Sustainability and Seven Day Services Taskforce

Interim Report

March 2015

The Scottish Government
Riaghaltas na h-Alba

Introduction

In late 2013 the previous Cabinet Secretary for Health and Wellbeing set out a vision for sustainable seven day services. It focussed on providing round the clock care for those who need it the most, with a genuinely seven day service for acutely ill patients. It also stressed the importance of patients receiving the support required to move through hospital and be discharged whatever the day of the week. He recognised that the NHS had already adapted to operate on a seven day basis, but said that more needed be done to remove inappropriate variation in how care is provided at weekends. A programme was established headed by a Taskforce to drive forward progress towards that vision.

The Taskforce met for the first time in April 2014 and this interim report provides you with an update on the work undertaken to date and suggests the next steps that are required to deliver the programme.

Context for the programme

The Scottish Government's ambition is to consistently deliver high quality care, whenever patients need it.

There is a broad consensus that the delivery of appropriate seven day services will improve patient care and clinical outcomes. It is about responding to the needs of patients and ensuring that the whole system works more cohesively and effectively. It is also ensuring that patients receive the same quality of care irrespective of the day of the week.

The overall context of this work is the Healthcare Quality Strategy for NHSScotland and the 2020 vision for Health and Social Care. In the context of quality this means a recognition that the model for the services provided must reflect the needs of patients and their families, and be delivered at the right time and in the right place for that patient. We need to develop health and social care systems to meet the significant demographic and financial challenges faced by our health and social care services. NHSScotland's approach to this is articulated in the 2020 vision and we note the recent announcement from the Cabinet Secretary for Health, Wellbeing and Sport that she will work with stakeholders to develop a refreshed routemap to 2020 and beyond by summer 2015. In developing a programme to deliver sustainable seven day services, we cannot just focus on hospital care. The complex interdependencies of the healthcare system mean pressures on one part of the system will inevitably impact on another. Designing an overall service that is sustainable is crucial.

In common with all healthcare systems in the developed world, NHSScotland faces a challenge with regard to sustaining a suitably trained workforce over the next 5-10 years. The Taskforce has been asked to identify the optimal service models and consider what is needed to deliver them. We recognise that the NHS Workforce already deliver services across seven days and as the programme develops the workforce implications of it will be considered carefully in partnership with the Scottish Government, NHS Employers and Staffside. This work will link with the vision for the NHS Workforce which is set out in *Everyone Matters: 2020 Workforce*

Vision[1]*.* The sustainability work stream, which aims to ensure that the right people are available to deliver the right care, in the right place, at the right time, is particularly relevant. All NHS Boards are working to deliver the commitments in *Everyone Matters* and this will support the delivery of our aims around sustainability and seven day services.

We recognise the challenges which NHSScotland faces, including an increase in patients, with more complex illnesses, the rising costs of expensive new drugs and the impact of inflation. While we need to make best use of our existing resources, we recognise that there is likely to be a financial impact to this work – both in terms of costs and benefits. As part of the next stage we will require to fully assess options and financial impact.

Approach to taking forward this work

The approach we are taking to this work is to:

- Define what we mean by seven day services
- Baseline/map current service levels across a number of clinical areas
- Define the requirements for seven day services in those areas
- Identify the steps needed to ensure sustainable seven day services across NHSScotland.

The work of the Taskforce to date has focussed primarily on the first two tasks. Drawing on those findings we now propose to consider the remaining tasks and develop a programme of work to support this.

Defining seven day services

Building on the vision set out, there has been substantial discussion in the Taskforce and its supporting groups about what is meant by a sustainable, seven day service. We have agreed the following as a definition of seven day services.

"The aim of the Sustainability and Seven Day Services Programme is to ensure that people requiring healthcare have timely access to high quality, person-centred, safe and effective care when they need it, regardless of the time or day of the week, and on a basis which is sustainable in the long term. Achieving sustainability and seven day services will require a whole system approach. This will focus on:

- Ensuring that all patients requiring clinically urgent or emergency healthcare have timely access to an appropriate clinical team who can determine and deliver their care.
- Ensuring that all such patients have access to appropriate investigations and tests when they are required.
- Ensuring that all patients have continuity of care including the capacity to be discharged and supported in their discharge from hospital seven days per week.

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[1] Everyone Matters: 2020 Workforce Vision

- Achieving the best possible outcomes and experience for patients by using available resources in a sustainable manner."

Baseline/mapping of current service levels

Given the complexity and the potential scope of this work, we are taking a phased approach. In the first phase we have chosen to focus on a number of clinical areas where patients need a seven day service. That does not indicate that other clinical areas are less important and they may be included in future phases of work. The Phase One clinical areas are as follows:

- Major Trauma
- Critical care
- Acute Surgery
- Acute Medicine
- Coronary Care
- Maternity and Neonates
- Diagnostics and Investigations
- Primary care.

To gain an understanding of the service currently provided and what the delivery models are in each of the Phase One areas, we are gathering together data and intelligence on these areas. We are also mapping the policy landscape in terms of:

- the national work which sets out the policy direction for those services
- whether the expectation of what a quality sustainable service for these areas has been articulated, and if so the stage implementation has reached.

Grounding our work in a strong evidence base will continue to be crucial in supporting the programme and we have highlighted that in our next steps.

Recognising the particular challenges of designing and delivering sustainable seven day services in remote and rural areas we are looking specifically at this aspect.

Patient and Service User Involvement

Core to the development of the Sustainability and Seven Day Services programme is ensuring that the intended outcomes are based on what is important to patients and service users, alongside their clinical outcomes. This is aligned with the strategic aim of the Scottish Government's Person-Centred Health and Care Portfolio which plans that by December 2015, health and care services are focussed on people.

The key aims of the patient and service user involvement are to:

- find out peoples' views and experiences of using services and what matters most to them, recognising that this will impact on their clinical outcomes and their ability to lead and manage their own health and care
- ensure the issues that are important to service users inform the vision for sustainable seven day services

- ensure that people with an interest have the opportunity, and are encouraged and supported, to help shape the future of services
- comply with national participation policy and good practice in health and social care.

As part of our baseline assessment we have also reviewed what we already know about patient experience of NHSScotland, using patient and service user information and intelligence sources including data from the national Inpatient Survey and Health and Care experience survey.

To deliver our aims for patient/service user involvement we will have a patient/service user workstream. We are discussing how this might be achieved with the national Person-Centred Steering Group.

Governance

In addition to the Taskforce, a number of supporting workstream groups have been established – an Evidence and Analysis Group, a NHS Board Leads Group and a Remote and Rural Group. We have established working groups for two of the phase one areas – Acute Surgery and Neonates and Maternity to drive forward work on behalf of the Taskforce.

We also recognise the importance of linking to the range of national workstreams underway to deliver the 2020 vision and the quality ambitions, including the Unscheduled Care Programme and the Review of Out of hours primary care services.

Central to the success of the programme is the consensus which has been achieved on the need for sustainable seven day services. NHS Employers, Staffside and professions are engaged with the programme through representation on the Taskforce and supporting workstream groups. The membership of the Taskforce at time of publication is listed in Annex A. There has also been engagement with a wide range of stakeholders to share the vision on sustainable seven day services and seek their input and expertise to the programme.

The sections below describe our interim assessment of the phase one areas and some of the work being taken forward by the Taskforce and its sub-groups. This is followed by a summary and some proposed next steps.

Major Trauma

Around 1000 people per year in Scotland sustain major trauma such as severe burns or major head injuries. We know that a key factor in their outcome is the time it takes from sustaining the injury to receiving definitive care by a specialist multi-disciplinary team.

Following a review by the National Planning Forum, the Scottish Government announced plans for an enhanced network of care for major trauma patients in Scotland which could save up to 40 lives a year[2]. The plans include the setting up of four new specialist major trauma centres in Aberdeen, Dundee, Edinburgh and Glasgow. From 2016, these centres will operate as hubs within a national major trauma network designed to improve trauma care across all hospitals that deal with such cases, with all the surgical specialities and support services to provide consultant led care, 24 hours a day, 7 days a week. Patients will be taken directly to one of these centres to be assessed and treated. If the patient cannot be taken to one of these centres within 45 minutes, they will be taken to a local hospital, with advice and support provided by the Major Trauma Centre as required. Implementation of the Major Trauma network is underway and is being led by the National Planning Forum's Major Trauma Oversight Group. Good progress has been made in a range of areas, with regional major trauma working groups now well established.

We note this work which will make a valuable contribution to the provision of a sustainable seven day service and will wish to remain closely linked to its implementation.

Critical Care

Critical Care units across Scotland deal with approximately 43,000 of the most seriously ill patients a year, in Intensive care units (ICU), High Dependency units (HDU) or combined Units. Of these admissions around 14,000 are into ICU or combined units and around 28,000 are into HDUs[3]. There is strong demand for these services in the evening and at weekends, with around 20% of admissions happen on a Saturday or Sunday and a third happening overnight (between 8pm-8am).

While there is no national Quality Framework for Critical Care, there are relevant standards from a number of UK wide professional bodies – such as the Intensive Care Society. In addition, the Scottish Intensive Care Society have an agreed set of Quality Indicators[4].

Patients with clinically urgent or emergency care needs have access to Critical Care units 24 hours a day, 7 days a week at present. However available data such as that from the Scottish Intensive Care Society Audit Group suggests a degree of variation in the way care is provided across the week

[2] Trauma patients 10% of data assumed for Scotland
[3] Audit of critical care in Scotland 2014, reporting on 2013
[4] Quality Indicators for critical care in Scotland

The National Planning Forum has recently considered the current critical care position and whether further action is required to ensure the sustainability of the service on behalf of NHS Board Chief Executives. Following consideration of an initial Critical Care Stocktake report Board Chief Executives have asked for its findings to be taken into account through the Scottish Government's work on the development of a National Clinical Strategy. We will wish to link to this work as it develops.

Acute surgery

Acute surgery covers a range of surgical specialties. Initially we are focussing on emergency general surgery, vascular surgery, urology and orthopaedics and have established an Acute Surgery Group to support this work.

Our mapping exercise has shown that acute general surgery services are currently provided on 29 sites; acute urology is provided on 21 sites[5]. In the next phase of work we will consider whether the current configuration of these services provides all the agreed components of a high quality service.

Increasingly the components of a high quality service are being described for a range of clinical services. Taking Vascular Surgical Services as an example the Quality Framework developed by the National Planning Forum in 2011 set out optimal models of care. For vascular surgery this included a population base of 800,000 and access to intensive care and complex interventional radiology. This has necessitated the development a model whereby multi-disciplinary teams provide complex vascular surgical care on a regional/cross boundary services in support of local hospitals who direct patients to such specialist units when it is required. Implementation of this framework is underway through the NHS Board regional planning structures. In some areas such as the West of Scotland implementation requires service reconfiguration, while in the North of Scotland, they are setting up an integrated vascular service for NHS Grampian and NHS Highland, delivered through a clinical network. Few would disagree that this is the correct approach to the delivery of a complex service such as vascular surgery. The implications of the requirement for safe surgery to be undertaken by large integrated teams will require to be considered in planning for a sustainable seven day service in other clinical areas.

We are also exploring the quality of decision-making and access to investigations at weekends in surgical wards across Scotland. As part of this we are undertaking a review of ward rounds at weekends in order to measure their effectiveness. Effective ward rounds improve patient care by providing an opportunity for the clinical team to:

- establish, refine or change clinical diagnoses
- review the patient's progress against the anticipated trajectory on the basis of history, examination, early warning scores and other observations, access to and the interpretation of tests and radiological investigations

[5] http://www.isdscotland.org/Health-Topics/Finance/Costs/File-Listings-2014.asp

- make decisions about future investigations and options for treatment, including do not attempt resuscitation and any ceilings of care
- formulate arrangements for discharge
- communicate the above with the multidisciplinary team, patient, relatives and carers
- carry out active safety checking to mitigate avoidable harm.[6]

As well as emergency patients, such interactions can have a positive impact on the on-going management of non-emergency patients, enabling their care to be progressed.

While we are exploring this through our Acute Surgery Group, it is applicable across a number of the Phase One areas. Once we have gathered a picture of current practice we will wish to consider whether guidance, a checklist or some advice for NHS Boards on this issue is required.

Acute medicine

Acute medical units provide care for patients who present as medical emergencies or who develop an acute medical illness while in hospital. They play a crucial role in deciding the correct clinical pathway for such patients – whether that is discharge, transfer to a specialist ward or for the most severely ill patients transfer to a High Dependency Unit or Intensive care.

There is already considerable work underway in this area under the banner of the Unscheduled Care programme. The Scottish Government are working with NHS Boards to ensure that they have sustainable systems and processes for unscheduled care pathways which optimise patient care and satisfaction across the week. Having assessed their current services, each NHS Board has developed a Local Unscheduled Care Action Plan which identifies their priority areas for improvement. A number of the deliverables within the Unscheduled Care programme will support delivery of the sustainability and seven day services programme and are consistent with our focus on access to appropriate decision makers and timeous diagnostics. For example, there is a stream of work on Pro-active Discharge Management which seeks to eliminate unnecessary waits and delays both on the day of discharge and across seven days. Key to this is morning and weekend discharges, which require engagement with senior decision makers to provide daily ward rounds and with the range of other key clinical services such as Allied Health Professions (AHP), pharmacy, and diagnostic services, as well as transport and other support services. Communication across acute services and with community partners is key to ensuring patient flow and many initiatives to improve this are being implemented.

Similarly a number of Boards are carrying out work to better manage flow through their Accident Emergency Departments. This work focusses on appropriate assessment and diagnostics services being available to manage demand across time of day and day of the week.

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[6] Ward rounds in medicine: Principles for best practice

As the Unscheduled Care programme moves into its next phase of activity, it will adopt a collaborative approach to leading improvement and building sustainability. It will do this by focussing on six essential actions to improving safety and patient flow across unscheduled care pathways. Seven day services has been identified as key across the essential actions.

With regard to pharmacy, the Scottish Government is considering the pharmaceutical care support and follow-up patients' needs either before discharge or post discharge. This would include, for example, medication reviews by pharmacists to ensure that patients are able to manage their medicines and get the optimum outcomes from their medicines whilst minimising harm, so that readmissions due to medication related causes are avoided. While this is relevant for Acute Medicine it is equally applicable to acute surgical discharge arrangements.

The Scottish Government and the Royal College of Physicians of Edinburgh are also undertaking a research project to evaluate Acute Medical care in Scottish hospitals which will help to inform our work. The project will consider the physical, process, procedural and personnel factors in each of 28 Acute Medical Units in Scotland. It will then analyse how the differing organisational factors relate to outcome data such as mortality rate, boarding/queuing rate, length of stay, readmission rate and direct discharge rate. It will also describe the current provision for seven day services within these medical units.

In addition, The Scottish Government is engaged on a national programme to improve patient flow, working initially on 4 pilot sites across Scotland (NHS Borders, NHS Tayside, NHS Forth Valley and NHS Greater Glasgow and Clyde). This includes identifying how existing weekday capacity can be better used to deliver services including elective surgery. It is seeking to identify how we can reduce any artificial variation that can have negative effects on how patients flow through the system and the quality and experience of care provided.

As we move forward we will wish to ensure that we link closely to these pieces of work.

Coronary Care

The Scottish Government issued a Heart Disease Improvement Plan in August 2014 which sets six priority areas which will contribute to the overall aim of improving the experience and clinical outcomes for patients living with heart disease[7]. The priorities include improving secondary and tertiary care cardiology. They stress the importance of patients with heart disease receiving the right investigation and treatment, administered by skilled staff in a timely, equitable and evidence-based manner. Actions being taken forward include improved patient-centred flow into, through, between and out of hospital for patients with chest pain and the development of local and regional pathways including strategy for cardiac investigation and intervention. We will link to the implementation of this Improvement Plan as it develops.

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[7] Heart Disease Improvement Plan 2014

Also of note is the Resuscitation Rapid Response Unit – 3RU, which provides a 24/7 on scene resuscitation service for patients in cardiac arrest[8]. It was piloted in Lothians as a joint project between the Scottish Ambulance Service and the Resuscitation Research Group at the University of Edinburgh. The 3RU team – a small team of paramedics, supported by doctors, nurses, dispatchers, medical students and a resuscitation officer – has shown significantly increased survivability rates for out of hospital cardiac arrests in Edinburgh - 33% as compared to the Scottish figure of 15-20%[8]. The Scottish Government is supporting a wider roll out of this scheme with funding of £200,000 in 2014.

Maternity & Neonates

Maternity

Births in a hospital setting in Scotland, generally take place in one of 38[9] maternity units, which may be consultant led or community maternity units. In addition women may give birth outside a hospital setting such as at home or in a private hospital.

The national Framework for Maternity Care in Scotland was refreshed by the Maternity Services Action Group on behalf of the Scottish Government in January 2011[10]. It sought improvements in maternal and infant wellbeing by supporting the planning and provision of high quality outcome focussed services. A key driver for the Framework was to ensure that women and their babies were cared for by the right team of people, with the right skills in the right place. The provision of high quality maternity services is also supported by the Maternity & Children Quality Improvement Collaborative (MCQIC) which was launched nationally in March 2013 and also encompasses neonatal and paediatric activity.

All NHS Boards have adopted the framework and have integrated it into their planning for Maternity Services, prioritising and adapting the principles and service standards to reflect existing local practices and particular service requirements in their area. Scottish Government funded Maternity Champions are in place in each NHS Board area to drive and co-ordinate improvement activity associated with the Framework and the MCQIC.

Given that the Maternity Framework and MCQIC already exist and describe a high quality seven day maternity service, our next steps will be to review the implementation of the framework and the programme and identify areas where further actions might be needed to support a sustainable seven day service across Scotland. In light of the changing pattern of demand for maternity service - with an increase in the age of average mother, more multiple births and more caesareans - we will wish to consider whether the current acute care model is supporting women and their babies to be cared for by the right team of people, with the right skills in the right place.

[8] Resuscitation Research Group
[9] http://www.isdscotland.org/Health-Topics/Finance/Costs/File-Listings-2014.asp
[10] Framework for Maternity Care in Scotland

To take forward this strand of work a Neonates and Maternity Working Group has been set up, which will report to the Taskforce. In light of the recent Scottish Government announcement of an assessment and refresh of the model of care for maternity and neonatal services, we will consider how best to link these two pieces of work together.

Neonates

Specialist neonatal services are provided across 16 sites in Scotland[11]. The level of service each neonatal unit provides is categorised into three levels:

- Special Care / Level One
- Local Neonatal Level Two - High dependency care and short-term intensive care
- Neonatal Intensive Care / Level Three.

The Scottish Government published *Neonatal Care in Scotland: A Quality Framework* in February 2013[12]. This Framework defines the approach and the requirements for delivering high quality care for newborn infants who require care at a level greater than standard perinatal care. It describes a service model which includes regional collaborative working to implement agreed patient pathways, maximising the use of available clinical expertise and supporting units to provide the right level of care.

NHSScotland is committed to the delivery of the Framework and while each Board is responsible for implementing the Framework, the three regional Managed Clinical Networks (MCNs) are facilitating co-ordination for their regions. The Units and MCNs are now implementing plans to drive forward improvements and working on delivery of the Framework.

Given that such a framework already exists, our next steps in this phase one area will be to review the implementation of the framework and identify areas where further actions might be needed to support a sustainable seven day service across Scotland. Areas we will consider include the availability of appropriate decision makers and supporting diagnostics across seven days, ensuring that preterm babies are being cared for in the most appropriate level of facility and looking at the national and local transport arrangements that support the return of babies and their mothers, when it is clinically appropriate, to their local units.

As described above we will consider how best to link this work with the recently announced assessment and refresh of the model of care for maternity and neonatal services.

[11] Review of Neonatal Care Services in Scotland
[12] Neonatal Care In Scotland: A Quality Framework

Diagnostics & investigations

Diagnostic services underpin an estimated 80% of all models of care irrespective of setting and clinical pathway[13]. Delivering sustainable services across seven days will require successful diagnostic services to be at the centre of service transformation.

Our initial baseline work has focused on diagnostic imaging and interventional radiology services. There has been a notable expansion in demand for such services in recent years. For example, in 2013/14 NHSScotland performed over 200,000 MRI, 450,000 CT and 550,000 Ultrasound examinations[14]; these numbers have increased by 30%, 25% and 20% respectively since 2010/11[15].

Interventional radiology also has an important and increasing role in managing critically ill patients. We are working with the Scottish Clinical Imaging Network to review the current provision of services in out of hours periods, building on previous research that suggested that out of hours provision was variable[16]. In the next phase of work we will consider this issue in more detail.

We are also aware of new models that are being developed to provide sustainable diagnostic imaging services, such as the out of hours diagnostic imaging model being implemented in NHS Greater Glasgow and Clyde and the improvement programme to underpin the roll out of radiography plain film reporting across Scotland. We are keen to explore these further with Boards.

We will also link to work being taken forward by the Scottish National Blood Transfusion Service to review the blood banks held in laboratories across the NHS in Scotland and identify opportunities to support the sustainability of the service. This work will be supported by the Healthcare Science National Delivery Plan, due for publication in spring 2015.

Our next phase of work will consider the other Healthcare Science services, that contribute to the delivery sustainable services across seven days.

Primary care

For most people contact with NHSScotland begins and ends outwith a hospital environment. Community based healthcare services, which encompass a wide range of professional roles are a key part of the unscheduled care landscape and a sustainable seven day service cannot be delivered without them. As well as the direct treatment and care such services provide, these services play a crucial role in avoiding unnecessary admissions to hospital and supporting appropriate discharge arrangements and moving forward we will consider what further contribution community based nurses and AHPs can make to the development of sustainable services.

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[13] Health Care Science National Delivery Plan
[14] http://www.isdscotland.org/Health-Topics/Finance/Costs/File-Listings-2014.asp
[15] http://www.isdscotland.org/Health-Topics/Finance/Costs/File-Listings-2011.asp
[16] Zealley, I.A; Gordon, T.J; Robertson, I; Moss, J.G; Gillespie, I.N; Provision of out of hours interventional radiology services in Scotland – Clinical Radiology 67 (2012) 855-861.

In out of hours periods NHS 24 is the first point of contact for most people requiring care. They receive around 1.5 million calls from patients across Scotland every year. NHS 24 receive advice over the telephone or are redirected to another service, including the Scottish Ambulance Service, the local General Practice Out of Hours service or the nearest Accident and Emergency Department. Responsibility for the provision of GP out-of-hours services rest with the 14 territorial NHS Boards.

Another option for referral or access to care is through community pharmacies. There are some 1,240 community pharmacies[17] located in our towns and communities across Scotland. Most are open 6 days a week, and NHS Boards operate a rota for out of hours which includes evenings, Sundays and public holidays. As part of the community pharmacy based NHS Minor Ailment Service (MAS), pharmacist in the community can also treat eligible patients for common and minor self-limiting conditions without the need to see a doctor. There are currently over 890,000 patients registered for MAS[18]. In addition, under Patient Group Directions, pharmacists in the community may dispense a drug, before receiving a prescription form, where the conditions for urgent supply are met and if the pharmacist is satisfied that it is appropriate to do so.

The recently announced Primary Care Out-of-Hours Services Review will review the current delivery landscape and recommend action to ensure primary care out-of-hours services:

- Are sustainable, high quality, safe and effective
- Provide access to relevant urgent care where needed
- Deliver the right skill mix of professional support for patients during the out-of-hours period.[19]

The review will look at all territorial NHS Boards' out-of-hours service models and profiles of access, demand and delivery. The range of primary care services are diverse and whilst the Review does not strictly exclude any specific service, its initial focus will be on how primary care services are provided to patients when their GP surgeries are closed. It is expected to provide recommendations by late summer 2015 and its outcome will inform the steps that are necessary to support sustainable seven day services.

Remote and rural

In recognition of the particular challenges facing the delivery of sustainable services in remote and rural areas, we have established a Remote and Rural Group sub-group to consider this issue. The Group immediately recognised that a range of initiatives have been implemented over the past decade and that much good work continues to be undertaken. In order to avoid repetition, in the first instance a review of all the existing work was undertaken and compiled as a register.

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[17] Practioners Services

[18] ISD Minor ailments service publication summary

[19] Review of Out of Hours Primary Care Services

The range of existing initiatives/projects include:

- Being Here – Scottish Government/NHS Highland programme of work to test new approaches to delivering healthcare in remote and rural areas of Scotland.
- The *Supporting Remote and Rural Healthcare* report that describes current NHS Education for Scotland (NES) initiatives to support the educational needs of the remote and rural healthcare workforce[20].
- *Being Rural* Policy and Action Plan from the Royal College of General Practitioners[21].
- The Strategy for Attracting and Retaining Trainees in Scotland (START) programme being jointly led by NES and the Dean of the West of Scotland focussing on attracting and retaining trainees, in which remote and rural issues feature strongly.
- Bespoke rural-track GP specialty training programme in the North region / NES GP rural fellowships.
- Health and social care transport pilots.

The last comprehensive review of remote and rural services *Delivering for Remote and Rural Healthcare* was published in 2008[22]. This report made a number of recommendations. These have been reviewed in order to identify those that have been successfully implemented and those areas where challenges remain. The implemented recommendations from that report that have been highly successful include the development of the Specialist Transport and Retrieval (SCOTSTAR) retrieval service and the creation of community hospitals utilising extended skill practitioners. The development of educational facilities to meet the specific needs of the remote and rural workforce has also been a notable success.

Emergency Medical Retrieval Service

A robust, rapid and effective retrieval service is an important component of any strategic plan for the delivery of sustainable remote and rural services. For the Islands and areas of rural Scotland this needs to be by air. The Scottish Government has already invested in the Scottish Ambulance Service's Air Ambulance Service, which undertakes around 3,500 missions each year. In April 2014, ScotSTAR was launched as a national service for the safe and effective transport and retrieval of Neonates, Children and Adults in Scotland. ScotSTAR has brought together three existing services (Scottish Neonatal Transport Service, Emergency Medical Retrieval Service, and Transport of Critically Ill and Injured Children) under one umbrella. This provides a vital road and air service for critically ill patients across Scotland, taking skilled clinicians directly to the patient thereby ensuring the best possible pre-hospital care.

A central base for this service is currently being constructed at Glasgow Airport and will open in summer 2015. From spring 2015 all retrievals will be centrally coordinated by a Specialist Services Desk. Draft quality standards and indicators have been developed and the outcomes for patients will be audited.

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[20] Supporting Remote and Rural healthcare

[21] Being Rural Policy and Action Plan from the Royal College of General Practitioners

[22] Delivering of Remote and Rural Healthcare

Rural General Hospitals

The Group identified that a key remaining area of challenge was the recruitment and retention of staff to work in Scotland's six Rural General Hospitals (RGHs)[23]. The NHS is not unique in this, living and working in a rural area doesn't appeal to everyone and remote and rural recruitment challenges exist at all levels and in many industries in rural areas.

For medical staff, the Taskforce have agreed to explore the establishment of formal links between individual RGHs and urban Hospitals. This will build on the current obligate networks that have successfully provided visiting specialists to RGHs for the provision of elective care. This could provide a number of benefits - patients in rural areas would have access to clinicians with skills maintained in hospitals with a high volume of cases, there could be greater opportunities for collaborative working between visiting and local staff, it could support the out of hours and emergency rota in the RGH, reduce reliance on locums and increase the number of patients treated close to home.

Several models as to how this would work in practice are being discussed. The simplest of these models has been progressed for the RGH in Fort William whereby a link for continuing professional education / development has been developed between NHS Lothian and the surgeons in Fort William. As a result two experienced surgeons have recently been recruited to positions that in the recent past attracted no suitable applicants. Surgical services in Fort William are now sustainable with three full time surgeons in position. We intend to coordinate further work with key stakeholders to consider innovative solutions to sustain the RGHs and this and other models are being explored with other NHS Boards with a view to developing further pilots. While this initial work has focussed on medical staff, this provides a model that could be used for other staff such as nurses and AHPs.

The Group have also been reviewing examples of excellent and innovative practice from rural services that may be suitable for wider implementation. A particularly interesting example is the provision of the GP out of hours Accident and Emergency /acute admissions service in Stornoway. In this model[24] GPs staff the Emergency Department overnight, supported by extended role nurses both in the hospital and in the community. This includes managing acutely ill children and neonates as well as adults. In addition to providing stainable service it is of note that in the pilot period from May 2012 to May 2013, overnight hospital admissions fell by 17% when this model was introduced. There were also marked reductions in the requests for laboratory tests (10%) and radiological examinations. A key component of the success of this model is in utilising the skills of the GPs in making judgements based on clinical examination combined with investment in developing the skills of paramedics, community nurse practitioners, emergency nurse practitioners and clinical support nurses.

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[23] Gilbert Bain Hospital, Lerwick; Balfour Hospital, Kirkwall; Western Isles Hospital, Stornoway; Caithness General Hospital , Wick; Belford Hospital, Fort William; Lorn and the Isles Hospital , Oban

[24] Data and information on Out Of Hours Project Pilot provided by NHS Western Isles.

Summary and Next Steps

The Taskforce was convened to consider the implications of delivering a sustainable seven-day clinical service across NHSScotland and to offer proposals as to how that could be achieved.

Delivering sustainable services

NHSScotland already delivers a seven-day service across a range of clinical areas. Emergency patients are admitted to hospitals across the country seven days per week and 24 hours a day. Similarly elective patients within hospitals receive care out-with the normal working day. Some NHS Boards also undertake elective operations at weekends and we note that the first allocation from the Scottish Government's Performance Fund includes an allocation to NHS Highland to support them in providing elective procedures at weekends.

While we have been considering how access to appropriate decision makers, tests and treatments can be provided when required in out of hour periods, we recognise that this cannot be considered in isolation of the service provided during the rest of the week. Improvements to care provided at weekends must be built on a sustainable workforce supported by appropriate infrastructure across the week. So while we recognise the importance of making best use of the resources we have, we need to look at new models of care rather than just stretching our existing resources across seven days.

A strong theme that has emerged is that services should be configured to ensure that people receive the care they need in the most appropriate location to deliver that care. This does not always happen at the moment. Too often, older people are admitted to hospital when a package of assessment, treatment and support in the community might have better served their needs, and maintained their independence[25]. Surveys conducted in Scotland and elsewhere, indicate that approximately a quarter of patients in acute beds in a morning no longer require healthcare in an acute setting. Approximately half of these patients are there due to healthcare related issues and many of them are waiting for a clinical decision to allow them to go home.[26] It is also important to recognise that towards the end of their lives people often move in and out of hospital, so a significant proportion of acute care patients require palliative and end of life care. A study of inpatients in Scottish hospitals suggested that almost 1 in 10 patients in teaching or general hospitals at any given time will die during that admission. Almost 1 in 3 patients will have died a year later, rising to nearly 1 in 2 for the oldest groups.[27] Models such as Anticipatory Care Planning can support conversations with patients, their families and carers and help people to think ahead and have greater control and choice over their care and support. A Palliative and End of Life Framework for Action will be published later this year and we will want to ensure that we reflect that in our work. The scale of this challenge will only increase as the service deals with the growing number of people with longer term and often complex needs, many of whom are

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[25] Reshaping Care and Integrating health and social care in Torbay

[26] Patient flow through day of care survey

[27] Clark, D; Armstrong, M; Ananda, A; Graham, F; Carnon, A; and Isles, C; Imminence of death among hospital inpatients: Prevalent cohort study – Palliative Medicine (2014), Vol. 28(6) 474 – 479.

older. The work that is being progressed to deliver the 2020 vision, including health and social care integration and the range of initiatives to avoid unnecessary hospital admissions and enable appropriate discharge from acute care are supporting the necessary change in the balance from acute care to community and primary care.

As the new integrated partnerships begin their work from April 2015, it will be important for us to engage with them on how their integrated strategic commissioning role of preventing admission and supporting appropriate discharge can support improvements in the continuity of care for patients across seven days.

Acute Care

The principle of delivering care the patient needs in the most appropriate place also applies within the acute hospital sector. Clinical care in acute hospitals is increasingly dependent on multi-disciplinary teams supported by the availability of complex technology. All of these components require to be sustainable in order to deliver a high quality service across seven days. Acute general surgery exemplifies the challenges to be faced. It is currently delivered on 29 sites but the complexity of the surgery varies. Increasingly it is recommended that surgical teams have access to an intensive care unit and interventional radiology services.

In the lead up to the implementation of the 48 hour working week for junior doctors, various work streams were undertaken looking at how to run safe and sustainable rotas. *WTD – The Implications and Practical Suggestions To Achieve Compliance*, a report done jointly by the Royal College of Anaesthetics and the Royal College of Surgeons England published in 2009, identified the minimum staff required to run a safe and sustainable rota, while providing a good work life balance was eight. The work done also shows that the number of staff needed in any workforce is dependent on the amount of cover required, how many staff are needed at certain times of the day, and the skills that are required at any particular time[28]. Therefore minimum staffing numbers covering rotas can vary significantly between different specialties and sites. Importantly they require a sufficient population base/case load to ensure that the health professional can maintain their skills.

This dilemma has been addressed for vascular surgery services by focusing the intervention components of the treatment in fewer centres while ensuring that some non-invasive components of the vascular service are delivered in local hospitals. Such a model provides optimal clinical care for patients as they are able to access the majority of services through their local hospital and if they require more complex acute care this is delivered by sustainable teams on a seven day basis.

In moving forward we will look to develop models that bring sustainable teams together in secondary care while maintaining access for patients to appropriate care in their local hospital.

[28] WTD – The Implications and Practical Suggestions To Achieve Compliance

Primary care

The recently announced review into out of hours primary care services will be important in supporting our progress towards sustainable seven day services. Also of relevance to our work is the UK Shape of Medical Training Review which considered how doctors' training could enable them to better meet the changing needs of patients, society and health services. One of the review findings was that patients need a different kind of doctor in the future whose training equips them to work across the interface between primary and secondary care. This means enhancing the skills of general practitioners and preparing hospital doctors to undertake duties in community settings. UK Health Ministers have welcomed the report and approved development activity to explore how medical training can be adapted to meet future patient and service needs. This will be taken forward in a planned way, and overseen by a Scottish Implementation group.

Drawing on these pieces of work where appropriate we will wish to consider new and emerging models of community based care that could enhance the local services for patients, while enabling acute hospitals to focus on their core activity; namely the treatment of seriously ill patients or those that require specific interventions. There are a range of options that could be considered from hubs to extended hubs and greater use of community hospitals.

Delivering a sustainable workforce

Sustainable services cannot be delivered without a sustainable workforce and we will consider carefully the workforce implications of this work as we move forward.

The solutions to sustainable seven day services require us to maximise the contribution from all healthcare professions in acute and primary care, working to the top of their professional capability.

In addition to the contribution from the medical profession, there are also numerous examples in the past of how nursing has taken on new or expanded roles across acute and community services, which has improved patient care. This can be seen in the introduction of nurse prescribers, hospital at night teams and minor illness advanced practice. As part of this programme we are keen to explore whether more can be done to empower and enable advance nurse practitioners to operate as senior-decision makers including in out of hours periods. Advance nurse practitioners already work in a wide variety of roles. In community settings they may be part of an enhanced primary care team or connected to GP services. Increasing numbers also work in secondary and tertiary care settings, such as Accident and Emergency, minor injury units, medical assessment units and hospital at night teams. They also work within specialities, such as paediatrics, neonatal care, cancer care, ophthalmology and orthopaedics.

The particular expertise of such nurses lies in their ability to operate both in specialist areas but also as a 'generalist', with a wide range of skills, a broad knowledge base and the ability to deliver specific aspects of care which complements the role of medical colleagues and other members of the health and social care team.

We would also propose as part of this programme to undertake a review of district nursing which looks at the current and future role of district nurses, ensuring that the available education and training supports this.

Allied health professionals (AHPs) also make a significant contribution to the care of patients in out of hours periods. While historically the majority of AHP services have operated on a five day basis, over the last two years the established AHP delivery pattern has been shifting and is now increasingly different across Scotland. This is primarily in response to service need, but also patient preference. Most recently the targeted use of AHP staff over weekends and out of hours periods in areas of service pressure has been making a significant contribution to patient flow, weekend (and earlier) discharge as well as the prevention of unnecessary admissions to hospitals through AHPs working in Accident and Emergency Departments, Admission Units, Frailty Teams, hospital at home, including community paramedics and other out of hours services. AHPs have also expanded their roles as prescribers, Advance Practitioners and AHP consultants across a range of specialties, working across hospital and community settings. We will build on this work, focussing on allied health professions that will make the most significant contribution to sustainable services across seven days.

It is crucial that we recruit the staff we need but also that we retain the staff we have and support them through providing them with good quality work, a good work life balance with working patterns designed to facilitate this, attractive working conditions and recognised career pathways.

Next Steps

From our work to date we have identified a number of actions which we would propose to take forward in the next phase of the programme.

- We will review the services provided in the 29 sites that undertake acute surgery to ensure that the models of care are sustainable while maintaining appropriate care in local hospitals.

- We will consider how the effectiveness of ward rounds at weekends can be improved to provide better patient care.

- We will consider further opportunities for nurses, AHPs and healthcare scientists to contribute to developing sustainable services, including how they can operate as senior decision makers in acute and primary care and by undertaking a review of district nursing.

- We will consider new models for reviewing and reporting diagnostic imaging and the provision of interventional radiology.

- We will co-ordinate further work to support the sustainability of Scotland's six Rural General Hospitals.

- We will continue to link to the range of national activity that is supporting the development of sustainable seven day services, including contributing to the

review of out of hours primary care and the refresh of maternity and neonatal care.

- To enhance local services, while protecting acute care resources, we will explore new models of care such as community hubs and the greater use of community hospitals with a view to developing pilots.

- We will use a strong evidence base to support us in progressing these next steps.

Sustainability and Seven Day Services Taskforce Membership

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Anne Aitken	Programme Director, Sustainability & Seven Day Services, Scottish Government
Jennifer Armstrong	Medical Director, NHS Greater Glasgow and Clyde
John Burns	Chief Executive, NHS Ayrshire & Arran and Chair of Diagnostics Steering Group
Stuart Burnside	Unite
Robert Calderwood	Chief Executive, NHS Greater Glasgow and Clyde
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