes.

MANS: And although a doctor has rung back and said they'd be coming, have you any idea when they will be coming, because this is six hours ago.

RECEPTIONIST: I've rung to the Hereford team now, what's happening with the call, and they said they are very busy and they can't give us a time because there are several calls in that area the doctor is dealing with at the same time.

HILL: By the evening the conversations were becoming increasingly heated.

ACTUALITY OF PHONE CALL

MAN: Now we are getting very very anxious about it.

RECEPTIONIST: Okay.

MAN: I think is absolutely diabolical.

RECEPTIONIST: Okay, sir.

MAN: And I want something done immediately.

RECEPTIONIST: Okay, sir. If you just bear with me, I'll check to see how long it'll be, okay?

MAN: Yes.

RECEPTIONIST: Hello?

MAN: Hello.

RECEPTIONIST: I have just checked with the dispatcher, and they say they couldn't give you a time exactly, unfortunately, but we are extremely busy, okay? But the call has been logged and somebody will be there as quickly as they can.

MAN: But they have been saying that all day long. We've been having that, this is what we've been having all day long. I am sorry I cannot accept that. I want a time and I want somebody out there quick.

HILL: A doctor from Prime Care finally arrived at nine o'clock that evening, some ten hours after the first call.

MANS: He just examined her chest and took her blood pressure - after we suggested he was to take her blood pressure. I said to him, does he think that she'd got bronchial pneumonia, and he waved his arms at me and said, 'No no, all chest infection,' and just said, 'Give her two antibiotics now, two in the morning,' and left a repeat prescription.

HILL: But shortly after the doctor left, Dorothy Man's son found her lying dead in bed.

MANS: He said, 'I think mum's died.' Well I just froze on the spot, totally. We were just devastated, it couldn't possibly have been true. The doctor had left her 45 minutes ago and the next thing you know she's died. Had we rang for a vet, a vet would have been there within a couple of hours and she'd have had some treatment. I mean, it makes you wonder whether we should have gone down that route. It's appalling really, as we can't get a better service than what we're getting. I mean, when it was just with our own GPs, at least they would have seen us within a couple of hours, whereas it now, it seems as though the pressure's on, there's not the doctors on duty. I mean, what chance do we do we get? We will never know, if a doctor had been able to come out a lot sooner, she could have been with us today.

HILL: The family complained to Prime Care about the delay. Its Medical Director is Dr Bill Holmes.

HOLMES: We have apologised for the fact that, at the busiest time of the year, a particular call was delayed, by the time the doctor arrived. But I think it is important to include in your description of that particular problem that the family were contacted on several occasions - the call wasn't lost - to make sure that the patient's condition was kept under review, and the doctor was not sitting twiddling his thumbs; he was round visiting lots of other patients who needed to be seen.

HILL: What was the demand like that weekend in question?

HOLMES: It was at an all time high.

HILL: Could you have anticipated that?

HOLMES: Part of the skill which all out-of-hours providers have is to anticipate demand, and one of the ways in which we measure the success of the service is by being able to demonstrate that we have the appropriate number of clinicians, call handlers, etc, to the demand that we predict. But we do need to remember that we are providing a service which is open-ended. We don't have any control over the number of calls that come in, and so when there are surges in demand, as there are from time to time, there is a knock on effect from that.

ACTUALITY OF PHONE CALL

MICHAEL: Good evening, Prime Care, Michael speaking. Are you calling on behalf of yourself or somebody else? You're calling on behalf of yourself. Thank you. Are you at home at the moment?

HILL: This is Prime Care's call centre in Birmingham. It's a massive warehouse with banks of call handlers who take down basic details. There are also a number of nurses and doctors who do the telephone consultations to decide whether a home visit is required. Every call has to be assigned one of three priorities if they are to have face-to-face consultation with a GP. Routine calls must be responded to within six hours. More urgent cases must be seen in two hours. And emergency consultations, priority 1 as they're known, must start within the hour.

MICHAEL: What I'm going to do now, I'm going to pass the call through. You will receive a call back from a doctor or a nurse to offer some advice. They will contact you on your home telephone number. Okay Margaret, thank you very much for calling. Bye bye.

HILL: How well they perform is always monitored, and the data shared with their customers, the PCTs. But it's never shared with the public. However, File on 4 has obtained Prime Care's national data under the Freedom of

HILL cont: Information Act. For Priority 1 emergency calls, the company is supposed to reach a target of attending 90% of calls within one hour. But their average figure from last August to February is just 60%.

HOLMES: There has been a steady and gradual improvement in the figures over the last twelve months.

HILL: Well not in priority 1 – it's 57%, 60%, 58%, 56%, 69% for February. I mean, it seems a bit of a plateau generally.

HOLMES: Well, I'm not sure I would agree with that. I mean, I think that that is an improvement. A target has been set nationally, to which we aspire and which we hit much of the time.

HILL: But priority 2 ones to be done within two hours, a similar figure there – late 60s, early 70s throughout that period.

HOLMES: I don't seek to hide the fact that we are struggling to hit the target that we have accepted, which the government has set, but I believe that the service that most patients receive has been gradually improving during that time. I think you have to compare that with how the service was in years gone by, and I think there has been an improvement during that time.

HILL: So it was even worse before?

HOLMES: Well, I think that's rather a negative way of looking at it. I mean, I think that it is the case that for the majority of patients, the service that they receive has got better.

HILL: As more GPs have opted out, that's meant more work for the largest call handler of them all.

ACTUALITY OF RECORDED MESSAGE

FEMALE VOICE: Thank you for calling NHS Direct. To enable us to respond to your inquiry correctly, you will be asked for some personal details, including ...

HILL: NHS Direct now covers 40% of the English population. They too have never published their performance figures. So, again, File on 4 applied for them under the Freedom of Information Act. We were given figures from November 2003 until January this year. Until then, government targets required 90% of phone calls to be assessed and completed within 20 minutes. NHS Direct's average rate for the same period is 56% - well short of the target. The organisation's spokesperson is Pam Bradbury.
You were supposed to have been doing a proper clinical assessment within twenty minutes, dealing with 90% of cases. You've, on average, achieved 50% to 60% of cases. That's considerably below the target.

BRADBURY: That was the old quality standard and clearly we were not achieving that then. We have moved on since then and we are now working to the new quality requirements.

HILL: But you clearly have not been meeting those very recent targets.

BRADBURY: We are definitely meeting those targets to achieve the start of an assessment within twenty minutes, we are achieving that target.

HILL: But you haven't achieved the previous targets by some margin.

BRADBURY: No we hadn't.

HILL: Only around half of your calls have been answered within thirty seconds, when it should have been around 90%.

BRADBURY: It's certainly a lot higher than that now. Again we are aiming to improve these. We are continually striving to meet these quality requirements.

HILL: The number of calls to NHS Direct has risen by 17% over the past year. But there are questions about how effectively they are coping and whether they're putting too much pressure on staff.

ACTUALITY SHOWING MANUAL

WATSON: This is an image of what we would actually see on the computer screen while we were talking to the caller. For example, with a caller who had a headache, you would then go into …

HILL: Heather Watson worked for NHS Direct as a nurse advisor for more than two years. As her job went on, she found it harder and harder to deal with the workload.

WATSON: As the volume of calls increased, there was a lot more emphasis put on it. We had monthly feedbacks and it would be highlighted if we'd taken quite a lengthy time over the calls, they did expect us to do about six calls an hour. You've got that added pressure, so you are really concerned about whether or not you might miss important information.

HILL: And what did they say to you when you were doing fewer than six calls an hour?

WATSON: They just analysed the times and say, well, perhaps you need to cut your time on when you're actually completing the call, when you're doing the write up at the end, not leave so many lengthy gaps in between calls, and just try to condense the calls a little bit better.

HILL: And what did you say to them about that?

WATSON: Well, I told them my concerns really, that it's not always possible when you're dealing with people, you know, it's not like selling a product or a credit card or something like that, and every case is individual, and I didn't think it would be safe to rush through calls.

HILL: Did you rush through calls?

WATSON: I tried not to.

HILL: Since she left over a year ago, Heather Watson has remained in touch with former colleagues and claims the service is still overstretched. But Pam Bradbury of NHS Direct insists their staffing levels are safe.

BRADBURY: We are not a target-driven organisation. We do not push targets. We do not expect our staff to get through x number of calls an hour.

HILL: But if you've got call volumes, patients waiting to be seen, surely managers must say to the nurses, look, you know, you've got to deal with these patients more quickly.

BRADBURY: I would hate to think that we saw them in that way, because at the end of the day patients are needing care. The managers will support the staff to meet the quality requirements, and if it's that we need more staff within the call centres, then that's what we do.

HILL: So you can categorically state that your nursing staff have never been told that they have to work towards dealing with six patients an hour?

BRADBURY: You're talking about one nurse. We have a workforce of four thousand. I can't comment on one individual nurse's perception. She was obviously clearly unhappy in the decision to go and work for NHS Direct. I think we have a strong workforce out there. Nobody is going to carry on delivering a service that we think would be unsafe for patients.

HILL: The major providers, Prime Care and NHS Direct, may be struggling to meet demand. But they're not the only people involved in providing out-of-hours cover. Some Primary Care Trusts are doing it themselves and others are paying locally run GP co-operatives or small private companies. And, according to our research, they too are not meeting targets.

ACTUALITY OUTSIDE HOME

HILL: I am standing outside the Ladywood Nursing home in the Derbyshire village of Kirkhalam. For its 44 residents, there's always three nurses on duty in the day and one at night. But when it come to getting hold of a doctor out of hours, staff here have had to wait a very long time.

PAT: I'm so cross and upset. I'd like to swear about it. I hate to think of my mother suffering, and she needn't have done. She was such a sweet lady. I think she could have been helped a lot.

HILL: Pat Partington and her husband Ken are still angry about the time it took for a GP to get to the nursing home. Staff were concerned about Pat's mother, Gladys Kinner who, at the age of 100, had become seriously ill.

KEN: There was the initial call at half past eleven and then there was a further call at 4 o clock in the afternoon. The person who took the call, we understand, said we will give this call some urgency, a relatively high priority. And then there was discussion by the care staff at the home, who asked that the attending medic should have some analgesic to alleviate Gladys' distress. The doctor did eventually arrive at twenty past one, without analgesics that had been specifically requested.

HILL: What do you think of that?

KEN: I think it's appalling. I mean, where is the communication between those that pass on the messages from the call centre to the guy on the ground? You don't like to think of anybody's last few hours having to endure torment, avoidable torment really.

HILL: The Partingtons have complained to the Health Service Ombudsman. Derby Medical Services, the co-op that runs the service, have refused to be interviewed. But in a statement they say they intend to send an unequivocal apology to the Partingtons. They point out that over the New Year weekend, the service struggled to cope with the demand, which was four times higher than they had expected.

HILL cont: Their statement does not directly address the allegation that the home's request for strong painkillers was not met. This is not the only GP co-op in England that has had problems meeting demand. Under the Freedom of Information Act, File on 4 asked 21 Primary Care Trusts across the country what percentage of emergency callouts they were achieving within one hour. Thirteen either met, or weren't far off the 90% target. Three said they did not have the information, despite being required to by the government. Of the rest, five - that's almost a quarter - were falling well short of the target. One of them only met 13% of these calls within the hour, instead of the 90% required. The minister responsible for GPs is John Hutton.

HUTTON: It's the first time we've had any national minimum quality standards applying for GP out-of-hours services, and they're designed to try and make sure, as far as we possibly can, that patients can have confidence in whatever part of the country they're in, services will be of a certain minimum standard.

HILL: But our snapshot across England of twenty different Primary Care Trusts shows that yes, the majority of the targets seem to be met, but there are a significant number where they are well short of those targets.

HUTTON: Yes that's true and I think that is clearly a matter that the Primary Care Trusts have to have to pick up with and we ourselves will make sure that we work with them to oversee improvements.

HILL: So the standards are, to a certain extent, limited by your postcode, where you live at the moment?

HUTTON: No, the standards apply everywhere in the National Health Service. It is the responsibility of the Primary Care Trusts to make sure that those standards are complied with, and where they're not being complied with for action to be taken at an appropriate level to deal with those failures. If you're saying to me, are out-of-hour services perfect, my answer is very clear - no they're not. Have they ever been perfect? No they've never been perfect. Are they getting better? I believe they are.

HILL: It's not just meeting targets where PCTs are having difficulty. It's becoming clear that, for many, the full cost of the new contract is more than they bargained for.

ACTUALITY IN YORK

HILL: This is York where, until recently, one of the countries largest co-ops was based. Since 1996, North Yorkshire Emergency Doctors, or NYAD as it was known, had been providing out-of-hours cover over a 6000 square mile patch. Before the new contract kicked in, family doctors paid them directly to cover evenings and weekends. But, according to NYAD's chairman, Dr Jamie MacLeod, when the PCTs took over responsibility for paying the bill, the financial climate changed, and negotiations became much more difficult.

MACLEOD: In some cases we were dealing with very good people who understood the whole service. In other cases we were dealing with people who didn't have a full understanding of the service and were very adversarial in the way they wished to conduct the contracting process. Quite a few PCTs worked on the basis of we have such an amount of money, you have to provide a service to fit it.

HILL: Did your income change overnight with this new arrangement?

MACLEOD: It changed by the order of 10%. We hoped that we'd be able to cope with that shortfall by various measures, merging with A&E departments, but it became clear that those were not going to happen as quickly as we wished.

HILL: And how shortly after that did you notice you were struggling?

MACLEOD: We noticed towards the end of November and we were therefore heading for a deficit. What we immediately did was to contact the Strategic Health Authority and the PCTs and asked whether we could have another £1 per patient to maintain the service.

HILL: And what did they say?

MACLEOD: The answer was negative.

HILL: As the weeks progressed, it soon became clear the financial difficulties were getting much more severe. And as a not for profit company, NYAD could not go into debt. Janet Probert was one of the negotiators on the other side. She represented Craven, Harrogate and Rural District Primary Care Trust - one of the nine PCTs which relied on NYAD. She denies the stance taken by the trusts was unreasonable.

PROBERT: We did spend a long time in discussions with NYAD. We have a letter from NYAD, confirming an agreed contract price that we agreed to pay them from the 1st October to 31st March, which was an agreed amount which we paid in six equal instalments. So when the service started, there was no disagreement about what we were paying.

HILL: But we've had correspondence from NYAD, which clearly flagging up in the very early days their difficulty in actually surviving financially under the regime. You were aware of that, were you?

PROBERT: There was a lot of correspondence between our organisations during the period when we were negotiating the contract. But I have a letter from them agreeing the contract price, and that is the price we worked off.

HILL: With the stalemate between the various parties, crisis was inevitable, and in December last year, NYAD became the first GP co-operative to go bust since the new arrangements came in.

PROBERT: There was a date in December where our finance people were meeting with NYAD's finance people. They had a meeting with, at that point it was a consultant who was acting as their Chief Exec, and he told our finance people that they didn't know if they would be able to open for trading that day. This was about 12 o'clock. We obviously contacted our lawyers and organised an emergency meeting, and

PROBERT cont: NYAD's lawyers got back to us to say that they would open that night at 6 o'clock, but they didn't know whether they'd be able to open the following Monday.

HILL: So there was a distinct possibility that, just days before Christmas, you may not have been able to provide an out-of-hours service?

PROBERT: That's right, so ten PCTs had to send action plans to their Strategic Health Authority, saying how they would continue to provide an out-of-hours service over the Christmas period if NYAD ceased to trade. There were discussions over that weekend between our chief executives and the NYAD directors, at which point it was agreed they would go into voluntary administration.

HILL: The Ambulance Trust for North East Yorkshire now provides GP out-of-hours cover for the area. Harrogate PCT has to pay the trust £1.5 million a year for this. Like the other PCTs, it's had some extra support from the government. But, according to Janet Probert, there's still a shortfall of £650,000.

PROBERT: It's one pot of money, and all these challenges, you have to do the things that are statutory requirements. So there will be a number of other services that I'm sure we all feel we ought to be investing in, but actually at the moment this isn't a service, we can't have a safe service in.

HILL: Can you give me a few examples of those areas?

PROBERT: We're one of the few PCTs in this area that doesn't have a community children's team, so our children with long term conditions and time limited illness have to either come into secondary care or be managed by an adult team. We don't have children's nurses in the community at the moment that can work with those families and provide the level of care we think they should have. I don't think anyone would feel that's the best way to manage this group of children.

HILL: There's no doubt the new GP contract is proving expensive for the PCTs. They do get extra money from the government to help pay for the out-of-hours services. They also receive £6,000 from each GP that opts out. But, under the new contract, they have to fund a pay rise of 20% for all family doctors, and it's against this background that many are negotiating contracts with out-of-hours providers, such as GP co-ops. File on 4 has carried out a survey of members of the National Association of GP Co-operatives. All sixty-three co-ops were sent a questionnaire. Thirty responded. Of the ones who replied, seven said they were facing cuts. And another fourteen, that's almost half, still didn't know, even though they are on the verge of a new financial year. According to the Association's spokesperson, Eric Peacock, who also runs a co-op in the north east, the problems go back to the deal the government struck with GPs.

PEACOCK: I cannot find – and I've asked many questions – of who worked out how much that funding should be. You look at the GMC contract that the doctors all signed the new one, and they lost £6,000 of their income because they are allowed to opt out of out-of-hours. But there's no correlation between that £6,000 and the actual cost of running an out-of-hours service. There's something like 60% funding and a shortfall of about 40% that the PCTs are having to find somewhere else. We've been in negotiations for quite a few months and they keep coming back saying, 'Can you try and reduce numbers of doctors on duty at different times?' but I think we're now at the stage where we've cut back to the very minimum that we feel that we can provide a safe and reliable service with.

HILL: What happens if they don't come back with the money you need?

PEACOCK: I will have to start getting rid of doctors and staff.

HILL: The Health Minister, John Hutton, insists PCTs have been given enough money to fund the new arrangements.
Where did you come up with this figure of £6,000 for GPs to lose if they no longer did out-of-hours?

HUTTON: That was a negotiation with the BMA over the new contract.

HILL: But how was it plucked out of the air, that figure?

HUTTON: It wasn't plucked out of the air. It was the result of some careful costing and economic analysis that we and the BMA did together, and it was figures that we agreed on together.

HILL: Do you think, in retrospect, that was enough to ask?

HUTTON: I think it was enough to ask in the context of those negotiations on the new contract. We, in addition, have doubled the NHS investment going into out-of-hours services, to make sure that PCTs have the right level of investment available to them locally to ensure the quality of these services.

HILL: The £6,000 you've asked each GP to take as a hit to opt out only accounts for about 60% of the actual cost of the service, and the Primary Care Trusts are having to find out of their own coffers money from elsewhere.

HUTTON: No, I don't accept that at all. I think that's a misreading of the situation. Primary Care Trust budgets rose by over 10% in cash terms last year, and we doubled the specific grant that we made available to Primary Care Trusts to provide for continuity in the provision of out-of-hours services. So I don't buy the argument that you've put to me, that this whole situation is characterised by cuts, by inadequate funding and by some scaling back of resources from the centre. Quite the opposite is the case.

HILL: Harrogate PCT tell us they haven't been able to provide nurses in the homes of children with life limiting conditions, as they should under the national service framework, because that money is needed to make up for the shortfall in out-of-hours GP services.

HUTTON: We've doubled the investment available to Harrogate PCT to support their out-of-hours services, so I'd certainly want to pursue that individual matter with the Primary Care Trusts, so I understand precisely what it is that they're saying to you, but clearly that is not an acceptable situation, and I don't believe that that position in any way accurately describes the national position facing Primary Care Trusts in England in dealing with out-of-hours services.

HILL: Whatever the causes of the shortfall, there's evidence that in some parts of the country, doctors are thin on the ground. In North Somerset there are just two GPs out-of-hours, covering more than 200,000 patients. South East and South West Oxfordshire has a population of 280,000. After 11 o'clock, there are only two GPs - one that patients generally travel to, the other one on call at home. Back in Yorkshire, GPs are also feeling stretched.

ACTUALITY IN CAR

HIXON: This is a seaside town, it's a holiday resort in the summer with a large number of tourists, and we also get a lot of day visitors during the better weather. We are going now to see an eight year old little boy who is complaining of pain in the stomach really, and you've always got to bear in mind whether it could be appendicitis.

HILL: Dr David Hixon is an advisor to the Ambulance Trust, which has taken over from NYAD, the doctors co-operative which went out of business. He also does out-of-hours shifts, and when he's on call has to cover a population of 45,000 people around Bridlington.

ACTUALITY AT HOUSE CALL

HIXON: Hello. What's your name?

AARON: Aaron.

HIXON: Aaron, right. And we'll have a look at, it's your tummy, is it, that's hurting? Oh dear me.

HILL: He says it's a long way from the situation ten years ago, when there would have been numerous doctors on call in the town.

HIXON: There's normally one doctor based here in Bridlington Hospital providing the out-of-hours service when the shift is filled. Unfortunately sometimes it's not possible to find somebody to fill a shift in any given town. So what happens is that the town has to be covered by a doctor who's covering a neighbouring town, which may be twenty or thirty miles away, and this does happen on quite a number of occasions. The situation is improving in recent months, but certainly before Christmas there were a lot of occasions when large areas of the county had no cover at all other than somebody thirty miles away. It is frightening really for the public, and I'm not entirely sure that most of the public have realised quite how bad it was. The fallback position for a serious illness or injury is that the patient can either dial 999 themselves or the person taking the call can send a 999 ambulance round. The difficulty with that is that the ambulances are run by the same organisation as the out-of-hours service, but the emergency ambulance crews have been absolutely hammered since the out-of-hours opt-out, and they're finding that their shifts are becoming intolerably busy with longer waits for emergency ambulances, and I've had situations myself where I've been waiting with seriously ill or injured people for a very long time indeed for an ambulance at times.

HILL: And that, you believe, is directly linked to the changes in opting out of the contract?

HIXON: Yes, I think it is, because what's happening at the moment is that the emergency ambulance crews are picking up the pieces from the GP out-of-hours service.

HILL: And, according to our research, other emergency services are also having to take up the burden of the change in GP out-of-hours arrangements.

ACTUALITY IN A&E

SHALLEY: This is our walking wounded area. We have eight cubicles along here, all filled with patients waiting to be seen …

HILL: Consultant, Martin Shalley, is in charge of the accident and emergency department of Heartlands hospital in Birmingham.

SHALLEY: Trolleys on our right are for those with more pressing injuries, where we need to examine them on a trolley.

HILL: How busy can this place be?

SHALLEY: Oh, we can be inundated, about two hundred patients a day will come through this area.

HILL: Mr Shalley, who is president of the British Association of Emergency Medicine, says he and his members have noticed more and more patients coming through the doors out of hours because they have difficulty getting hold of a GP.

SHALLEY: Until this year, the annual rise had been about 2%, this year we have seen here an annual rise of 9%. This is borne out by national figures of between 8 and 9%. Nothing else much has changed in healthcare other than the change in GP out-of-hours provision. We think that that has probably had a significant impact on our attendances.

HILL: The government say there is no evidence that there is a link between changes to the GP contract and demand on your service.

SHALLEY: Almost all of us have an idea that our workload has increased. On occasions we noted that up to seventy patients out of something like 270 could be construed as GP or Primary Care patients. I think it reflects patients' concerns about how to access Primary Care. If you are unsure, you will go to where you know you can get seen and treated.

HILL: File on 4 sent a detailed questionnaire to all 660 members of the British Association of Emergency Medicine across the UK. Ninety-seven responded. We asked them to give us figures for the month of December, and asked

HILL cont: whether patients had visited A&E because they said they could not see a GP out of hours. Seventy-eight said yes and two said no. A significant number who responded to our survey said the extra demand caused by GP out-of-hours changes was making it very difficult to cope. Indeed, during last December, ten consultants said patients had suffered harm as a consequence of the change in out-of-hours GP cover. Two said it had even led to patient deaths. However, Health Minister John Hutton does not accept there is a link and maintains that the rise in demand on casualty services took place before the new GP contract came in.

HUTTON: There's been a double digit rise in attendances at all of our emergency treatment centres, including emergency A&E centres, and that has been a trend that has been in place for several years in the National Health Service, a trend that pre-dates the movement of responsibility for organising out-of-hours services.

HILL: But our survey of members of the BAEM would suggest the out-of-hours changes had had a direct effect on the activity of their unit. Seventy-eight of those ninety-seven who responded said that patients visited A&E in that month because they couldn't see a GP. Only two said that that wasn't the case.

HUTTON: I understand that, and it is a commonly held and expressed view. All I'm saying is that when we've looked at the detailed information and the figures, we have not been able to track any direct correlation whatsoever between those Primary Care Trusts that were the first to operate these new arrangements, and attendances in A&E departments. In fact, when we compared those PCTs that had operated the new arrangements and those that hadn't, the increase in attendances at A&Es were the same.

HILL: And ten of those felt that patients had suffered harm because of these new arrangements, and two said that patients had died because of these new arrangements during December last.

HUTTON: Well obviously that would be a terrible thing to have happened. I'm aware of one case in Northumberland where a lady did die, and there has been a full report and inquiry made by the local NHS into that incident. I'm not aware of other individual cases, but so far one case has come to my attention and we have done a full inquiry into that.

HILL: File on 4's survey certainly doesn't represent a definitive picture across the country, but it is a further sign of problems with the new out-of-hours arrangements. We've heard evidence of delays in responding to patients' needs; claims from doctors that they are being stretched too thinly; and warnings of a financial crisis looming for the year ahead. It's an issue which will face whatever government is in power after the coming election.

SIGNATURE TUNE