

# **Pulling together: transforming urgent care for the people of Scotland**

**The Report of the Independent Review of Primary Care Out of Hours Services**

**Main Report**

**For more information on the National Review, please visit the Scottish Government website:**

**<http://www.gov.scot/topics/health/services/nrpcooh>**

# Cabinet Secretary's Foreword

We treasure our National Health Service. I don't believe that starts and stops with core NHS services. We treasure all the incredible services provided day and night by a whole host of social care and other partners, in the public, third and independent sectors.

Following the Christie Commission, our commitment has been to ensure that there is clarity in the increasingly complex landscape so we find ourselves accessing ever more integrated, person-centred services that make sense to us and allow us to feel in control of our own lives. This is at the very heart of our *2020 Vision* for Scotland's Health.

A significant part of what matters to us is our sense that these caring partners – in the NHS and beyond – are there for us when we need them. None of us can take this for granted. Those who provide these services are just like us – they have families, commitments, lives. The challenge of 24/7 365 days a year service delivered to an exceptional standard is considerable.

It is within this integrated framework that out of hours primary care services sit. The GPs, nurses, other professions, administrators and technical staff all help to provide vital access not only to advice but also to urgent appointments when we need them at night and at the weekend. Their dedication and commitment is remarkable and makes a real difference to thousands of Scots every night and weekend.

The out of hours primary care system has been facing increasing challenges, with pressure of work rising and increasing numbers of people seeking help and advice. So the time was right to review the system and to look for expert advice on how to sustain and build this essential service to the people of Scotland.

It is clear that this would be no simple task. In order to meet the challenges set down by Christie and to deliver our *2020 Vision*, this had to be a wide ranging review, incorporating many different viewpoints and seeking to get a clear view of the contribution that different professions, organisations and sectors could make to building a service for the future that was safe, high quality and sustainable. I was delighted that Professor Sir Lewis Ritchie was able to commit to providing this expert advice and to leading the Review and I thank him for his work and all those who have contributed to this important piece of work.

I believe that in the report that follows we have the clear, authoritative advice we were looking for. All relevant authorities, organisations and those with a stake in out of hours primary care and urgent care more generally must now reflect on this advice. I expect to set out how the Scottish Government plan to respond early in 2016.

A handwritten signature in black ink, reading "Shona Robison". The signature is written in a cursive, flowing style.

SHONA ROBISON

Cabinet Secretary for Health, Wellbeing and Sport

**November 2015**

# Chairman's Introduction

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The onset or worsening of illness can occur at any time of the day, any day of the week. Irrespective of the time and place, the people of Scotland deserve a high quality service which fully meets their needs and does so reliably and at all times.

The commission of the Cabinet Secretary for Health, Sport and Wellbeing was to secure person-centred, sustainable, high quality and safe primary care during the out of hours (OOH) period - when general practices are closed. I hope that the recommendations from this Review should help to achieve that, but looking forward, also begin to lay the foundations for consistent urgent and emergency care, on a continuous basis (round the clock, 24/7), throughout Scotland. The National Conversation, instigated by the Cabinet Secretary, should help to shape and secure these aims.

OOH primary care services are under considerable pressure, as is daytime general practice. They are completely interlinked and mutually supportive. Improvements made to OOH primary care services should be applied from a person-centred, whole systems perspective, in order to avoid any adverse impact on daytime services. The converse is also true.

We must think anew about what is best for both urgent and emergency care for the people of Scotland and also be very sensitive about the imperative of narrowing health inequalities. We should now move towards a seamless service, which garners and retains the confidence of the people of Scotland and represents a valued working and learning environment for all those delivering health and care services – whether that be NHS, local authority social services, the third and independent sectors, and other agencies.

My colleagues and I have approached this Review in an inclusive way, on the premise that all those who receive and deliver health and care services are entitled to shape them. We are indebted to the public of Scotland who have participated through individual contributions in response to our Review and also during our national engagement programme. Equally, we have been gratified and humbled by the commitment and dedication of our colleagues who work for the statutory services and the third and independent sectors, throughout Scotland. We are very indebted to all those who generously supported this Review in many ways, times and places, who are too numerous to mention by individual name.



## Guiding Principles in Health and Care Service Design and Delivery

We suggest that a service that is fit for the future should be underpinned by key guiding principles:

- **Person-centred** - for those who receive and those who deliver services
- **Intelligence-led** - making the most of what we know about our people and their needs
- **Asset-optimised** - making the most of all available assets and resources
- **Outcomes-focused** - making the best decisions for safe and high quality patient care and wellbeing

In addition to these guiding principles, such services should be:

- **Desirable** – high quality, safe and effective
- **Sustainable** - resilient on a continuous basis
- **Equitable** - fair and accessible to all
- **Affordable** - making best use of public funds

People seeking urgent help and advice need to be seen by the right professional, at the right time and in the right place – which might be face to face either physically or remotely, by telephone or video link. Traditionally, clinical advice and assessment has usually been delivered by general practitioners (GPs) face to face. In the future, health and care needs will be delivered by the most appropriate member of a multi-disciplinary team in person, or remotely - according to need and circumstances. The ongoing commitment and expertise of GPs to OOH services is essential and must be secured. Future urgent care provision must also include key and expanding contributions from the nursing workforce, pharmacists, paramedical practitioners, other allied health professionals, social services workers, third and independent sector personnel and support staff.

For this new approach for urgent care delivery to be successful, multidisciplinary and multi-sectoral teams should be effectively trained, work together and be well supported by a professional team of administrative and support colleagues. We also need to create the right conditions to value people, facilitate communications,

learning and continuous professional development. This requires technologically enabled and innovative working environments, which are fit for purpose - for both service delivery and training. These environments must also be safe and secure for both patients and professionals alike.

Strong leadership will be crucial going forward, as will rapid and robust workforce planning at national and local levels, with the right capacity, capability and skill mix to underpin these aims.

A key recommendation in this Review is to develop a national implementation plan, supported by local implementation guidance. This recognises the importance of a holistic approach for urgent and emergency care at national and local levels.

We indicate that clarification of the roles, responsibilities and leadership of Health and Social Care Partnerships and Integrated Joint Boards will be essential to rapidly progress community based urgent care.

I am very conscious of the expectations from this Review, which concludes that we must rapidly transform our OOH urgent care provision in Scotland. We should also ensure robust and seamless pathways of community care - linking effectively with emergency departments and other acute hospital services. Some of our recommendations should have an impact in the short-term, but many will take some time to be fully implemented. The journey of effective and efficient integrated health and social care has barely begun – there are many miles to travel.

Closing on a personal note, for most of my career, I have been privileged to work in both daytime and OOH services on the front line, as a serving general practitioner. Reflecting back, I have experienced some of the most fulfilling moments in the OOH period, working closely with medical, nursing, ambulance service and support colleagues – [pulling together](#) as a team to help patients in urgent need, their carers and families.

Getting urgent and emergency care right is of paramount importance for the people of Scotland and for those who provide care for them. The case for immediate action is clear. We need to do this well and to do this with resolve.

A handwritten signature in black ink, appearing to read 'Lewis D Ritchie', with a horizontal line underneath.

Lewis D Ritchie

Chairman  
National Review of Primary Care Out of Hours Services

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## Remit of Review

The National Review of Primary Care Out of Hours Services ('the Review') was asked to evaluate the effectiveness of the delivery of primary care out of hours services in Scotland. This evaluation involved reviewing the current situation and recommending action to ensure that primary care out of hours services:

- Are person-centred, 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 OOH period

**Please note:** The remit specifically excluded consideration of dental and optometrist services.

# Key Definitions

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## Primary Care

Primary care provides access to care at the right time when it is required and secures ongoing care in the community and continuity of relationships, where this is important.\* In addition to GP practices, primary care services covers: community services – including: district and community nursing, mental health and dental services, community pharmacies, optometrists - and for effective health and social care integration - social care services, third and independent sector provision.

\* Securing the future of general practice: new models of care. The Kings Fund & Nuffield Trust, 2013.

## Out of Hours

This describes the period when general practice services are normally closed. By regulation, general medical (GP) services\*\* are provided between 08.00 and 18.30, Monday to Friday, with no obligation to deliver services outwith these times. In practice out of hours provision often starts at 18.00.

\*\*As defined by the National Health Service: General Medical Services Contract Scotland Regulations, 2004.

## Urgent Care

Urgent care in the community that requires a response before the next routine care service is available.

## Emergency Care

Care that requires an immediate response to a time-critical health care need.

# Executive Summary

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The National Review of Primary Care Out of Hours Services ('the Review') was asked to evaluate the effectiveness of the delivery of primary care out of hours (OOH) services in Scotland and to provide recommendations for improvement in the context of Health and Social Care Integration. This Report seeks to address the remit and makes **28 Recommendations**.

## Chapter 1 – Key Messages

Headline issues addressed by the Review are summarised and high level recommendations made.

## Chapter 2 – Recommendations:

All of the recommendations are grouped into this chapter. These recommendations were synthesised from the views of the public, health and social care professionals, professional organisations and bodies, and from published literature and research commissioned by the Review – see [Chapter 3](#). Recommendations are proposed about a new model of care; individuals with specific needs and access requirements; health inequalities; the future workforce and the roles of its multidisciplinary members; the roles of Health and Social Care Partnerships and Integrated Joint Boards (IJBs); Special Health Board and Public Bodies; the third and independent sectors and other statutory agencies. Recommendations are provided about supporting the public to promote prevention and self care, where appropriate and to seek the right OOH and urgent care service, when needed. National workforce, OOH service specification and implementation plans are recommended, with guidance for local translation. Proposals are also made about research, evaluation, affordability and best use of resources.

## Chapter 3 – Review Purpose and Process

The background to the Review, its remit and process are described.

- The main Review Group led the process with multidisciplinary, multi-sectoral and public membership.
- An Executive Group was established to support the Review and distil all the evidence and recommendations arising from the process and engagement.

- Four thematic Task Groups were established: Models of Care, Workforce and Training, Quality and Safety, Data and Technology. These reported to the Executive Group.
- Workstreams were instigated for groups of people with specific needs and access requirements: Palliative Care, Mental Health, Frail and Older People, Children, and Health Inequalities. Support was provided by the Royal College of Nursing (RCN), Scotland.
- A virtual Reference Group was established with multidisciplinary, multi-sectoral, public and international representation, offering rapid external peer review to the Executive Group.
- A schematic for the Review structure is available at [Figure 3.1](#).
- A Short Life Working Group was established to examine terms and conditions for GPs working in OOH services.
- A rapid systematic literature review and further research was commissioned from the Scottish School of Primary Care ([Annex F](#)) and on the Review section of the Scottish Government web site.
- Data, statistics and analyses were provided by Information Services Division (ISD) - see Key facts about services ([Annex B](#)).
- Financial data were provided by NHS Directors of Finance ([Annex C](#)).

## Chapter 4 – Engagement and Consultation

This chapter describes the extensive engagement process for the Review, including visits to all Board Areas in Scotland, visits to, and communications with Special NHS Boards and Public Bodies. [Figure 4.1](#) provides a schematic of the national engagement programme. Local public discussion groups were commissioned via the Scottish Health Council and took place throughout Scotland. The work of the Review was supported by a dedicated website and by intermittent press releases, requesting public and professional views. Wider consultation with many groups and agencies took place, including a national consultation event and a meeting with MSPs also took place. The process and interim progress of the Review were shared and discussed with many groups. Account was taken of relevant interfaces with other on-going Scottish Government workstreams and reviews.



## Chapter 5 – Findings

Describes and summarises the views of the public on OOH services, supplemented by the *Health and Experience Survey 2013/14*. The discussion group work, analysis and report provided by the Scottish Health Council were central to this task. This work was supplemented by the national engagement visits to all Board areas and workshops, including one set up by the Health Care Alliance Scotland (Alliance), seeking views about how best to use and access services.

Views of health and social care professionals, the third and independent sectors were captured at meetings during the visitation programme to Board areas. Submissions were received from the Chief Nursing Officer, professional organisations and bodies. These are summarised in [Annex D](#) and available in full on the [Review website](#). A requested submission from NHS Health Scotland, regarding health inequalities is summarised in [Annex F](#) and available in full on the [Review website](#).

## Chapter 6 – Models of Care

A new model of care is described where a multidisciplinary, multi-sectoral urgent care coordination and communication function will be provided at [Urgent Care Resource Hubs](#), which would be configured for both service delivery and training purposes. They would be established primarily to coordinate urgent care for OOH services – but should be considered on a 24/7 basis. They would facilitate multidisciplinary co-location, co-working, co-production and co-learning. They would be able to provide best information about and for the people served in their localities and help deploy the most appropriate services and resources available in order to secure timely and optimal care and support, according to need. This would fit with the principles of a person-centred, intelligence-led, asset-optimised and outcomes-focused service. Modelling, piloting and evaluation will be required. [Urgent Care Resource Hubs](#) would be networked to local [Urgent Care Centres](#), presently referred to as Primary Care Emergency Centres which should be fit for purpose and be located to maximise accessibility and service resilience. [Figure 2.1](#) provides a high level schematic of the proposed model. Recommendations are also made about NHS 24 and SAS synergies and the requirements of some groups of people with specific care and access needs ([Recommendations 1-7](#)).

## Chapter 7 – Workforce and Learning

The importance of valuing our workforce looms large in this Review. At the outset, person-centred was re-defined as applying to both the person receiving care or support and the person delivering it. In order to meet the needs of future OOH and

urgent care services it is essential to develop a high calibre, high morale workforce of sufficient capacity and capability. The Review was established recognising that serious GP shortages were compromising the sustainability of OOH services, which remain fragile and may worsen without resolute and urgent action.

Recommendations are made on: workforce planning at national and local levels, interdependent linkages between daytime and OOH services, the importance of the educational and working environment and an organisational development approach. The skills and expertise of all professional working in OOH services must be optimised – with individual practitioners working to maximise use of their skills and the full scope of their practice. Recommendations are made for the future contributions of the GP, nursing, pharmacy, paramedical, other allied health professionals, associate physician and social services workers. The importance of working and learning in professional partnership is stressed across the sectors, as is valuing the vital and unsung contribution of support workers. Strong and resolute professional leadership at all levels will be required to assess and implement the Review's recommendations. ([Recommendations 8-19](#)).

## Chapter 8 – Quality and Safety

Quality and safety are central to ensuring care and support both for patients and their carers, to secure best results – an outcomes-focused service. Present quality governance arrangements reflect former systems established by individual providers rather than a more holistic, person-centred approach, going forward. The advent of health and social care integration provides an opportunity and obligation to develop robust integrated quality planning, quality improvement, assurance and accountability, across all sectors. Optimal urgent care is a pressing matter for the people of Scotland, a unifying cause and a clarion call to action.

The new model of care proposed by the Review, delivered by a growing multidisciplinary team drawn from all care sectors, requires to be underpinned by a clear and shared service specification which should be rapidly developed. Reflecting a truly person-centred approach, new standards and indicators should incorporate both patient/carer outcomes and staff experience and must also take account of health inequalities. Proportionate and risk based quality of care scrutiny reviews for OOH and urgent care services should be developed collaboratively by Healthcare Improvement Scotland and the Care Inspectorate. Proposals are made to undertake a scoping exercise for improvement support of OOH services at national and local levels. A national multi-sectoral Quality Governance Group is recommended to oversee quality and ensure that standards are being set, met and improved upon, including the sharing of best practice ([Recommendation 20](#)).

## Chapter 9 – Data & Technology

Improved Information Technology (IT) and eHealth systems will help to deliver many of the recommendations made by the Review. This recommendation reflects the guiding principle that future models of OOH and urgent care should be intelligence-led. While IT systems have evolved and significant progress has been made, the huge potential of shared electronic records has yet to be fully realised. Individuals who may be sick and seriously ill may traverse from home through a number of care sectors in a very short space of time. Care providers may access a myriad of separate databases, along the journey of care. Care at interfaces with separate databases and recording systems or methods adversely impacts on safety and hampers effective communications and collaboration. Person-centred care requires reliable and accurate person-centred information, available at the right time and in the right place. The proposed Urgent Care Resource Hub model offers a potential opportunity to help coordinate and interpret information at area and locality levels – particularly in complex cases and those with enduring conditions. This person-centred intelligence function should help to optimise assets and care outcomes. Consistency in data sharing across sectors should be the rule, preserving security and confidentiality. A collective service review of OOH IT systems currently in use and related governance arrangements is urgently required in order to deliver national consistency in use and optimisation of individual patient care and information.

The deployment of high quality video-links remains patchy and further exploitation is required – connecting Urgent Care Resource Hubs with Urgent Care Centres, in remote and rural areas, in intermediate care settings such as residential homes and community hospitals, in the Scottish Prison Service and for mobile clinical decision support by SAS. Cultural barriers to effective deployment should be addressed as they often outweigh technical issues. Innovation, development, deployment and evaluation of mobile applications ('apps') are also recommended to support self care and best use/access to services ([Recommendation 21](#)).

## Chapter 10 – Role of Health and Social Care Partnerships and Integrated Joint Boards

Strong strategic leadership will be required for implementing the recommendations made by the Review. Getting OOH services and urgent care right for the people of Scotland should be a compelling priority for all sectors. Excellent care should not be just reactive but be pro-active. Opportunities for prevention and pre-emption should be pursued to add to individual and community resilience ([Recommendations 5,15,16](#)). The view of the key leadership role and function of Health and Social care Partnerships and IJBs was commonly and consistently expressed throughout the Review process. Recommendations are made about strategic planning, quality and safety imperatives and promotion of inter-sectoral organisational development - to

help erode cultural differences and to promote the common weal ([Recommendation 22](#)).

## Chapter 11 – Role of Special Health Boards and Public Bodies

Special Health Boards and Public Bodies should play key supportive roles going forward for OOH services and urgent care, as they did during the course of the Review. Relevant Review recommendations are mapped onto each organisation, as are the guiding principles adopted by the Review: of person-centred, intelligence-led, assets optimised and outcomes-focused care. The complementary principles of desirable, sustainable, equitable and affordable services are also applicable to the functions of these Boards and Bodies - for example NHS Health provided advice on the impact and mitigation of health inequalities – mapping to the principle of equitable services. The synergistic collaboration of NHS 24 and SAS should be very important as they work together to ensure optimal triage and clinical care processes and dispositions. Equally the regulatory, scrutiny and improvement roles of Healthcare Improvement Scotland and the Care Inspectorate should combine in common cause to ensure the quality and safety of OOH and urgent care throughout Scotland. The imperative of health intelligence cannot be understated and NHS NSS should continue to develop its role and aspirations at national and local levels. The Scottish Health Council should continue to promote best engagement of the people of Scotland in participating and shaping future care services, including self care and best use of urgent and emergency care services. A further proposal was for the Scottish Government to carefully consider optimal governance arrangements for NHS 24, SAS and NHS NSS, in the light of the recommendations of the Review ([Recommendation 23](#)).

## Chapter 12 – Role of the Third and Independent Sectors and other Agencies

Both the third and independent sectors are significant contributors to OOH care services. The third sector very often attends to particularly vulnerable members of society. The third sector submitted a paper for the Review as did the independent sector via Social Care and both offered recommendations. Many of the proposals by Social Care have been assimilated by generic OOH services recommendations made by the Review. The principles offered by the third sector, several of which were cross-cutting, were considered and with minor changes were assimilated into the Review recommendations – issues of role awareness, improved intelligence, better inter-sectoral governance, sustainable funding and enhanced inter-sectoral communications were raised.

The assets and future role of the Scottish Fire and Rescue Service should have more prominence in relation to health and social care provision, particularly in their prevention and first responder roles and co-responder roles, in close partnership with SAS. This has immediacy for community cardiac arrest events with cardiac defibrillator equipped vehicles.

Royal National Lifeboat Institution (RNLI) lifeboats may be deployed for evacuation of urgent cases from remote islands when alternative transport arrangements are unavailable or inappropriate, particularly in adverse weather conditions. Where there are working linkages between the RNLI, SAS and HM Coastguard, these should be supported by a formal Memorandum of Understanding.

The Review heard concerns about capacity and co-dependency of GP personnel across OOH primary care, prisoner care and forensic medical services. The Review was unable to pursue this further, in the available timeframe and therefore recommends that further work should be considered of the issues concerned. This would include better use of telehealth, linked electronic records, quality assurance of OOH services for prisoners, and exploration of the potential for advanced practitioners for clinical forensic services ([Recommendation 24](#)).

## Chapter 13 – Promoting Person-Centred Care

The first guiding principle of the Review was that optimal OOH care should be person-centred in terms of those who receive care and those who deliver it. Much of the focus of the Review has been on valuing staff. It is appropriate that we return full circle to person-centred care for the people of Scotland. It is a compelling principle which must be heeded:

- Helping people and their carers to be informed and engaged through education, information sharing, addressing health literacy needs, emotional and psychological support
- Helping the professionals to be enabling and collaborative, through leadership, communication skills, training and reflective practice
- An organisational infrastructure that promotes continuity, ease of access, customises time according to need, IT support and service design
- Rich social support, relationships and sustained resources in our communities that keep people well.

There is an opportunity to develop OOH and urgent services that are responsive to the self-management and health literacy needs of people. The rationale and recommendations for these are set out in Scotland's national health literacy action plan [Making it Easy](#) and are wholly endorsed by the Review ([Recommendations 25 and 5,6,7](#)).

## Chapter 14 – Research and Evaluation

The Review commissioned a rapid systematic review of the international literature, and focus group research from the Scottish School of Primary Care and undertook separate survey work ([Annex F](#)) and available in full on the [Review website](#).

During the course of this systematic review yielding 274 research papers for scrutiny, a paucity of robust evaluation of models of OOH services was found.

The lack of relevant published literature and planned service evaluations in OOH services have significantly hampered understanding of best practice. Future research and development (R&D) support should inform and evaluate new models of OOH and urgent care services, including economic assessment ([Recommendation 26](#)).

## Chapter 15 – National Implementation Plan and Local Guidance

The Review has proposed 28 recommendations covering new models of care, workforce - including increased multidisciplinary capacity and capability, quality and safety, data and technology, responsibilities and leadership and enhanced roles for statutory authorities, third and independent sectors and other agencies. These are ambitious - but reflect extant and looming challenges of demographic change, increasing multimorbidity, complexity and rising service demands. The recommendations offered reflect the imperative of transformational rather than incremental change. Careful reflection on the recommendations is therefore essential for all stakeholders at national and local levels. This is amplified by financial constraints and the need to maximise benefits, as discussed in [Chapter 16](#). Set in the context of early and evolving health and social care integration, implementation of the recommendations in the Review will require inter-sectoral collaboration of a very high order. Careful, considered and resolute preparation of quality assured implementation planning is vital at both national and local levels ([Recommendation 27](#)).

## Chapter 16 – Finance and Best Use of Resources

Recognising significant financial challenges in the next 10 years it will be particularly important that all services produce increased efficiency and productivity in order to deliver safe, high quality person-centred care. Increased investment in primary care OOH and urgent care services specifically will need to demonstrate best value for money and areas of disinvestment pursued. Particular areas for resource allocation

are identified where maximising service benefits will be essential including: Urgent Care Resource Hubs, Urgent Care Centres, eHealth, workforce capacity and capability, SAS in synergistic working with NHS24 and SAS strategic aspirations ([Recommendation 28](#)).

## Chapter 17 - Conclusions

28 recommendations and a number of sub-recommendations are presented for consideration and reflection. They embrace new models of care, the needs of specific groups, enablement and empowerment, accessibility, health literacy, inequalities and the promotion of person-centred care. Workforce issues occupy a number of our recommendations - capability, capacity, challenges and the need for unprecedented primary care workforce planning at national and local levels with a key focus on valuing and supporting staff throughout their careers. Better quality and safety are essential for optimising patient care and this will be underpinned by better use of and access to electronic records, telehealth, telecare and mobile applications caring for our patients and the people of Scotland, supporting self-care where appropriate and ensuring best access to services when needed. A number of recommendations are made about the future roles of the third and independent sectors and other agencies, the leadership roles of Health and Social Care Partnerships and Integrated Joint Board, and the support roles of Special Health Board and Boards. Recommendations for research and evaluation are mooted and there is a strong emphasis on shared inter-sectoral planning at both national and local levels with the key imperative of ownership. The final recommendation addresses finance and best use of resources.







# 1 Key Messages

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## Overarching

- The Scottish Government recognises the importance of primary care as the first point of contact in health care for most people - including the out of hours (OOH) period when people need urgent care.
- Putting the person at the centre of care is a fundamental principle of the Scottish Government's future vision for the people of Scotland. In this Review, the 'person' refers both to those who need services - their carers and families - and those who provide services. Urgent care services should be more easily accessible and navigable for all.
- During the one year period 1 May 2014 to 30 April 2015, almost one million contacts were made with primary care OOH services. Over the same period, NHS 24 dealt with ~1.3 million calls. This compares with ~900,000 emergency department/A&E attendances in the OOH period, amounting to 56% of their total workload. The Scottish Ambulance Service (SAS) dealt with ~500,000, '999' and general practice urgent calls in the OOH period.
- 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 years age group and the under 1 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 ~32% by the year 2024 and ~66% by the year 2034.
- The annual cost of delivering primary care OOH services reported by Scotland's territorial Boards in 2014/2015 was £81.8 million. NHS 24 incurred costs of £40.4 million, giving a total of £122.2 million invested by the NHS in supporting OOH services across Scotland, excluding Scottish Ambulance Service costs, which are not demarcated by time.
- Following the introduction of the 2004 General Medical Services Contract, the responsibility for delivery of general practice services during the OOH period transferred from GPs to territorial Health Boards. This has resulted in a number of unforeseen and adverse consequences - including insufficient participation of GPs in OOH services.

- The present situation for OOH services is 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.
- Future urgent care will be delivered by well-led and trained multidisciplinary and multi-sectoral teams. GPs will no longer be the default health care professionals to see patients for urgent care, but they must continue to be an essential part of multidisciplinary urgent care teams, providing clinical leadership and expertise, particularly for complex cases. People seeking help need to see the right professional at the right time, according to need.
- An enhanced capacity multidisciplinary OOH workforce should be rapidly built up, including: advanced nurse practitioners, community nursing staff, paramedical staff and other allied health practitioners (AHPs), clinical pharmacists, physician associates and social services staff. The contribution of administrative and support staff is crucial and must be clearly valued and recognised.
- Future provision of OOH and urgent care services should not be constrained by traditional boundaries or demarcations.
- Going forward, this should include a more prominent role for the third, independent sectors and other agencies, including the Scottish Fire and Rescue Service.

## Enabling Person-Centred Support and Services

- Future service design and delivery should be based on best meeting the needs of the public and those who deliver services, taking full account of individual requirements, irrespective of circumstance. This should enable tailored advice, support and self care, and where required, direction to the right service, at the right time.

## Workforce

- Workforce planning, recruitment and retention should be accorded high priority and urgency for both daytime and OOH services - particularly for GPs and district nurses, given the aging profile of both workforces and the serious impact of imminent retirement or withdrawal from service.

- Moving to a sustainable and multi-disciplinary OOH workforce will require new thinking, different ways of working and investment across the workforce using best organisational development practice.
- National workforce planning for OOH services should be rapidly configured and translated to support integrated workforce planning to meet the needs of areas and local communities.
- The collection of systematic and comprehensive primary care workforce data is essential on an ongoing basis.
- The effectiveness of OOH services will rely on strong leadership, provided by the most appropriate professional, in relation to local circumstances and requirements.
- Staff working in OOH services deal with many difficult pressures - particularly delivering care during unsocial hours and through the night. This involves caring for patients who may be seriously unwell, often working in isolation from colleagues. To ensure a sustainable and well supported workforce, OOH services should prioritise embedding induction, supervision for all staff and decision- making support for all clinicians.
- GPs undergoing their specialist postgraduate training should receive increased exposure to high quality training in OOH services. After completion of training, GPs should be encouraged, enabled and supported to participate in the delivery of OOH services to meet the health care needs of the Scottish people.

## Quality and Safety

- The quality and safety of OOH services should be underpinned by a clear service model specification of revised quality standards and quality indicators. A national Quality Governance Group should be established to oversee and support continuous quality improvement and promote good practice.
- OOH services should be regarded as a core component of services requiring robust support at Board area level. Healthcare Improvement Scotland should be commissioned to scope out how best local, regional and national improvement support may be required, in collaboration with the Care Inspectorate.

## Infrastructure and Technology

- A new model of urgent care is proposed by developing Urgent Care Resource Hubs. These hubs would provide a coordinating function for multidisciplinary and multi-sectoral urgent care and should provide patient and service intelligence, supporting multidisciplinary teams. While primarily established for OOH services, they should be considered for 24/7 urgent care coordination. Piloting and evaluation will be important, to inform future progress.
- Existing Primary Care Emergency Centres should be considered as a future network of Urgent Care Centres. These should be fit for purpose for service delivery and training, and appropriately located to facilitate patient access and service resilience. Community pharmacies should play a more prominent future role in the OOH period, providing advice and treatment for minor ailments. Day time requirements for NHS urgent care in the community would normally continue via direct access to general practice services, community pharmacies and with NHS 24.
- Digital infrastructure should be further developed, to enable better electronic records, information and knowledge exchange – which should lead to improved communications, decision making and better patient outcomes. This should also include enhanced use of video-conference technology, telehealth and telecare - and the development of mobile applications 'apps', to promote self care and to assist best use and access to urgent care services. Good communications are particularly critical for remote and rural areas where inadequate mobile and broadband infrastructure compromises care delivery.

## Leadership

- Health and Social Care Partnerships and Integrated Joint Boards (IJBs) will be required to provide strong leadership for OOH and urgent care services, going forward. They must place sufficient priority on the delivery, improvement and monitoring of quality and safety for these services working with NHS Boards, Local Authorities, the third and independent sectors.
- The strategic planning process of Health and Social Care Partnerships and IJBs should look for opportunities for integrated OOH service provision from Local Authorities and the NHS, including co-location opportunities, and the provision of optimal urgent care services on a 24/7 basis.

## Finance

- Over the next decade it is unlikely that health funding will grow at the same rate as the increase on demand for services. All of our services will therefore need to deliver increased efficiency and productivity in order to deliver the safe, high quality care required. Increased investment in OOH and urgent care services will need to demonstrate best value for money.

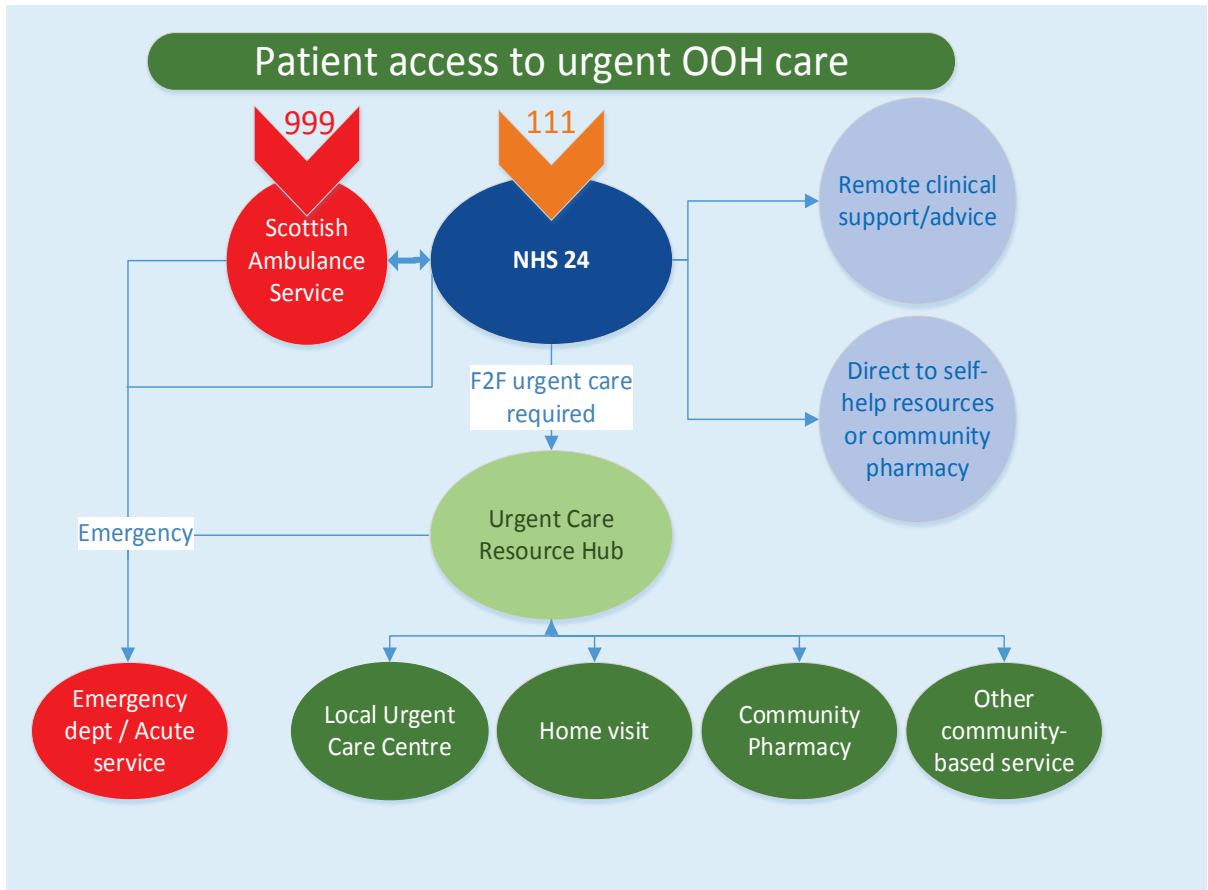
## 2 Recommendations

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### Recommendation 1 - A New Model of Care for Out of Hours and Urgent Care Services

1. It is essential that a whole system, holistic approach is taken for the provision of 24/7 urgent and emergency care for the people of Scotland. Whilst this review has as its core remit a review of out of hours (OOH) primary care services, the model described here takes account of potential future requirements of 24/7 urgent care in the community. This includes the roles of NHS 24 and the Scottish Ambulance Service (SAS), and the key interface with emergency departments/A&E services and acute hospitals, set in the context of health and social care integration.
2. In keeping with the *2020 Vision* for the people of Scotland, for adults and children with urgent care needs, a safe, effective and responsive service must deliver care as close to home as possible for patients, carers and families.
3. In order to achieve that services should:
  - provide better support for people to self-care, when appropriate
  - recognise more the crucial role of carers and to support them to care for their dependants
  - help those who need urgent care to obtain the right advice and support, in the right place, at the right time
  - provide consistent and responsive urgent care services on a 24/7 basis
4. A framework for a new model of OOH and urgent care services across Scotland that is:
  - multi-disciplinary and multi-sectoral
  - person-centred, intelligence-led, asset-optimised and outcomes-focused
  - underpinned by a robust infrastructure that is fit for purpose and clinically safe
  - designed to deliver consistent high quality care supported by a clear service specification

The proposed model is shown schematically in [Figure 2.1](#)



**Figure 2.1 A New Model of Out of Hours Care**

(Please note: F2F = face to face)

## Recommendation 2 – Future Synergy of NHS 24 and the Scottish Ambulance Service

1. NHS 24 and the Scottish Ambulance Service (SAS) presently operate separate triage processes for callers seeking help and assistance. Greater synergistic working should occur between NHS 24 and SAS to improve patient pathways of care. A joint review of all clinical triage processes, pathways and dispositions, is recommended, involving independent experts.
2. NHS 24 should rapidly develop a five year strategy and implementation plan, which maximises and quality assures the functionality of its services and infrastructure. This should include digital innovation by the Scottish Centre for Telehealth and Telecare, taking into account the particular needs of urban, remote and rural communities. The optimal deployment and location of staff, including exploration of working from home options should also be considered.
3. SAS should continue to implement its community care outreach aspirations in its strategy *Towards 2020: Taking Care to the Patient*, ensuring and maximising service benefit and best use of resources. Paramedical practitioners (paramedics) are currently supporting OOH services in a number of models across Scotland and an early review, aimed at organisational learning and governance arrangements, is proposed ([Recommendation 14](#)). The development of additional urgent care capacity in SAS should be pursued, while ensuring that further improvements in emergency care are also delivered - including the role of SAS in Scotland's *Out of Hospital Cardiac Arrest Strategy*.

## Recommendation 3 - Urgent Care Resource Hubs

1. **Coordinating urgent care:** The future model proposed by this Review is based on the development and evaluation of Urgent Care Resource Hubs, co-ordinating well-led and well-supported multidisciplinary health and social care teams to deliver urgent care – including third and independent sector providers.
2. **24/7 urgent care:** Although primarily established for OOH service requirements, these Urgent Care Resource Hubs should be considered for coordination and support of urgent care on a 24/7 continuous basis.
3. **Electronic records and anticipatory care plans:** Urgent Care Resource Hubs should have secure and confidential access to appropriate electronic records to support optimal decision making about the needs of patients -



particularly those with complex or enduring physical or mental health conditions, and their carers. This includes access to third sector electronic databases, including ALISS (A Local Information System for Scotland). This should also be enhanced by more systematic locality and general practice anticipatory care planning ([Recommendations 6 and 21](#)).

4. **Location and capacity:** The location and capacity of these Resource Hubs should focus on Health Board area and locality requirements but should also take account of inter-Board patient flows. Economies of scale and critical mass should also be considered and therefore regional coverage may be appropriate for example, for the Highlands and Islands.
5. **Effective communications:** Urgent Care Resource Hubs would operate on the basis of a single point of contact, to streamline best professional-to-professional communications.
6. **Asset optimisation - managing demand and supply:** These centres should keep continuously updated about service demand and all available staff and care resources, including: care at home, acute hospital and community/intermediate care beds/resources (community hospitals, residential nursing and care homes), status and location of third and independent sector services, hospital-at-home and rapid response teams provision, and the operational status of all general practices and community pharmacies. This should add to resilience and result in more effective and rapid deployment of resources.
7. The Scottish Ambulance Service is presently and continuously aware of the operational status and whereabouts of all their vehicles. This capability needs to be extended both nationally and locally to underpin resilient services and best use of available human and physical resources. Other asset mapping capacity is already happening in SAS in relation to BASICS doctors, community first responders and the location of publically accessible heart defibrillators. This asset based collaboration with the Scottish Fire and Rescue Service underpins present cardiac arrest co-response pilot studies ([Recommendation 24](#)).
8. **Training and learning function:** Urgent Care Resource Hubs are a potential platform for shared learning across sectors. The design and implementation of these hubs should be considered in developing this approach.
9. **Care pathways:** Local care pathways need to be developed, clearly understood and effectively implemented, particularly at the interface between

urgent community care services, emergency departments, other acute hospital services and the Scottish Ambulance Service. Clinical decisions should be supported by directly accessible professional-to-professional advice arrangements when required.

10. **Remote and rural challenges:** Developing robust pathways of care is particularly crucial for remote, rural and island communities with unique challenges of geography, population sparsity, workforce recruitment constraints and poor mobile and broadband connectivity ([Recommendations 6, 21 and 24](#)).
11. **Potential public health role:** In addition to their core role in coordinating day-to-day urgent primary care activity, Urgent Care Resource Hubs might be considered, suitably augmented, for a coordinating role in relation to responding to significant public health emergencies such as communicable disease outbreaks (including the interface with Health Protection Scotland and the support of civil contingency emergencies).
12. **Evaluation:** This proposed new model, which significantly builds upon existing administrative functions for OOH services, requires robust piloting and evaluation in order to inform future progress and development.

## Recommendation 4 - Urgent Care Centres

1. Urgent Care Centres (presently described as Primary Care Emergency Centres), should be developed to deliver local OOH urgent care services. They should be fit for purpose, technologically enabled and robustly networked to an Urgent Care Resource Hub.
2. Urgent Care Centres should be safe and secure environments which are appropriate for the optimal care and wellbeing of patients, multidisciplinary care teams and volunteer workers.
3. Urgent Care Centres should normally be configured as both clinical and educational environments, to facilitate training and learning.
4. Urgent Care Centres should be located in the right place, taking due account of transport and travel factors for patients and staff, in order to optimise both access for the public and resilience for the service. They may be co-located with Urgent Care Resource Hubs, emergency departments or minor injury units, providing opportunities for collaboration, co-working and co-production,

encouraging patients and carers to use the service best suited to meet their needs.

## Recommendation 5 - Public Awareness, Support and Best Use of Services

1. OOH services remain poorly understood across Scotland both by the public and by professionals, often resulting in people finding it difficult to know where to seek advice or to go with their urgent care requirements. This has at times, resulted in poor alignment of services with clinical needs. In order to enable optimal person-centred care, it is recommended that a specific and sustained high profile campaign and programme be developed to promote public awareness and engagement, using models of best practice. This includes learning through experience of using urgent care services (experiential learning).
2. In addition to enabling better care, and assistance for carers, this programme should promote best access to, and effective use of urgent and emergency services, including clarity of the terms 'urgent' and 'emergency' care. This should also include meaningful participation of the public in the shaping and delivery of locality based services, innovative use of digital technology, websites and development of relevant mobile applications ([Recommendation 21](#)). International experience should also be assimilated, including the Nuka programme in Alaska.

## Recommendation 6 - People with Specific Needs

1. It is essential that people with specific needs receive appropriate care and support. Recommendations are therefore made about a small number of groups with specific needs: Children; Palliative Care; Mental Health; Frail and Older People and those with Special Access Requirements. This is [preliminary work](#) only and should be developed further. Condition-specific local care pathways and care provision, for example for patients with cancer or chronic obstructive pulmonary disease, should also be considered.
2. People should be supported to access resources to prevent escalation or deterioration of their health problems, including comprehensive implementation of anticipatory care plans.

## Palliative Care

1. People at the end of life and their carers should be able to directly access care and assistance, by local helpline on a 24/7 basis, without recourse to national NHS 24 triage - in order to secure swift, effective and compassionate care.
2. Palliative care patients and their carers should have extended access to responsive and timely community nursing support, including Macmillan and Marie Curie nurse practitioners, alongside allied health professionals (AHPs), as required.
3. Local care pathways for palliative care should be developed systematically, be clearly understood by service users and providers, implemented effectively, and quality assured. There should be an emphasis on home, and hospice care at home support, wherever possible.
4. All of the former recommendations to be underpinned by safe and secure shared electronic records and comprehensive anticipatory care plans ([Recommendation 21](#)).

## Mental Health

1. Psychiatric urgent care and emergencies must be prioritised no less than physical conditions.
2. The work of the Mental Health Scottish Patient Safety Programme around transitions of care should continue to ensure that all transfer arrangements are appropriate, and where delivered by SAS, this is done in a timely fashion, irrespective of location. The challenging area of air ambulance and other reliable transport support for remote locations should be part of this work
3. Distress Brief Interventions should be piloted and evaluated to determine their benefits.
4. Health and Social Care Partnerships and Integrated Joint Boards (IJBs) should work with partners to make available more community-based places of safety for people experiencing mental health crisis or who are under the influence of drink or drugs to avoid the default use of custody suites or emergency departments where these are not appropriate locations for their care and support. This will require close collaboration between statutory, third and independent sector assistance, particularly with the support of Police Scotland.

## Frail and Older People

1. Daytime and OOH services should be configured and responsive to the growing numbers of frail and older people in Scotland, many with complex conditions.
2. The access needs of frail and older people should be carefully addressed in future provision of urgent care and OOH services (see [Special Access Requirements](#) below).
3. Anticipatory care planning should be implemented systematically, taking best account of the needs and wishes of frail and older people, their carers and families ([Recommendations 2 and 21](#)).
4. Care homes should be able to access a wider set of community supports to reduce avoidable admissions of older, frail people from this sector in the OOH period.
5. The care of frail and older people - who have the misfortune to fall and are unable to resume their previous position unaided - is variable. A minority (7 of the 31) Integrated Joint Boards in Scotland at the time of writing of this report have agreed and implemented systematic plans to respond to the needs of uninjured people who fall. This should be remedied as a matter of urgency, in the context of the *Prevention and Management of Falls in the Community Framework for Action 2014-16*.

## Children

1. GPs, advanced nurse and paramedical practitioners, should have rapid access to telephone advice from paediatric specialist staff during daytime and OOH periods.
2. GP, advanced nurse and paramedical practitioner training, should include a strong focus on paediatric clinical skills.
3. The NHS Inform (NHS 24) website should have a clearly signposted section on young children who become unwell with common causes and suggestions for parents as well as primary and secondary school staff and others caring for children. This should be extended to the development of appropriate mobile applications ([Recommendation 21](#)).

4. NHS 24, territorial Health Boards and Integrated Joint Boards (where children's services are delegated) should continue to work together to develop local urgent care pathways for children, and to ensure they are effectively implemented in accordance with the principles of *Get it Right for Every Child* (GIRFEC).
5. Regular local interactive multidisciplinary educational sessions - supported by consultants with paediatric responsibilities, should be encouraged and resourced to facilitate clinical quality improvement and service development

## Special Access Requirements

1. The needs of individuals with special access requirements should be carefully addressed in future service provision, in particular for people with sensory or other physical impairments, people whose first language is not English and people who are frail, older or who have dementia.
2. Access to services may also be compromised by poor literacy, poverty constraints, telephone or IT/computer access issues, additional support needs and travel difficulties, particularly in remote and rural areas where transport - including local community arrangements - should be configured to support equity of access in the OOH period ([Recommendation 7](#)).

## Recommendation 7 - Health Inequalities

1. The design and implementation of all OOH services should demonstrate how they are ensuring equity of access and outcome, in proportion to the levels of need for everyone who presents with an urgent healthcare requirement.
2. Service specifications for delivering OOH services should take account of social as well as clinical needs of the population they serve. Quality and safety implementation and monitoring of OOH services should be assessed for their impact on health inequalities.
3. Current primary care resources for general practices are maldistributed by health care needs, according to socioeconomic status (Guthrie et al).. Levels of multimorbidity increase with increasing deprivation. This should be taken into account, when configuring future daytime and OOH service provision, including the experience of 'Deep End' practices.

## Recommendation 8 - Effective Workforce Planning

1. A national primary care workforce plan should be developed and implemented without delay – including enhanced and sufficient training places for future GP, nursing, pharmacy and AHP workforce requirements, for both daytime and OOH primary care services. This should also include re-appraisal of the specific contributions of, and recruitment by: Medical Schools, Schools of Nursing, Schools of Pharmacy, the Scottish Ambulance Academy, educational providers for other Allied Health Practitioners, social services workers, and the key role of NHS Education Scotland (NES).
2. Robust workforce planning also needs to be urgently replicated at NHS Board, local authority and Health and Social Care Partnership and IJB levels, in order to secure a sustainable and empowered multidisciplinary workforce for the future in the short, medium and longer term. These workforce plans need to be continuously kept under review. Robust workforce planning needs to be in place and include organisational development strategies that support the delivery of future models of care.
3. An organisational development (OD) approach should be adopted that supports a better understanding of role/task across professions/sectors to determine where there is a need to do things differently. This would support the development of multidisciplinary/multi-sectoral teams with the potential to up-skill the workforce to undertake more enhanced roles, where appropriate, and with the training and support to do so. This should enhance the capacity to create teams that get the right support to people at the right time. This extends to the role of carers, third and independent sectors, given the important contribution they make to supporting people in communities.

## Recommendation 9 - Interdependent Linkage between Daytime and OOH Services

1. Daytime primary care and OOH services are inextricably linked. A robust inter-relationship between daytime provision and OOH care needs to be in place to enable reciprocal support systems and processes to operate effectively. In particular, it is important that any changes made to OOH services do not destabilise daytime provision or the converse, and that the resilience of both are strengthened. The same principle applies to the interface between community, primary care and acute hospital services.

## Recommendation 10 - The Importance of the Working and Educational Environment

1. **Capability:** Sustainability of the OOH service requires continual training and experiential learning opportunities for new and future clinical and care staff. In particular, this includes doctors in training and those training for advanced practitioner roles in nursing and the allied health professions. A positive organisational development culture values and sustains quality training in environments that are safe for patients and supportive both for learners and educators.
2. **Capacity:** Achieving the above conditions requires adequate numbers of clinical staff to engage in these important roles and workforce levels should be commensurate with this requirement.
3. **Career development:** While necessary, it is no longer sufficient to provide exemplary undergraduate and postgraduate training for practitioners. Provider organisations must focus greater attention on optimal use of the workforce, irrespective of stage of career. This should take the form of career development support, better succession planning and could help to improve job-fulfilment and staff retention. This is a generic recommendation which applies both to daytime and OOH services and to all care sectors, including acute hospital care.

## Recommendation 11 - Future Contribution of the GP Workforce

1. General Medical Practitioners (GPs), as for all health professionals, should be clinically accountable for the provision of safe effective and patient centred care. They should work within each locality and their OOH service to secure:
  - Longitudinal care and continuity of relationships where this is important
  - Access to care at the right time when it is required
2. **Contracts:** Appropriate engagement, contractual arrangements and best practice should be in place to enable and incentivise these new commitments in order to improve access to services and encourage more flexible working, as capacity allows. Key to this is flexibility about timing and duration of shift patterns, superannuated/non-superannuated contracts, indemnity provision and development support, as required. This includes adequate recognition and support for GPs who continue to provide 24/7 care for their patients, as occurs in some remote and rural areas. This same principle applies equally to all members of multidisciplinary teams undertaking new or extended roles.



3. **National GP Performers' List:** Arrangements should be put in place to streamline this process and effectively create a National GP Performers' List to enable GPs to work flexibly across Health Board boundaries.

**GP Specialty Training:** *Shape of Training: Securing the future of Excellent Patient Care* (The Greenaway Report) proposed that GP specialty GP training should be enhanced. The RCGP have recommended that this be achieved by a fourth year of training. However there has been a lack of progress to move to an enhanced four year training programme on a UK wide basis. GPs at completion of their certificate of training (CCT), after three year specialty training are competent, but may feel insufficiently experienced. This may be contributing to a reluctance to undertake OOH work. Existing four year training posts in Scotland should be reviewed to ensure the experience maximises educational opportunities for the future GP workforce. In the meantime newly qualified GPs should be offered a salaried one year post, which will include OOH work with enhanced support and continuing professional development (CPD) in OOH medical care.

4. **OOH Commitment from GPs:** RCGP Scotland and the Scottish General Practitioner Committee of the BMA submitted a joint principle to the Review that it is a core professional value that GP care in the community is available at anytime and it is essential that GPs remain a central part of OOH services to ensure holistic, coordinated patient care. GPs should be encouraged and enabled to contribute a proportion of work in OOH services. GPs within five years of completing their CCT and those returning to work in OOH services after a service break, should receive help and support from a GP mentor.

## Recommendation 12 - Future Contribution of the Nursing Workforce

1. **Advanced Nurse Practitioners:** Advanced Nurse Practitioners (ANPs) have a significant contribution to make in delivering sustainable and consistently high quality OOH care. It will be important to ensure that there are sufficient ANPs, who can work to their maximum potential. The results of the Chief Nursing Officer's (CNO's) review of ANPs should inform delivery and improvement of these services and is due in April 2016.
2. A national definition of advanced nursing practice should be developed which will support better and consistent understanding of the scope and responsibilities of their role, including independent prescribing.

3. Consistent standards for the training and education of all ANPs and clear nursing career development pathways should be designed.
4. A model role descriptor and an agreed set of national ANP competencies for different fields of practice will ensure that the level of practice of ANPs is recognised consistently across Scotland within the terms of *Agenda for Change*, for both the current and future workforce. There should be national consistency in definitions, roles, education (including fast tracking) and remuneration. This is required for good governance and service monitoring.
5. **District Nursing:** The CNO's current review of district nursing contributions includes a specific focus on their role in OOH services. The role of district nurses is essential to support 24/7 community healthcare. The review is seeking to underpin a nationally consistent district nursing role, where nurses have the capacity, capability infrastructural support and access to resources, enabling to meet patient need. The CNO's review is expected to report in April 2016.
6. Health Boards should consider the full range of options at their disposal to deal with recruitment and retention issues within their nursing workforce to ensure sustainable OOH services. This could include the use of temporary measures such as recruitment and retention premia to fill hard-to-recruit-to posts. Nurses should have access to relevant resources and support to effectively deliver their roles.

### Recommendation 13 - Future Contribution of the Pharmacy Workforce

1. Community pharmacies throughout Scotland make an essential contribution to care both in daytime and during the OOH period. Community pharmacies should have a greater profile and urgent care role going forward.
2. **Electronic Record Access:** In order to undertake their role effectively, they will require protocol-driven secure access to electronic patient information to underpin best care and to facilitate optimal communications with other health services.
3. **Minor Ailments Service:** Greater public awareness and use of the Minor Ailment Service (MAS) should be encouraged in community pharmacies to advise and treat these and other common clinical conditions.
4. **Patient Group Directions:** Extension of the community pharmacy patient group directions (PGDs) to enable assessment and management of a broader range of common clinical conditions should be carried forward.

5. **Enhanced Clinical Skills:** The developing role of pharmacists with additional clinical skills and prescribing capability should be further encouraged and utilised, including their role in OOH services and within NHS 24. This will require appropriate educational and training support.
6. These recommendations, including the extended set of recommendations provided jointly by Community Pharmacy Scotland, Health Board Directors of Pharmacy and the Royal Pharmaceutical Society Scotland, should be taken forward in the context of the *Prescription for Excellence* strategy for pharmaceutical care in Scotland.

### Recommendation 14 - Future Contribution of the Paramedical Workforce

1. Paramedical practitioners (known as paramedics) and specialist paramedical practitioners currently make a significant contribution to urgent care 24/7 in all communities in Scotland. In the future they should have a more substantive role in working with other colleagues including GPs, ANPs, community nurses, AHPs, clinical pharmacists, physician associates and social services staff to ensure the delivery of consistently high quality OOH urgent and emergency care. These roles are described in the forward strategy of SAS: *Towards 2020: Taking Care to the Patient*.
2. A clear description of the training and competency framework of specialist paramedical practitioners should be developed which should support better and consistent understanding of the scope and responsibilities of the role.
3. Consistent standards for the training and education of all paramedical grades should be prepared
4. Clear paramedical career development pathways should be designed.

### Recommendation 15 - Future Contribution of Allied Health Professionals and Physician Associates

1. In addition to paramedical practitioners, other Allied Health Professions (AHPs) have key and developing roles in the effective management of patients to ensure that they receive the most appropriate urgent care in a community setting. This includes AHPs supporting the work of NHS 24 - for example physiotherapist input to musculoskeletal disorders.

2. AHPs have a particularly important role to play in integrated community rehabilitation teams, maximising the potential of prevention and planned care to pre-empt avoidable urgent care and hospital admission. That role will require flexible access to services, including weekend working.
3. AHPs should play a leading role in the implementation, spread and sustainability of the *Falls Up and About* pathway, to aid early identification of triggers for repeat falls/attendees ([Recommendation 6 – Frail and Elderly](#)).
4. As urgent care develops, it is likely that point-of-care testing (POCT) will increasingly be deployed. AHPs will have an important role in cost-effective implementation and governance.
5. The role of physician associates (PAs - also known as physician assistants) who work for, and with doctors, should also be considered for inclusion in the required skill mix of the future clinical workforce.

### Recommendation 16 – Future Contribution of Social Services Workforce

1. The Social Service workforce will have key and developing roles in supporting individuals to ensure they receive the most appropriate support in a community setting.
2. Along with other members of inter-sectoral teams, they will continue to play key and developing role in the prevention of, and response to falls in the community and other urgent care needs – for example via the community alarm system. In the future this should include other forms of innovative remote monitoring via telecare, video-linking and mobile applications ([Recommendations 15, 21](#)).
3. Learning and development programmes should be inter-professional for all practitioners and be embedded within formal performance and development plans.

### Recommendation 17 - Working and Learning in Professional Partnership

1. As health and social care partnerships continue to develop their role, OOH social services will work more closely with clinical services and these professional links should be strengthened. This becomes an integral part of client/patient support wherever and whenever needed.

2. Inter-professional learning should become normal practice and there should be a clear and consistent education and training programmes for all practitioners working at advanced practice level, irrespective of discipline, which includes academic and experiential learning, and practitioners should have annual appraisals, including a review of skills.

## Recommendation 18 – Valuing Support Staff

1. The importance and value of support staff who currently lead the planning, logistics and resourcing of OOH services should be better recognised and valued by NHS Scotland. This includes: administrative, managerial, control room and technical staff, receptionists, call handlers and drivers.
2. As for the nursing workforce, Health Boards, Local Authorities, Health and Social Care Partnerships and IJBs should consider the full range of options at their disposal to deal with recruitment and retention issues to ensure a sustainable OOH service ([Recommendation 16](#)).

## Recommendation 19 - Leadership

1. In order to implement the recommendations made by the Review, strong leadership will be crucial at all levels, supported by professional managerial and support staff. Sufficient leadership calibre, capacity and training are essential in order to shape and lead the future development of urgent care services both locally and nationally

## Recommendation 20 – Quality and Safety

1. This recommendation reflects the guiding principle that future models of OOH and urgent care should be outcomes-focused.
2. Quality and safety are central for the future development of OOH and urgent care services. All care sectors should place sufficient priority on the delivery, improvement support and monitoring of quality and safety for these services.
3. The new model of service delivery proposed by the Review should be underpinned by a clear service specification. This should be rapidly developed by Healthcare Improvement Scotland in collaboration with key stakeholders.

4. Existing standards and indicators should be revised to support future OOH and urgent care service specifications, incorporating both patient/carer outcomes and staff experience. This should take full account of individual care needs, including health inequality issues.
5. OOH and urgent care services should be incorporated as a key focus of proportionate and risk based quality of care scrutiny reviews by Healthcare Improvement Scotland and the Care Inspectorate.
6. Health Improvement Scotland should be commissioned to undertake a scoping exercise of improvement support requirements for OOH and urgent care services at national and local levels, in liaison with the Care Inspectorate.
7. Quality governance systems embrace quality planning, quality improvement, assurance and accountability. OOH and urgent care services should reflect best practice across all care sectors.
8. A national multi-sectoral Quality Governance Group should be established to oversee quality and ensure that standards are being set, met and support continuous improvement in OOH and urgent care services. This Group should also actively promote the sharing of best practice throughout Scotland.

## Recommendation 21 – More Effective Use of Data and Technology

1. This recommendation reflects the guiding principle that future models of OOH and urgent care should be intelligence-led.
2. Improved Information Technology (IT) and eHealth systems will help to deliver many of the recommendations made by the Review and take into account the aspirations of the *Scottish eHealth Strategy 2014-17*.
3. A consistent view is required of all relevant health and social care information necessary to provide optimal OOH and urgent care. Subject to agreed consent, this information should be available securely to the right people at the right time, irrespective of care setting and location.
4. Consistency of data sharing should be improved and should underpin better person-centred care. All health and social care stakeholders should agree a common summary of defined data items and updating protocols.
5. Current referral records and mechanisms are fragmentary and are often still paper based. Referrals from OOH services to all care sectors should be

electronic and fully auditable, in order to ensure effective and timely continuity of care.

6. The NHS NSS National Unscheduled Care Framework presently advises on the procurement of NHS IT systems. In partnership, this framework should now be reviewed in the light of future health and social care integration requirements.
7. A collective service-led review of OOH IT systems currently in use and related governance arrangements is urgently required in order to deliver national consistency in use and optimisation of individual patient care and information.
8. High quality and reliable video links should be in place between Urgent Care Resource Hubs and local Urgent Care Centres ([Recommendations 3 and 4](#)). This technology should also be deployed to support practitioners in remote and rural locations, in intermediate care settings - residential care homes and community hospitals, in the Scottish Prison Service and for mobile healthcare delivered by SAS. The technology may also be appropriate for location in the homes of some patients with complex care needs.
9. The Scottish Centre for Telehealth and Telecare, in collaboration with the Digital Health & Care Institute, should look to support the development and roll-out of proven technologies at scale, including innovation and accredited mobile applications for self-care and access to the most appropriate care services. Such innovation should be subject to appropriate evaluation.

## Recommendation 22 – Future Role of Health and Social Care Partnerships and Integrated Joint Boards

1. Strong leadership for urgent care and OOH services will be required from Integrated Joint Boards (IJBs) and Health and Social Care Partnerships going forward. They should place sufficient priority on the delivery, improvement support and monitoring of quality and safety for OOH and urgent care services ([Recommendation 20](#)).
2. The strategic planning process of Partnerships and IJBs should look for opportunities for integrated OOH service provision from Local Authorities and the NHS, including co-location opportunities, and the provision of urgent services on a 24/7 basis.

3. Future models of care should meet local need and focus on early intervention and prevention. Opportunities should be sought to build on success where best practice has been demonstrated of integrated multi-disciplinary health and social work teams providing 24/7 services. These should include partnership arrangements with the third and independent sectors.
4. Joint organisational development plans should focus on supporting staff to integrate cultures and ways of working and increase mutual respect between professions. There is a need for learning and development strategies to be in place that support strong distributive leadership across professions/sectors. These are crucial factors if effective co-working is to become embedded across Health and Social Care Partnerships and IJBs.

## Recommendation 23 – Future Role of Special Health Boards and Public Bodies

1. **NHS National Services Scotland** should play a lead role in interpreting and delivering the Review recommendations from a public health intelligence perspective at national and local levels, in active collaboration with territorial Health Boards. This includes live operational use of intelligence, as well as for strategic planning, service monitoring and development purposes. Work is already in progress on this, including the development of a health and social care dataset at individual patient/service user level to inform local strategic commissioning. This needs to be coordinated across all urgent care sectors, not just the NHS, and conforms to the principle of intelligence-led services ([Recommendations 1,3,21](#)).
2. **NHS 24** and the **Scottish Ambulance Service** should be encouraged to work together more closely across all their processes, with a view to improving effectiveness and efficiencies of the patient journey of care in order to deliver best outcomes ([Recommendation 2](#) - see also for NHS 24 [Recommendation 21](#)).
3. **NHS Education Scotland** should continue to deliver the lead role in developing training and leadership support for a reconfigured clinical workforce, in order to secure optimal urgent care for the people of Scotland ([Recommendations 8-19](#)).
4. **NHS Health Scotland** should lead the delivery of a health inequalities impact assessment process, following assimilation of the recommendations from this Review. This contribution should also inform supported self care and



best use of health and care services, with a view to best patient outcomes and narrowing health inequalities ([Recommendation 7](#)).

5. [Healthcare Improvement Scotland](#) should strengthen its support for quality improvement approaches and resources applicable to urgent care in the community, in active and synergistic collaboration with the [Care Inspectorate](#). ([Recommendation 20](#)).
6. The [Scottish Health Council](#) should continue to promote best engagement of the people of Scotland, in participating and shaping future care services at national and local levels, including self care and best use of urgent and emergency care services ([Recommendation 5](#)).
7. In light of the recommendations made in this Report, the Scottish Government should carefully consider optimal governance arrangements of the national services provided by NHS 24, SAS and NHS National Services Scotland.

## Recommendation 24 – Future Role of the Third and Independent Sectors and other Agencies

1. The future role and contribution of the third and independent sectors and other agencies should be clarified and expanded, as appropriate, according to defined needs. These should take into account the following principles:
  - Improve understanding and support for their contribution to OOH and urgent care services, prevention and self management
  - Improve intelligence about their contribution to Scotland's health and wellbeing in both daytime and OOH services
  - Explore models of governance in statutory and non-statutory organisations to ensure a person-centred safe and effective service
  - Health and Social Care Partnerships and IJBs should explore models of funding to the third sector to ensure their agreed contribution to both daytime and OOH services is sustainable
  - Improve systems for communication and for connecting both statutory and non-statutory providers of care\*

Which could potentially be addressed via the Urgent Care Resource Hub model\*

2. The future role and assets of the Scottish Fire and Rescue Service should have more prominence in relation to health and social care provision, particularly in their prevention and first responder roles. This has immediacy for community cardiac arrest events, in close partnership working with the

Scottish Ambulance Service. The Scottish Fire and Rescue Service is well placed and willing to contribute further to the urgent care and wellbeing of the Scottish people, beyond their traditional roles, including as first responders. Their potential future contributions to prevention and urgent care provision should be carefully considered, defined and valued - including potential involvement in uninjured falls pathways.

3. Where there are working linkages between the SAS, the Royal National Lifeboat Institution (RNLI) and HM Coastguard, these should be supported by a formal Memorandum of Understanding. This is particularly relevant for patient transport/evacuation requirements from island communities - where alternative transport arrangements are unavailable or inappropriate and in adverse weather conditions. The Review heard concerns about capacity and co-dependency of GP personnel across OOH services, Scottish Prison Service prisoner healthcare and Police Scotland custody healthcare and forensic medical services. The Review was unable to pursue this further in the available timeframe and therefore recommends that further work should be considered of the issues concerned. In particular, further exploration should be considered of the potential of remote telehealth consultation, electronic national record linkage ([Recommendation 21](#)) and quality assurance of OOH services delivered across Scottish prisons ([Recommendation 20](#)). In relation to forensic medical services, a multidisciplinary approach should be considered, in keeping with the recommendations for OOH services future development by the Review, in the context of the National Guidance on the Delivery of Police Care Healthcare and Forensic Medical Services (2013).

## Recommendation 25 – Promoting Person-Centred Care

1. Individual quality improvements by themselves do little to support self management and there is a growing understanding that a whole system approach that promotes the process of partnership working to plan and coordinate care (care and support planning) is required. Key ingredients include:
  - Helping people and their carers to be informed and engaged through education, information sharing, addressing health literacy needs, emotional and psychological support
  - Helping the professionals to be enabling and collaborative, through leadership, communication skills, training and reflective practice
  - An organisational infrastructure that promotes continuity, ease of access, customises time according to need, IT support and service design

- Rich social support, relationships and sustained resources in our communities that keep people well
2. There is an opportunity to develop OOH and urgent services that are responsive to the self-management and health literacy needs of people. The rationale and recommendations for these are set out in Scotland's national health literacy action plan [Making it Easy](#)

## Recommendation 27 - Research and Evaluation

1. The lack of relevant published literature and planned service evaluations in OOH services have significantly hampered understanding of best practice. Future research and development (R&D) support should inform and evaluate new models of care, including economic assessment ([Annex F](#)). A number of agencies and institutions should be involved. The Scottish School of Primary Care, a funded part of the Primary Care Transformation Programme, should provide an important contribution.

## Recommendation 26 - National Implementation Plan and Local Guidance

1. A national implementation plan is recommended, including performance impact, key indicators and timescales. This should include support for local implementation guidance, including a service specification, as local ownership is key for success.
2. The plan should also take account of related work streams already in place and underway, including: the National Clinical Strategy, the Task Force on Sustainability and Seven Day Services, the National Unscheduled Care Programme, the Chief Nursing Officer's Review of Advanced Care Practitioners and District Nurses, the Public Health Review and the eHealth Strategy.

## Recommendation 28 – Finance and Best Use of Resources

1. All recommendations offered should be scrutinised for affordability and resource implications. This includes clinical and cost-effectiveness considerations, opportunity costs and potential cost savings.



Primary care out of hours team at the Urgent Care Centre, Royal Victoria Hospital Edinburgh, including driver, GPs, nurse practitioner, receptionist and centre support staff

## 3 Review Purpose and Process

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### Purpose

The National Review of Primary Care OOH Services ('the Review') was asked to evaluate the effectiveness of the delivery of primary care OOH (OOH) services in Scotland. This evaluation involved reviewing the current delivery landscape and recommending action to ensure primary care OOH services:

- Are person-centred, sustainable, high quality, safe and effective care
- Provide access to relevant urgent care where needed
- Deliver the right skill mix of professional support for patients during the OOH period

The Review was established by Scottish Government in response to a consistent range of issues for OOH services. These include: recruitment and retention of sufficient GPs to work in OOH services, particularly in busier OOH centres and during peak holiday times such as Christmas and Easter. This is exacerbated by:

- Shifting attitudes in relation to achieving a work/life balance and the preparedness or willingness of doctors to cover OOH sessions
- Busier and more complex day-time general practice reducing the inclination or ability of GPs to work additional OOH sessions
- Proximity of some doctors' earnings to key pensionable thresholds

In addition:

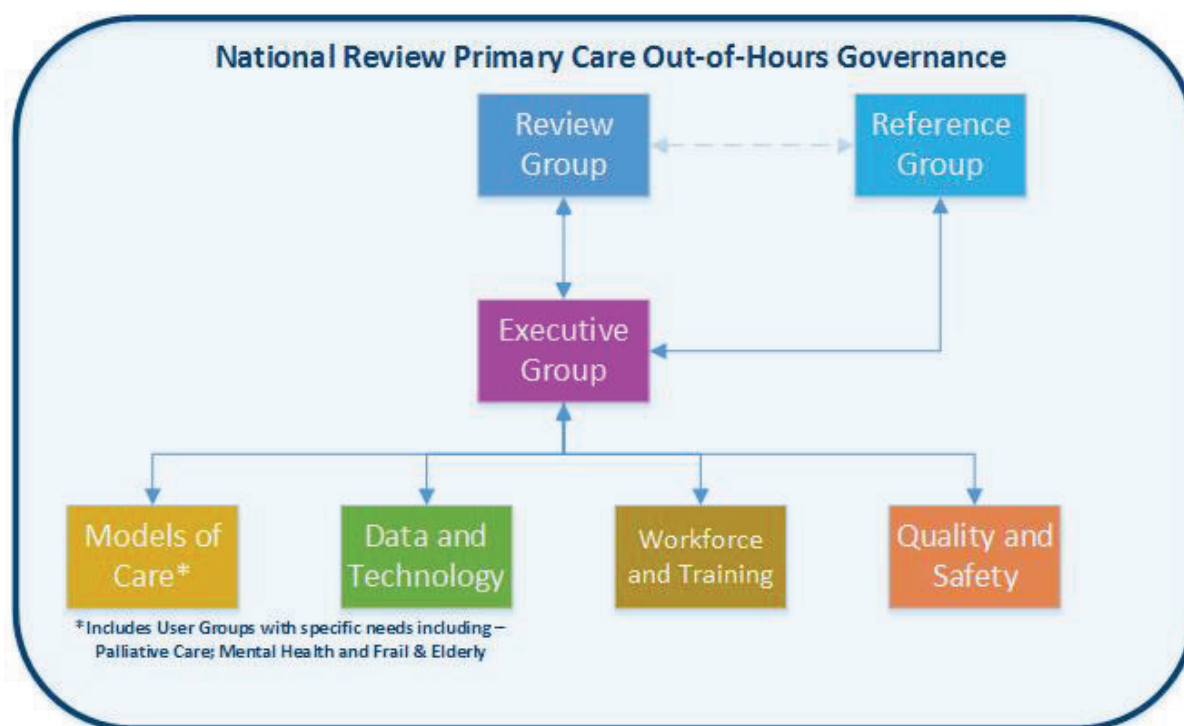
- Staff availability is unpredictable making it difficult for Health Boards to forecast and plan staffing rotas and achieve necessary balance of skills mix.
- Demand can be difficult to predict leading to difficulty in delivering a consistent service which leads to difficulties in managing public expectation.
- Perceived unreliability of OOH services, increasing demand and inconsistency can cause pressure on other services such as emergency departments and acute hospital services.
- NHS Boards may be required to adjust their service delivery at short notice. Measures to deliver safe services now regularly include: increased session rate payments to attract GPs and secure sessions (with territorial Health Boards often competing with each other to secure GPs and other clinicians) and running the service from fewer local Primary Care Emergency Centre sites.

## Review Process

The Review established a programme management structure in order to try to secure an open, interactive and inclusive process. The Review commenced in February 2015 and reported to the Cabinet Secretary for Health and Wellbeing in November 2015.

The Review structure as illustrated in [Figure 3.1](#) below. Membership details for each of the Review groups, is provided at [Annex A](#).

**Figure 3.1 – Review Group Structure**



### Review Group

The Review Group was chaired by Sir Lewis Ritchie and comprised membership from a range of health and social care professionals, including stakeholders from the statutory services, third sector and public representatives. Its purpose was to provide overall direction and guidance to the Review process, ensuring that recommendations met the aims and objectives of the Review remit.

### Executive Group

The Executive Group membership comprised chairs of the four themed Task Groups, the Reference Group and other colleagues providing specific support, including information, finance and academic input. It was also led by the Review



Group Chair. Its purpose was to provide overall support for the Review through interfacing with and supporting the themed task groups in their development of recommendations.

## Reference Group

The Reference Group was co-chaired by Dr John Gillies, former Chair Royal College of General Practitioners Scotland and by Eileen Moir, former Nurse Executive Director, Healthcare Improvement Scotland. The Reference Group performed the function of external peer review to the Executive Group and offered critique on emerging findings and recommendations. The group operated virtually - using email communication and included multidisciplinary, multi-sectoral and public involvement. Membership was drawn from Scotland, England, Northern Ireland and Wales, New Zealand and Canada in order to provide a broad perspective.

## Task Groups

The following themed Task Groups were established with chairs and deputy chairs, who were all subject matter experts:

### Models of Care

This Task Group was chaired by Dr Andrew Russell, Medical Director, NHS Tayside. Ellen Hudson, Associate Director, Royal College of Nursing Scotland, acted as deputy chair. The prime objective of the Models of Care Task Group was to advise on models of care including varying range of needs, remote and rural considerations, specific requirements and other groups. Whilst there is a wide range of people with specific and distinct requirements, five were identified for preliminary examination during this review:

- a. Palliative Care
- b. Mental Health
- c. Frail and Older People
- d. Children
- e. Health Inequalities

The work on people with specific needs was taken forward by Ellen Hudson, largely in workshop format, with the support of the Royal College of Nursing, Scotland.

## Workforce and Training

This Task Group was chaired by Professor David Bruce, Director of Postgraduate GP Education, NHS Education Scotland. Mike Sabin, Associate Director of Nursing and Midwifery, NHS Education Scotland, acted as Deputy Chair. The prime objective of the Workforce and Training Task Group was to develop options for

recommendations, particularly in relation to the key aim of the Review to deliver the right skill mix of professional support for patients during the OOH period.

## Quality and Safety

This Task Group was chaired by Dr Brian Robson, Executive Clinical Director, Healthcare Improvement Scotland. Alison McDonald, Chief Nurse East and Mid Lothian, NHS Lothian acted as deputy chair. The prime objective of the Quality and Safety Task Group was to develop options for recommendations as to how the quality and safety of OOH services can be best measured, assessed and improved.

## Data and Technology

This Task Group was chaired by Libby Morris, GP NHS Lothian and clinical adviser eHealth, Scottish Government. Christine Hoy, Health and Social Care Alliance Scotland, acted as deputy chair.

The prime objective of the Data and Technology Task Group was to develop recommendations for improved functionality for:

- Communications and data flows to support new ways of working in OOH services.
- Requirements for clinical records, decision support and integrated records

## Working Group on GP Terms and Conditions

In addition to these Task Groups, a Short Life Working Group was established to consider and advise on terms and conditions for the employment of general practitioners working in OOH Services. This Group was chaired by Ian Reid, formerly Executive Director of Human Resources, NHS Greater Glasgow and Clyde.

## Information Input

Information Services Division (ISD), NHS National Service Scotland provided data and statistical support to the Executive and Task Groups throughout the Review process. This work was led by Fiona Mackenzie.

## Finance Input

On behalf of Health Board Directors of Finance, Katy Lewis, Finance Director of NHS Dumfries and Galloway, assisted by Margo McGurk, Finance Director NHS 24,



provided a financial analysis of NHS costs of the current OOH services. These costs are summarised in [Annex C](#).

## Research Input

The Review requested Healthcare Improvement Scotland to commission a rapid systematic international literature review of OOH services and qualitative research from the Scottish School of Primary Care. This was undertaken by Professor Katherine O'Donnell and colleagues, General Practice and Primary Care, Institute of Health and Wellbeing, University of Glasgow and is summarised in [Annex F](#). This systematic review considered 274 papers:

**Key areas identified in the systematic literature review as being crucial in the development of high quality OOH services were:**

- Good communication and information technology, both across out-of-hours service providers but also across the daytime and OOH interfaces.
- Better understanding of how patients view OOH services and the decisions they make in relation to which service they choose to attend.
- Development and evaluation of new professional roles in OOH care, in particular pharmacy, but also other organisations out with health care
- Better engagement with early career GPs, with trainees and with undergraduate medical students to promote the value and professionalism of providing OOH care.
- Improvement in career development and training for other professional groups.
- Single, centralised systems have to be *'future proofed'* to address the contextual realities of different areas, for example patients in remote and rural areas have different needs and capacity to respond compared to those in urban areas. This is also true in relation to socioeconomic deprivation.
- Co-location and integration of services will have to be rigorously evaluated, including process evaluations to understand the impact and challenges this brings to different professional groups.

The results of this literature review informed the working of the Task Groups and formulation of the Recommendations in Chapter 2.



Multidisciplinary team at Mid-Argyll Community Hospital and Integrated Care Centre co-located with Scottish Ambulance Service

## 4 Engagement and Consultation

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### Engagement Programme

The Review sought evidence from a wide variety of sources.

#### Board Area Visits

Engagement with all territorial Health Boards and associated Integrated Joint Boards was regarded as a core part of the Review process. Each territorial Health Board area was visited by the Review Chair (twice in the case of NHS Highlands, at different locations). These meetings included discussions with health, social care and third sector colleagues, with front-line clinical and support staff, with public representatives, as well as visiting OOH services in operation. [Figure 4.1](#) provides a map of the visitation programme.

Prior to visiting each Board area, a summary report was requested on the status and issues for OOH services in their area. These reports were discussed during the visitation programme.

During the course of the Review, the Chair also visited:

Co-located NHS 24, Scottish Ambulance Service (SAS) and GP OOH administrative centres at Cardonald, Glasgow; co-located NHS 24 and SAS centres at South Queensferry; co-located NHS 24, OOH and A&E services in Aberdeen; co-located NHS 24, SAS and Highland Hub facilities in Inverness. Visits also took place to: Scottish Prison Grampian and the Scottish Fire and Rescue Service Station at Maud, Aberdeenshire.

#### Special Board and Public Body Visits

In addition, the Review Chair held discussions with senior managers, including Non-Executive Directors, of the following Special Health Boards/Bodies to discuss their role in supporting the future of OOH and urgent care in Scotland: Healthcare Improvement Scotland, NHS Education Scotland, NHS 24, the Scottish Ambulance Service and National Services Scotland. NHS Health Scotland provided specific advice on health inequalities.

# National Review Out of Hours Services National Engagement Programme 2015

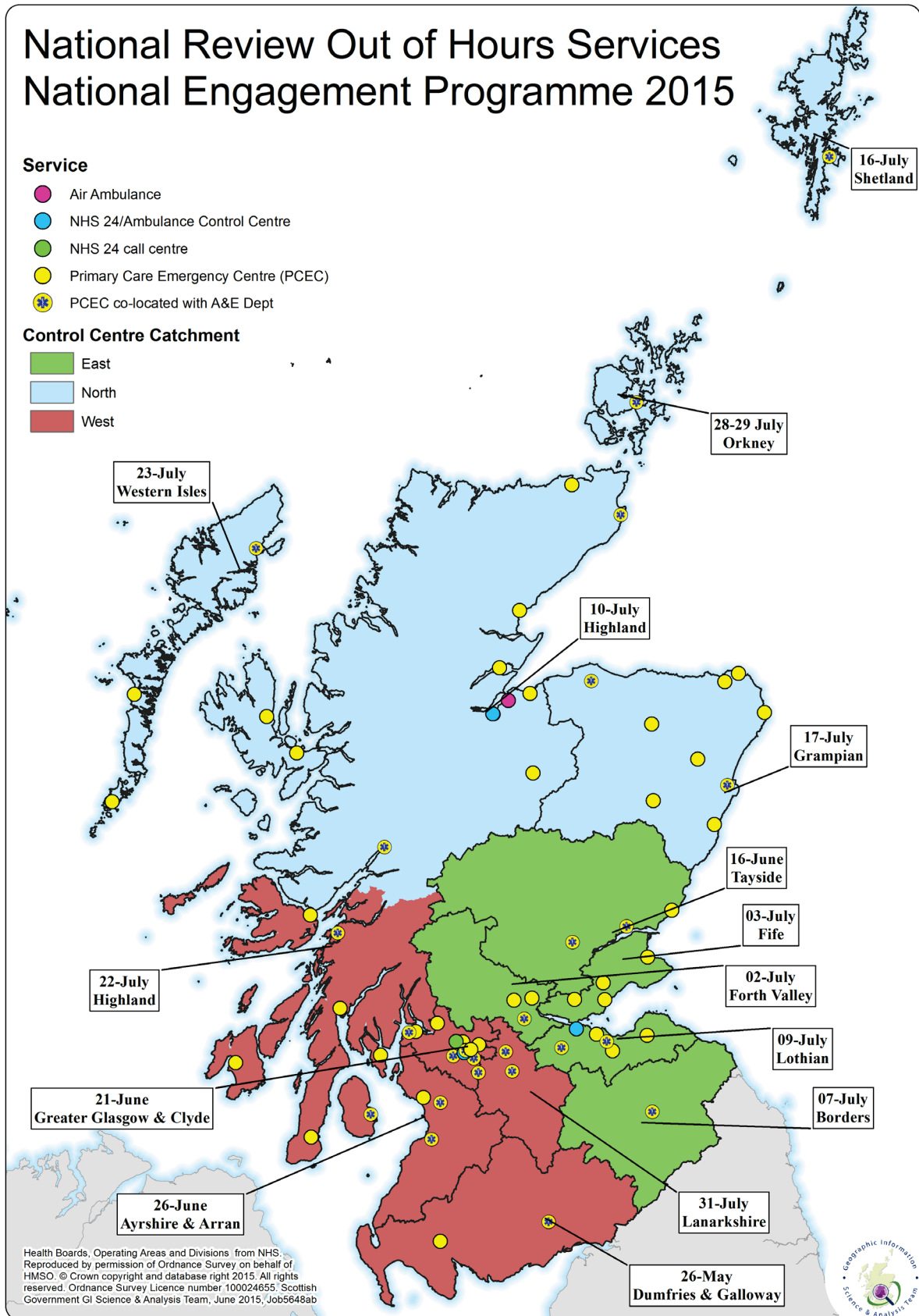


Figure 4.1 – National Engagement Programme – visits and dates

## Public Discussion Groups

The Review commissioned the Scottish Health Council to run public participation events in all Health Board areas across Scotland. These took place on all Board areas in Scotland with the exception of Orkney. A collated report of findings was subsequently prepared by the Scottish Health Council and submitted to the Review. That report is now available on the website of the Scottish Health Council:

## Website and Press Releases

Website: <http://www.gov.scot/Topics/Health/Services/nrpcooh> and email addresses: ([OutofHoursReview@scotland.gsi.gov.uk](mailto:OutofHoursReview@scotland.gsi.gov.uk)) were established in order that members of the public and other interested parties could submit their views and issues to the Review. The OOH website and email address were publicised in a number of press releases.

## Wider Consultation

Opportunities were actively sought for wider engagement with all stakeholders as part of the Review process.

A number of workshops took place during the course of the Review to inform its deliberations.

A national consultation event was held at Dynamic Earth in Edinburgh in September 2015, with an invited audience from health, social care and partnership colleagues. This event discussed the progress of the Review to date, preliminary findings, and sought assistance with the further shaping of the Review.

The Review Chair met the Chair of the Health and Sport Committee of the Scottish Parliament in June 2015, who kindly sponsored a meeting with members of the Scottish Parliament (MSPs) in September 2015, in order to discuss the progress of the Review and to seek MSP input.

The Review Chair also corresponded with all Scottish Members of the UK Parliament (MPs), inviting their specific contributions and input to the Review.

The Review team and a small delegation from the Scottish Ambulance Service also undertook a fact finding visit to the Exeter base of the South Western Ambulance Service NHS Foundation Trust (SWASFT), which is responsible for the operation of all ambulance, NHS 111 and primary care OOH services in South West England.



Discussions were also held and information sought about the services run by Derbyshire Health United which is responsible for the operation of the NHS 111 and primary care OOH services in Derbyshire.

Further discussions were held with the Scottish Fire and Rescue Service and the Royal National Lifeboat Institution (RNLI), to determine their potential engagement in the development and delivery of future OOH and urgent care services in Scotland.

## Interfaces

There are a range of Scottish Government groups currently involved in reviewing and seeking to improve health care services care which the Review took cognisance of in its work. The following list is not exhaustive but represents some relevant initiatives underway:

- Sustainability and Seven Day Services
- National Unscheduled Care Programme
- Local Unscheduled Care Action Plans
- Health and Social Care Integration
- Chief Nursing Officer's Reviews of Advanced Nurse Practitioners and District Nursing
- Primary Care Leads
- Primary Care Strategic Forum
- Prescription for Excellence
- National Clinical Strategy
- Nursing and Midwifery Strategic Aims
- Public Health Review

The Review tried to take account of these interfaces. The Review Group membership included: Scottish Government leads of the Task Force on Sustainability and Seven Day Services and the National Unscheduled Care Programme. There were also membership linkages with the Prescription for Excellence Programme and the Public Health Review. Connections and relationships were made in relation to health and social care integration colleagues, with the Primary Care Leads and OOH National Operations Groups. The Review Chair also held informal meetings with the lead officer for the National Clinical Strategy.

The process and interim progress of the Review was presented at a number of committees, groups and workshops including: Scottish Government National Committees, NHS National Executive Directors, Integrated Joint Board Chief Officers Group, a COSLA (Convention of Scottish Local Authorities) sponsored workshop on OOH services, and discussion with other relevant national committees/bodies,

including Scottish Care. The Chair engaged proactively with the third sector and attended a gathering of a range of third sector organisations, hosted by the Scottish Council for Voluntary Organisations (SCVO). The Health and Social Care Alliance Scotland was also very supportive throughout and convened workshop activities, on behalf of the Review.



Community Pharmacy Team



# 5 Main Findings

## The Views of the Public

The views of the public on primary care out-of hours- services were drawn from several sources. The Health and Care Experience Survey of 2013/14 provides a detailed source of public opinion on health services and care provision:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/Survey1314>

The Review also commissioned a specific public engagement process by the Scottish Health Council, based on local discussion groups held in territorial Health Boards areas. Thirdly, the Review received a number of written comments from members of the public following announcement of the Review and subsequent press releases, either in writing or by submission to the Review website/email address. This was advertised by a number of press releases as the Review progressed.

### Findings from the Health and Care Experience Survey 2013/14 Patients' overall experience of their care

As for other aspects of NHS care, the majority of patients using OOH services report positive experiences of their care. However, OOH services receive a clearly less positive rating compared to other health services, as covered by the National Patient Survey 2013 -14 (see [Table 5.1](#) below).

**Table 5.1**

Aspect of Care	% positive
Radiotherapy care and treatment	97%
Maternity Care (labour& birth)	93%
In-patient care and treatment	89%
GP daytime care and treatment	87%
Social care	84%
<b>OOH care and treatment</b>	<b>71%</b>

### OOH versus daytime/in-hours general practice care

The aspects of care that those seeking help from OOH services were most positive about were *'being listened to'* and things being explained *'in a way that they could understand'*. However, these are less positive than the equivalent questions for daytime GP care. Similarly, low scoring questions such as staff having *'all the*

*information required*' were less positive for OOH care than for care from a doctor or nurse at their GP practice during daytime hours (see [Table 5.2](#) below).

**Table 5.2**

Question	% positive
GP care – the doctor listened to me (note: the remainder of GP entries refer to GP daytime care)	95%
<b>OOH – I felt I was listened to</b>	<b>84%</b>
GP – the doctor talked in a way that helped me understand my condition and treatment	90%
<b>OOH – Things were explained to me in a way I could understand</b>	<b>85%</b>
GP - I felt that the doctor had all the information needed to treat me	90%
GP - I felt that the nurse had all the information needed to treat me	93%
<b>OOH - I felt that the person had all the information needed to treat me</b>	<b>74%</b>

### Variation in responses

- Patients' OOH experiences varied depending on which service they were ultimately treated by. The least positive overall rating came from patients that ended up being referred to GP practices next day rather than being seen in the OOH period. The Scottish Ambulance Service and paramedic practitioners received the most positive overall rating. A&E services received the least positive scores for OOH time waiting. NHS 24 consistently received the lowest scorers across all OOH questions but was also the service that received the highest demand.
- Those who rated their health as *fair* or *bad* as opposed to *good* reported significantly poorer experience of OOH services.
- Those in large urban areas were more likely to be positive about their OOH care than those in remote and rural locations.

### Patient and public areas of concern

Patients were not asked explicitly for suggested improvements. However, they were given the opportunity to provide unguided comments on the care they received. A number of themes came through in these comments, highlighting particular areas of concern.

**Waiting:** Patients' experience of accessing OOH experience were often characterised by waiting: waiting for NHS 24 call back, waiting for visits and then waiting at a clinic or A&E department if they visited. Often there was a cumulative effect from waiting at different stages. It was also clear from comments that these waits were often anxious.

**NHS 24 and repetitive questioning:** A considerable number of patients commented on what they felt to be an excessive degree of questioning from NHS 24. Whilst some recognised the need for some form of triaging, many found the questions - by different members of staff at different stages - overly repetitive, arduous and seemingly irrelevant.

**Remoteness and rurality:** A concern amongst patients, living in these areas, was a sense of distance from OOH services. A number of comments quoted the unsatisfactory length of time needed to access services

**Children:** As in the comment above, children frequently featured in the stories received through the survey. There were plenty of positive examples recounted by appreciative parents, but it was also clear that parents experienced heightened levels of anxiety around children – more so than for their own health. There was a general expectation that unwell babies and young children should be seen quickly

**Practicalities and facilities:** There were also a range of comments touching on further practicalities like the location, lack of parking, premium phone call rates and other difficulties in getting transport to OOH care.

**GP practice opening times:** The survey found that 15% of patients felt that their GP practice opening times were not convenient. Across the survey as a whole (the survey also covers daytime GP care) accessing GP services was the biggest concern for patients.

**Negotiating the system:** A few comments reported difficulty or dissatisfaction with OOH services as currently set up, while others requested clarity. The main complaint was with 'having' to go through NHS 24 first. This was in light of the criticisms of NHS 24 above, but it was also because patients 'knew' what care they needed or 'just wanted to speak to a doctor'. It seemed an unnecessary step to justify this through NHS 24's questions. Others reported being told-off for seeking medical help at clinics or hospitals directly.

## Common themes arising

- Knowledge of who to turn to, what to do in the event of feeling unwell when the doctor's surgery is closed and which service to turn to first
- Experience of using the service
- Comparing the experience with that of using general practice surgery during normal working hours
- Regarding using OOH services, participants were asked whether this was something they would normally go to their GP about and if so why did they not go to a GP during normal working hours?
- From experience of using the OOH service, people were asked if they could offer suggestions on how it could be improved

## Findings from Scottish Health Council Engagement Programme

- The Scottish Health Council organised a series of 13 discussion groups (one each health board area in Scotland with the exception of Orkney which had to be cancelled due to local factors) to gather feedback to inform the Review. A total of 112 people took part who considered a number of pre-set questions which aimed to elicit views on their experience of using our of hours services.
- A wide range of feedback has been gathered as a result and a full report be published on the Scottish Health Council's website simultaneously with publication of the Review Report. It is available on the Scottish Health Council website.

## Summary of some of the common themes which emerged from the local discussion groups is listed below:

- The feedback does not seem to suggest that there were any significant differences in views or experiences brought about by geography although a couple of issues (such as transport, travelling distances and service awareness of local circumstances/arrangements) were mentioned in most (if not all) rural areas and Island communities. Also and significantly, a number of people who had used the OOH services were very complimentary about the service being provided and of their experience and treatment.

## Common themes arising

- Knowledge of who to turn to, what to do in the event of feeling unwell when the doctor's surgery is closed and which service to turn to first
- Experience of using the service
- Comparing the experience with that of using general practice surgery during normal working hours

- Regarding using OOH services, participants were asked whether this was something they would normally go to their GP about and if so why did they not go to a GP during normal working hours?
- From experience of using the OOH service, people were asked if they could offer suggestions on how it could be improved

Based on the feedback received from the 13 public discussion groups, the Scottish Health Council offered five specific recommendations in their summary report:

- **Shared records:** Although there have been some efforts to move to a system where patients' medical records can be shared across all services, this continues to be an issue that causes great frustration and dissatisfaction with users and carers. Therefore efforts need to be redoubled to ensure real progress is made.
- **Locality awareness:** There needs to be increased awareness of NHS 24 about local geography and care locations, so that patients are not unnecessarily travelling long distances when accessing OOH centres.
- **Better access for people with specific needs:** Improve access and address barriers to using OOH services (NHS 24, in particular) for people with sensory impairments, people from ethnic backgrounds, people whose first language is not English, older people and those with dementia - and generally people with support needs, their carers and relatives.
- **Better understanding of how best to access and use services:** Implement a sustained, longer term programme of awareness raising across Scotland to include how people should access OOH services and for what purposes. This programme should address patient expectations and include all sources of out of OOH support, including third sector agencies.
- **A commitment to a seamless service with regular evaluation:** Sufficient resources and priority should be dedicated to ensure that seamless OOH services are being provided for all patients, their families and carers. Regular evaluation of patients' experience of OOH services is recommended which would include measuring public confidence in any new models of service provision.

## The Views of Professionals

The views of health and social care professionals working in OOH services were taken account of in a number of ways. Firstly, the structure and process of the Review itself was inclusive and designed to capture as wide a perspective as possible. Views and opinions were captured during visits to Board areas, NHS Special Boards, at Officer Groups and meetings, in workshops, and at a national consultation event. Secondly, the Review sought contributions from specific professional groups and organisations. Thirdly, as for public views, professional views were sought in writing or electronically, via the [Review website](http://www.gov.scot/Topics/Health/Services/nrpc00h): <http://www.gov.scot/Topics/Health/Services/nrpc00h>

### Formal submissions received from:

- Jointly, the Royal College of General Practitioners, Scotland and the Scottish General Practitioners' Committee (SGPC) of the British Medical Association, together with separate letters from each organisation.
- The Chief Nursing Officer, endorsed by the Scottish Executive Nurse Directors (SEND) and the Royal College of Nursing
- Jointly, Community Pharmacy Scotland, the NHS Scotland Directors of Pharmacy and the Royal Pharmaceutical Society, Scotland
- The National Allied Health Professions Advisory Committee
- The National Out of Hours Operations Group
- The Scottish Social Services Council
- Social Care, on behalf of the independent sector
- Chief Officers of Integrated Joint Boards

### In addition:

A report on the role of the third sector in OOH services was commissioned and is available on the [Review website](#).

The above formal submissions and reports are archived in full on the [Review website](#).

Extracts from these documents, including recommendations and principles offered are summarised in [Annex D](#).

NHS Health Scotland submitted a document regarding addressing health inequalities in the context of OOH Services and is summarised in [Annex E](#). The full version of the document is available on the [Review website](#).

To complement these submissions and activities the international literature review of OOH services and GP focus group qualitative research, which was commissioned from the Scottish School of Primary Care (report produced, which is summarised in [Annex F](#) and available in full on the [Review website](#)) provided additional evidence.

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As part of the engagement programme, NHS 24, the Scottish Ambulance Service, NHS Education Scotland, NHS National Services Scotland and Healthcare Improvement Scotland all offered contributions to the Review, regarding their potential contributions to OOH Services, going forward.





Scottish Ambulance Service Paramedics



## 6 Models of Care

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### Aim

The prime objective of the Models of Care Task Group was to advise on models of care including varying range of needs, remote and rural considerations, specific requirements and other groups. While there is a wide range of people with specific and distinct requirements, five were identified for preliminary examination during this review:

1. Palliative Care
2. Mental Health
3. Frail and Older People
4. Children
5. Health Inequalities

The work on people with specific needs (other than children) was largely taken forward in workshop format, with the support of the Royal College of Nursing, Scotland. The full report of the Models of Care Task Group is available on the [Review website](#) and includes specific examples of patient experience.

**Recommendations 1-7 primarily relate to models of care and best use of OOH services**

### Background

The current model of OOH care has evolved from changes in the General Medical Services (GMS) contract in 2004, which allowed General Practitioners to opt out of providing OOH care. Prior to this there was a range of OOH provision, led by GPs, from large urban co-operatives through to remote practices providing their own OOH care with the support of NHS 24. Established in 2001, NHS 24 expanded to become an all-Scotland service by November 2004, providing telephone triage for people or carers seeking urgent primary care. Presently 45 GP practices (out of a Scottish total of 980) in remote and rural areas provide for the OOH care of their registered patients, representing 1.3% of the population.

Subsequent to this, there has been a significant rise in the demand for OOH primary care and an increasing ambiguity as to what the expectations are for the provision of OOH care. Currently such care is driven by patients or carers accessing care/medical help to deal with a care/medical crisis which cannot wait for a routine

appointment. It is also no longer limited to OOH general practice services but includes access to other services like emergency departments, SAS, palliative care services, social care services and the third sector.

The increased demand and workforce challenges in daytime general practice have presented increasing day time access issues, resulting in some patients seeking routine care in the OOH period. This may also be about the personal choice of individuals as well - for example where people may no longer accept that they need to take time off work to access health and care services in a culture of 24/7 access to many other services.

The demands of daytime working along with flexible working practices have also seen fewer doctors being willing to provide OOH care. Changes in training for GPs has reduced the amount of time spent in the OOH period and this has resulted in doctors who may be competent but not confident in providing OOH care. As a consequence there are fewer doctors in the early stages of their careers providing OOH care. New models should improve the engagement of this group of doctors as part of the solution.

Over the past eleven years, NHS Boards have had to work creatively to secure OOH provision across Scotland. New models have emerged piecemeal across the country, many already based on a multi-disciplinary approach.

## Methodology

### Evidence considered

- The work of the National Unscheduled Care Programme - see [Annex G](#) for a diagram of the six essential actions for unscheduled care.
- The integration principles set out in the Public Bodies (Joint Working) (Scotland) Act 2014. These principles are included in [Annex H](#).
- The rapid review of international literature and emerging findings from the public and professional engagement programme.
- A number of current models of OOH care were considered. A focus was made on identifying what models appeared to work well, whether there were any challenges/ barriers to wider implementation, whether they could work in remote and rural areas as well as urban settings, and whether they had the potential to be scaled up.

## Scope of primary care OOH services

OOH primary care services provide care for people who have urgent health or care problems that cannot wait until regular daytime services are available

## Issues which impact on future OOH models

- Those requiring OOH services should be able to access the services they need easily and swiftly
- Formal public sector services are only part of the solution to providing quality OOH care
- OOH services should work within a robust governance framework
- Multidisciplinary teams are key to ensuring integrated OOH service delivery for patients.

## Core Elements of an Integrated OOH Model

For safe and effective OOH care '*one size doesn't fit all*' - taking into consideration the geography of Scotland and the particular issues faced both in remote and rural as well as urban areas

A model is proposed which is based on principles that outline the core elements that should be in place in order to provide safe, effective and person-centred care and which support service providers to deliver.

- This model acknowledges that local variation and flexibility is essential.
- The exact configuration of commissioned OOH services including workforce requirements will be the responsibility of individual Health and Social Care Partnerships and IJBs
- A primary care OOH services should be built around the integration planning and delivery principles set out in the Public Bodies (Joint Working) (Scotland) Act 2014

## Service Configuration for an OOH Model

The future model comprises OOH services delivering integrated care in a co-ordinated fashion requiring effective partnership working of multi-professional and multi-agency teams.

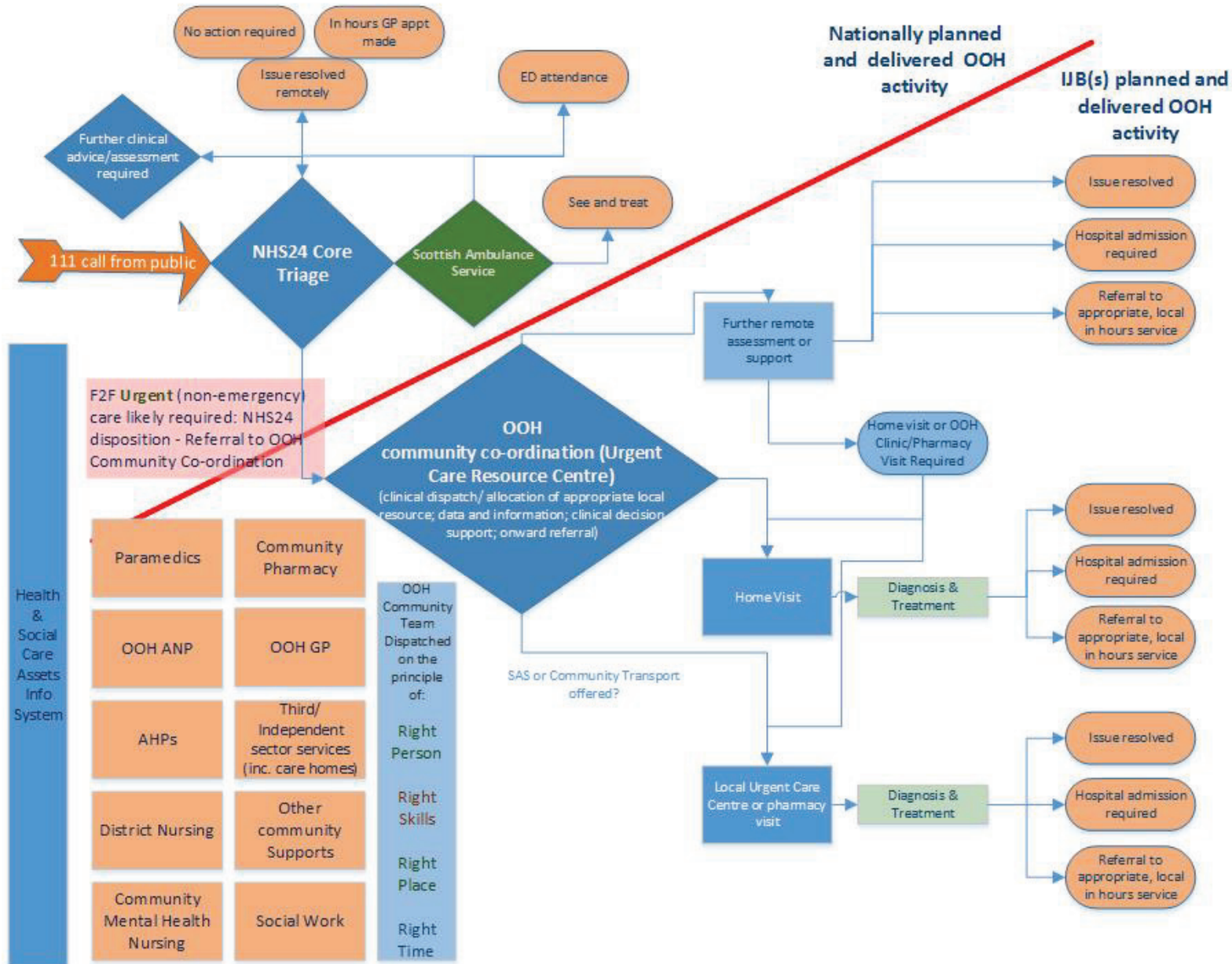
A quality service, improved outcomes and best value should be at the core of future OOH services. The patient journey of care should be as seamless as possible, ensuring that the patient is directed to the appropriate part of the service whilst using the fewest number of steps, services or interfaces. This includes fewer steps where information is asked for repeatedly (by NHS 24 and local OOH services) and ensuring patient knowledge is transferred and built upon throughout the patient pathway of care.

OOH services should aim to point patients to the service most suited to deliver the needs of patients and carers, and minimise access barriers. This means getting the right practitioner to assist care needs at the right place, in a timely fashion, according to need. That might be provided face-to-face or remotely by telephone call or video-link.

The present model of OOH services is illustrated on page 69. In describing a future model of OOH urgent care there are a range of functions with key inter-dependencies. These are outlined below and are also illustrated diagrammatically on page 70.

OOH 118 hours per week

# A NEW MODEL FOR PRIMARY CARE OOH SERVICES IN SCOTLAND



## NHS 24 function

- NHS 24 should continue to be the first point of entry to OOH services for the public. NHS 24 would continue to triage calls and stream referrals received to self-care, OOH services, A&E services and the Scottish Ambulance Service (SAS), as required. Going forward, better synergistic working between NHS 24 and SAS is essential.
- Following triage by NHS 24, patients requiring telephone advice and interventions, but requiring no onward referral, would be managed by NHS 24 through a range of in-house professionals.
- Access to clinical advice should be available, through effective professional-to-professional telephone/video-link services.
- Triage by NHS 24 and onward referral to Urgent Care Resource Hubs (as suggested below) should help to ensure timely onward referral of patients requiring urgent clinical care - to GPs and other clinicians, according to need. In addition, onward referral should involve a range of multi-disciplinary and multi-agency responses available within the locality. This will utilise the joint expertise of all OOH team members, in order to enhance patient experience and to ensure safe delivery of patient care and outcomes.

## Community Co-ordination Function – Urgent Care Resource Hub

- OOH services would have 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. The term suggested for this is: [Urgent Care Resource Hub](#).
- Integration authorities, either working independently or delivering economies of scale by collaborating with partner authorities to provide regional services, would have the responsibility for ensuring that there is this community co-ordination function within the OOH services they are responsible for providing.
- The size, configuration and location of this co-ordinating function would be determined by local circumstances. It would be supported by patient based information systems such as Key Information Summaries and electronic decision support as well as access to ALISS (A Local Information System for Scotland), the third sector database. All patient information from NHS 24 will go to the Urgent Care Resource Hub (for governance purposes and because it simplifies the process and ensures a focus for effective local co-ordination of care).
- This new model would see an increased number of multi-disciplinary/multi-agency patient disposition responses initiated via the co-ordinating centre, which would be responsible for matching patients to the most appropriate response to meet their needs. This would be to a range of community based



health and care services including GP OOH services, paramedical practitioners, ANPs, community nursing teams (supporting home visits), community pharmacy, social services, third sector providers, community psychiatric nursing services; requests for patients to attend an OOH centre facility which in some areas might be co-located with this co-ordinating centre

- The community co-ordination function would also support access to local 'speak to doctor' and professional-to-professional calls - for example, if a telephone call is required between a district nurse, care home nurse or ambulance paramedic who needs to speak to the OOH doctor for further advice. This function is also required for OOH practitioners to be able to talk to a specialist physician, geriatrician or other specialist in order to aid in management decisions at the time when the OOH practitioner is present with the patient. This function enables professional-to-professional support for practitioners.

## Urgent Care Centres

**Urgent Care Centres (UCCs)** - presently referred to as Primary Care Emergency Centres (PCECs) - would deliver urgent care within local communities. Their location and fitness for purpose would also need to take into account access issues – especially for patients living in remote and rural areas, and economies of scale. They should be configured as both service delivery and learning environments which are safe and secure for the wellbeing of patients and staff. Although primarily configured for OOH service delivery the infrastructural assets of Urgent Care Centres should be used to best purpose for local care needs on a 24/7 basis.

There may be merit in seeing more seriously unwell patients adjacent to A&E/acute services where they are likely to be referred or require investigation where this is an option to do so. This model, co-locating primary care and A&E/acute services is being developed in England. This model aims to minimise unnecessary transfers of acutely unwell patients. However, for some of our communities such an approach would restrict access and as a consequence, no prescriptive view has been taken. Co-location may be particularly appropriate for remote and rural locations, where demand and staffing levels of A&E and OOH services are lower and might provide additional resilience for local services. The merits/demerits of co-location of A&E and OOH services was also highlighted by the rapid literature research commissioned by the Review, which concluded that co-location and integration of services should be rigorously evaluated, including process evaluations, to understand the impact and challenges this brings to different professional groups.

## People with Specific Needs

To inform the final recommendations of the Review Group, the Models of Care Task Group was asked to consider how to develop future services to deliver quality OOH care to four groups with specific needs: those with poor mental health; those with palliative care needs; those who are older and experiencing frailty, and those experiencing health inequalities (defined as those living in areas of multiple deprivation) for the purposes of this work.

A report was prepared, built on the outputs of four workshops intended to inform the general recommendations of the Models of Care Task Group and help to ensure they underpin a principle of equity of outcome in the OOH period for those with some of the greatest care needs in our communities. The report is available on the [Review website](#).

In addition, further work was commissioned from Dr Kate McKay, Senior Medical Officer, Scottish Government, on the specific needs of children for OOH services. This will be considered separately, below. She submitted a paper which is available on the Review website. The Review also received specific assistance from Dr Zoe Dunhill MBE, former Consultant Paediatrician.

The workshops on people with poor mental health, with palliative care needs, who are older and experiencing frailty, or those experiencing health inequalities were designed to explore the core elements, strengths and challenges of existing models of services designed to meet the needs of the identified groups. In particular, issues of access, available advice and support were explored. Participants in each workshop were drawn from professional, public and third sector bodies with a stake in current service provision, as well as those representing service users.

## Key generic themes

Five key generic themes were identified at the workshops:

1. Those requiring OOH services should be able to access the services they need easily and swiftly.
2. Formal, public sector services are only part of the solution to providing quality OOH care. Many third sector organisations, for example, are specifically set up to provide support to those with particular needs, such as those in mental health crisis, and already provide OOH services.
3. OOH services should work within a robust governance framework, particularly given that many of those working in these services are often isolated in their practice.

4. Multi-disciplinary teams are key to ensuring integrated OOH services deliver for patients.
5. OOH services should be able to demonstrate their effectiveness and value for money to ensure long-term sustainability into the future.

## Key messages about frail older people, mental health, palliative care and health inequalities

In addition to these common themes there were also some very specific issues raised that relate to one or more of the groups with specific needs:

- There are too few places of safety for those who are under the influence of alcohol or drugs during the OOH period and who are unfit for psychiatric assessment. A&E and custody are frequently not the most appropriate place to provide quality care in these circumstances. In a similar vein, fewer frail older people would need to be admitted OOH inappropriately if there were improved “holding options” for support and clinical interventions in their place of residence. Improvements to person-centred and effective care would be possible with greater local investment in this area.
- The cost of calling some telephone services can mean that people living in poverty choose not to access OOH services appropriately. To deliver equity of outcome, phone access to all health care and support services should be free. This will require those advice and support lines provided by the third sector, in particular to be funded appropriately.
- Some crises, such as mental health crises, can be prevented by providing free and easy access to emotional support and practical advice during the night and at weekends. Investing in more local, first line services – particularly by building on those services already provided by the third sector – could greatly reduce the demand on specialist OOH care and provide better outcomes.
- People at the end of life should be able to access services directly over the 24 hour period without recourse to NHS 24 to ensure swift and effective care. This should come with extended admission protocols to allow 24/7 admission to hospice care.
- Palliative care patients should have extended access to community nursing and ANP support, with nurses able to verify expected deaths in the community.
- Care homes should be able to access a wider set of community supports to reduce avoidable admissions of older, frail people from the sector in the OOH period.
- Hospital-at-home care was recognised as a positive, multi-disciplinary contribution to improving care in the community and delivering the [2020 Vision](#). However provision should now be available in all areas of Scotland

with extended hours of operation and the full involvement of social care services to provide effective, high quality and person-centred care for older people around the clock. This will also require clarity on who is accountable for acute clinical interventions in the community and, if this service is to be within the remit of OOH primary care team, it will also require those clinicians to have both the capacity and competence to deliver.

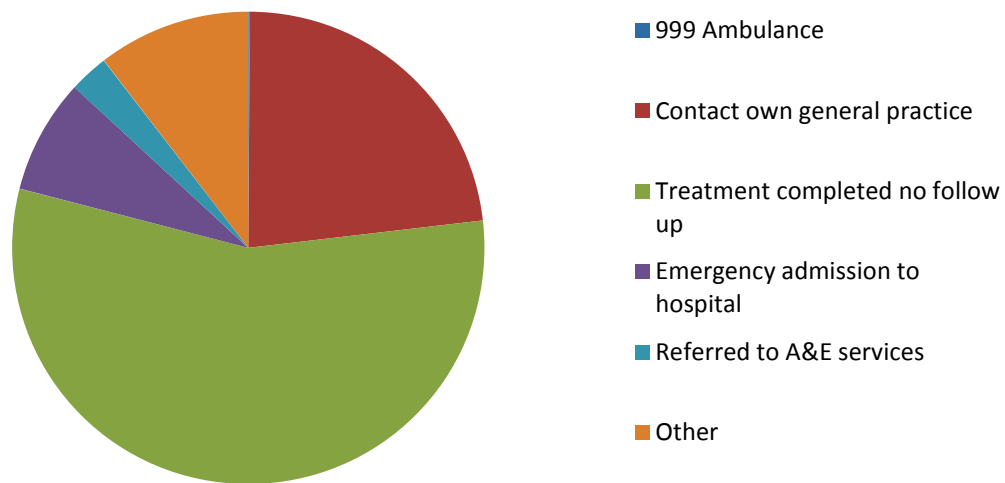
- All localities need an effective falls response service to assist people in a crisis and avoid unnecessary admissions. They should also provide co-ordinated follow-up services to prevent further falls or injuries wherever possible.
- All localities should offer a comprehensive home environment assessment for those older people identified as frail to reduce the risk of falls, accident and injury. Those with chaotic lives, who often also have poor health outcomes, need better support to access core services rather than relying on crisis intervention through OOH services. The good work demonstrated in 'Deep End' practices should be extended, but not all those in need of healthcare will be registered with a general practice. Further walk-in, non-appointment sessions, should be considered to complement standard daytime general practice service provision. In addition, minor ailment services (MAS) provided by community pharmacists should be improved and extended as an additional local support to avoid urgent OOH interventions.

## Key messages about children

Young children are presented frequently by parents/carers to both OOH and A&E services in Scotland, particularly, the under 1 year age group. Between 1 April 2014 and March 2015, under 1 year olds had a consultation rate of 743 per thousand of the population and under 5 year olds had an attendance rate of 433 per thousand of the population. Focusing on the under 1 year olds, of the total of 45070 seen over that one year period, 86% were seen at a Primary Care Emergency Centre whereas only 2% received a home visit.

In terms of OOH service outcomes, in 0.1% of cases, a 999 Ambulance was called; in 23% of cases the parent/carer was advised further contact with their own GP practice; in 56% of cases treatment was completed with no follow up planned; in 8% of cases an emergency admission was arranged to hospital; 2.6% of cases were referred to A&E services. The remaining 10% were classified as other dispositions. This is illustrated in the diagram below:

## OOH Service Outcomes for Children under 1 year of age



A similar picture is seen for A&E service attendances. The under 1 year age group is a potentially high-risk subset of children, where attendance rates have been steadily increasing over the last 10 years. Following such attendances, there is a high proportion of 'zero day admissions' (duration of stay in hospital under 24 hours) suggesting many of these illnesses are short, self-limiting acute conditions, many of them viral illnesses.

More than 60% of children under 1 year of age presenting to A&E services are brought by their parent or carer. This is particularly true of more vulnerable populations, of lower socio-economic status, and in some ethnic groups.

Like other OOH care services, there is some parent/carer confusion about what is the right care pathway and the right service to access. Services are not uniform throughout Scotland - Health Boards have different systems in place, depending on whether there are facilities to observe or investigate young babies, for example, with fever.

The Royal College of Paediatrics and Child Health (RCPCH) published care standards in 2015: *'Facing the Future Together for Child Health'*. This report includes a number of suggestions to enhance the collaboration between acute paediatric units and primary care services for the care of children who present with acute symptoms. This should be seen as complementary to the Scottish policy: *'Get it Right for Every Child'* (GIRFEC), which is the national approach to improving the wellbeing of children and young people in Scotland.

There is therefore scope to improve OOH services for children and the following recommendations were considered:

- GPs, advanced nurse and paramedical practitioners should have rapid access to telephone advice from paediatric specialist staff during daytime and OOH periods
- GP, advanced nurse and paramedical practitioner training should include a strong focus on paediatric clinical skills.
- The NHS Inform (NHS 24) website should have a clearly signposted section on young children who become unwell with common causes and suggestions for parents as well as primary and secondary school staff and others caring for children. This should be extended to the development of appropriate mobile applications ([see also Recommendation 21.9](#)).
- NHS 24, territorial Health Boards, Local Authorities, Health and Social Care Partnerships and IJBs (where children's services are delegated) should continue to work together to develop local urgent care pathways for children, and to ensure they are effectively implemented in accordance with the principles of *Get it Right for Every Child* (GIRFEC).
- Regular local interactive multidisciplinary educational sessions - supported by consultants with paediatric responsibilities, should be encouraged and resourced to facilitate clinical quality improvement and service development.



Advanced Nurse Practitioner Team, Cumbrae



## 7 Workforce and Training

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### Aim

The prime objective of the Workforce and Training Task Group was to develop options for recommendations, particularly in relation to the key aim of the Review to deliver the right skill mix of professional support for patients during the OOH period.

The full report of the Workforce and Training Task Group is available on the [Review website](#).

Recommendations 8-19 primarily relate to workforce and training.

### Background

As described elsewhere in the Review, OOH services are coming under increased pressure from insufficient workforce capacity largely due to insufficient availability of GPs to fill rotas. While there is variability throughout Scotland, all Boards face significant challenges and the service is fragile and unsustainable in its current form. This is exemplified by significant recent increases in Health Board expenditures on locum and agency costs as highlighted in Key NHS Financial Data ([Annex C](#)).

### Methodology

- The shared work of the Models of Care Task Group was fully taken into account when working up workforce proposals.
- A questionnaire was issued and analysed survey to primary care OOH service managers and undertook telephone interviews. Specific questions recognised the vital role played by non-clinical administrative support staff in keeping OOH services delivery infrastructure viable and consistent.
- In conjunction with RCGP Scotland a survey questionnaire was distributed to all 514 GP members within five years of completing their GP training (First 5s) to seek their views about OOH services and participation therein.
- As part of the academic support commissioned by the Review, qualitative research with two focus groups took place - one was with GPs who had recently completed their training and another with more experienced GPs.

- ISD provided analysis of OOH relevant workforce survey data from the Primary Care Workforce Survey 2013 available. A further 2015 Workforce Survey is underway, at the time of publication, but was too late to contribute latest data for the Review
- The work of the Workforce and Training Task Group was also informed by the Short Life Working Group established to provide guidance on terms and conditions for GPs working in OOH services.

## Future Contribution of the GP Workforce - Recommendation 11

### Evidence

*Shape of Training: Securing the future of Excellent Patient Care.* (The Greenaway Report) and: *The future of primary care: Creating teams for tomorrow.* (Report by the Primary Care Workforce Commission, Health Education England

Joint principles submitted by the RCGP Scotland and the Scottish General Practitioners Committee (SGPC) of the BMA and Position statement from the National OOH Operations group, summarised in [Annex D](#) and available on the [Review website](#).

### GP Workforce Profiles

Figure 7.1 below shows the age-sex profile of all GPs (known as GP Performers) in the Scottish NHS workforce at 2014 - excluding GPs in training. This demonstrates the increasing numbers of female general practitioners (a percentage that has changed from 45% to 55% Female, over the past ten years).

Figure 7.1 GP Performers in post by age and gender in 2014

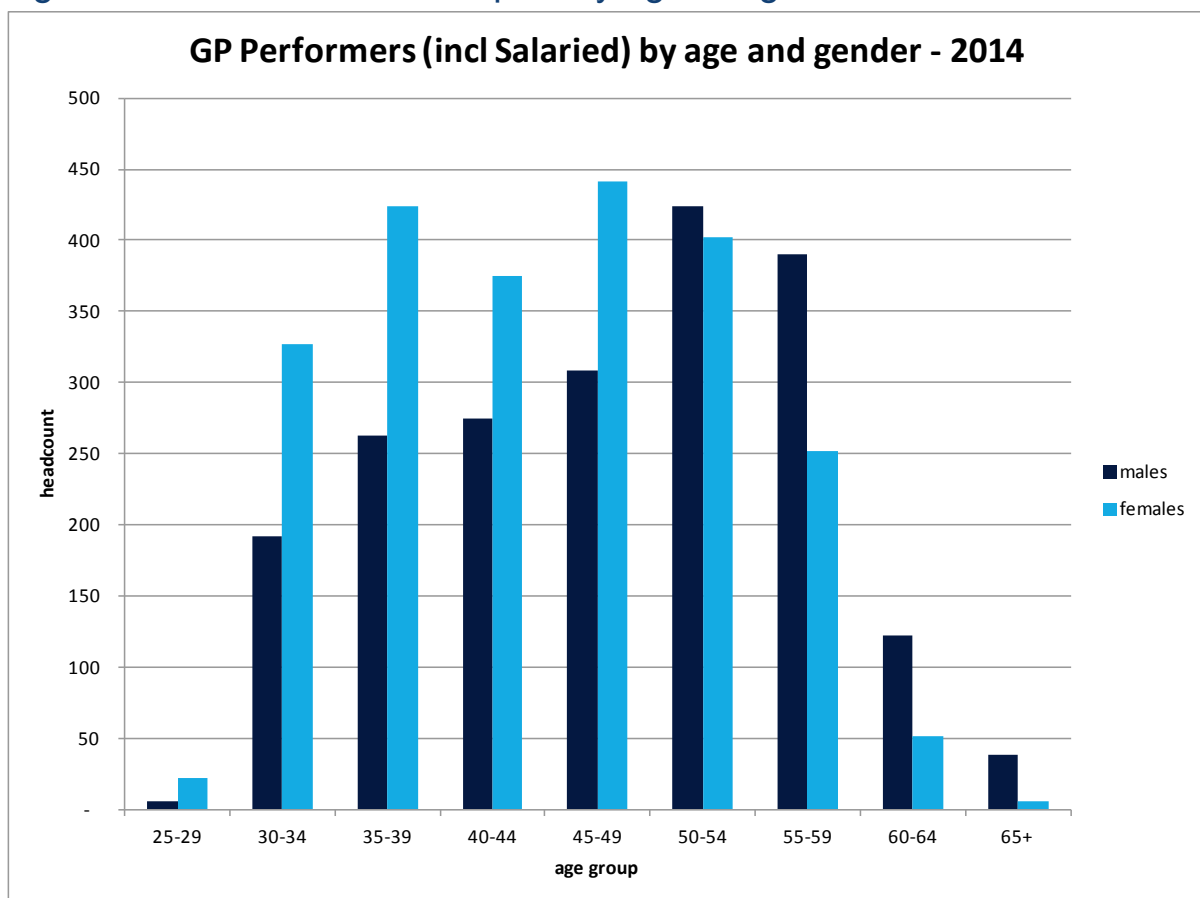
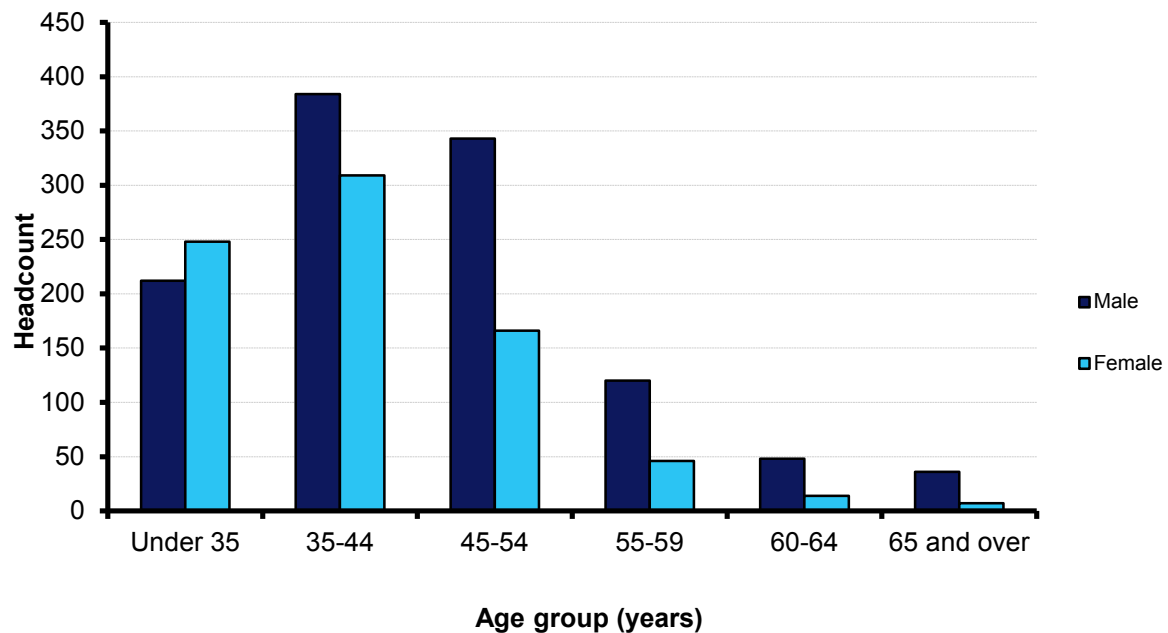


Figure 7.1 also shows that there are significantly more GPs in the 50-54 years age cohort (826), compared to the 45-49 cohort (749), the 40-44 cohort (650) and the 35-39 cohort (687). These figures herald the potential of serious shortages in the future

GP workforce. This re-emphasises the urgency of comprehensive primary care workforce planning for both daytime and OOH services, including systematic data collection of workforce numbers ([Recommendation 8](#)). The recruitment and retention of GPs appears to be UK wide rather than specific to Scotland.

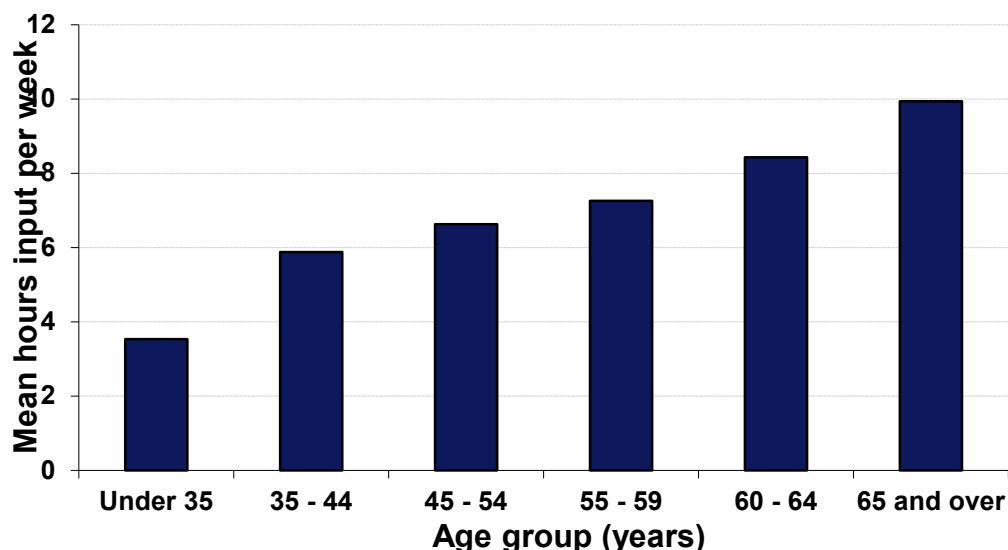
**Figure 7.2** below shows the age-sex-profile of all GPs working in OOH services in 2013. Whereas there are more females than males in the whole GP workforce a smaller number of females contribute to working in OOH services. The age profile of GPs working in the OOH service is younger than the general workforce.

**Figure 7.2 GP Performers working in OOH Services in 2013 by age and gender**



**Figure 7.3** below shows the time commitment of GPs working in OOH services by age group. There is an inverse linear relationship with age in relation to hours of GP commitment per week, with a significantly smaller number of hours worked by the youngest GP cohort, aged under 35 years. The exact explanation for this remains unclear and is likely to be multi-factorial. GPs in the youngest cohort were recruited into the specialty, following the introduction of the 2004 GMS Contract, which no longer required GPs to be responsible for, and to work in OOH services. Recent research (Fay et al), suggests that today’s young doctors value both work-life balance and personal fulfilment more highly than their predecessors. Of all specialties, GP recruits rated hours/working conditions significantly higher than all other specialty recruits (93.9% of GP recruits v 46.7% of all specialty recruits) and did likewise for domestic circumstances (69.9% v 32.5%).

Figure 7.3 Commitment of GPs working in OOH Services by Age Group



Older GPs working in OOH services contribute on average, a greater contribution of working hours than younger GPs. This is counterbalanced by the workforce age profile which is biased towards younger GPs. However, as older GPs withdraw or retire from OOH services, this could have disproportionately adverse effects on service delivery, unless younger GPs work more in OOH services, as they become more experienced.

To inform this further, survey work undertaken by the Workforce Task Group, revealed that although the majority of first 5s GPs thought their training had prepared them well, a significant minority were unsure and a small number that training had not prepared them well. In this survey, improved OOH shift flexibility was seen as important as was improved multidisciplinary team working and administrative support. It was felt that senior clinical GP support/mentoring was important but lacking, and aggravated by limited access to patient electronic records. Pay and conditions were seen as unsatisfactory by many and flexibility regarding superannuated/non-superannuated contracts was sought. Day time general practice working was seen to be increasingly demanding and stressful and unless conditions improved, then this would inhibit participation by GPs in OOH services. The key and increasing importance of work/life balance was again raised in this survey.

This survey of GPs was reinforced by the commissioned focus group research which reached similar conclusions. The limited sample interviewed in this research study, suggested that more senior GPs may possibly have a greater sense of 'professional duty' than younger GPs, but this is a preliminary view and requires further

elucidation. One unequivocal finding was that all GPs felt that patients were confused by the increasingly fragmented approach to daytime and OOH care and that such services were about delivering urgent (not convenience) care and that there had to be clear messages and support of the public to know how best to access and use urgent care services.

### Short Life Working Group on GP OOH Terms and Conditions

The emerging findings from these surveys and from the engagement programme gave a consistent message that many GPs working in, or who have recently withdrawn from OOH services, are discouraged and confused by existing terms and conditions. Rather than delaying some weeks until the Review was published, a Short Life Working Group (SLWG) on GP OOH Terms and Conditions established and produced a report which is available on the [Review website](#).

As anticipated, a large array of terms and conditions throughout Scotland, was uncovered by the SLWG for GPs working in OOH service. The findings of the SLWG report have been shared with Scottish Government and discussed with NHS Board Chief Executives and Workforce/Human Resources Directors. The SLWG concluded:

- There are a variety of arrangements which are now in existence to engage GPs in OOH work. The importance of these arrangements was recognised to reflect local circumstances, which suit both employers and GPs.
- This variation is impacting on services to attract and retain GPs to work out of hours. Employment or engagement packages to encourage working in OOH services should be more attractive. There was a mixed view on engagement packages for sessional GPs, about including employment rights which are in place for other staff, such as annual leave and study leave. Including such rights would come with a cost in both financial and human resources, but should be considered as part of future implementation of the recommendations of the Review.
- Extending indemnity cover to all GPs providing OOH services and introducing an opt out on superannuation should have a greater impact on attracting and retaining GPs working in OOH services than effecting changes in terms and conditions.
- The Scottish Government, employers and GP representatives should engage in a discussion about the balance between local determination of pay and conditions of service for this group of staff, compared to a national approach which is now in place for all other staff groups.
- At the moment GPs working in OOH services need to apply separately to each territorial NHS Board they wish to work in, to be registered on that Board's Performer's List. This was felt by many GPs to be a barrier to flexibility and overly bureaucratic. Moving to one National Performer's List

would be beneficial, in terms of both clinical governance (with a consequential impact on patient safety) avoiding duplication of effort and unnecessary expense for doctors who wish to provide services to more than one Board. That has been translated as a recommendation by the Review and work is underway to achieve that objective.

## GP Specialty Training

The *Shape of Training: Securing the Future of Excellent Patient Care*. (The Greenaway Report) recommended in 2013 that GP specialty training in the UK should be extended to four years instead of the usual three years and been adopted as official policy by the Royal College of General Practitioners. There has as yet, been no UK wide agreement to implement this recommendation. In Scotland at January 2015, the total headcount of trainees was 1053 of which approximately 60% were in four year training posts compared to 40% in three year posts. The four year posts are not seen to be as attractive as three year posts, because the additional time is spent in hospital posts rather than more training experience in general practice. Survey work and informal views suggested that after three year speciality training, newly qualified GPs are competent but may not feel sufficiently experienced or confident to participate in OOH services. This needs to be remedied as a matter of urgency with increased exposure to OOH experience – existing four year posts should be reviewed to determine fitness for purpose and post certificate of Certificate of Completion of Training (CCT) new one year salaried clinical development posts should be offered which will include OOH work, with enhanced support and continuing professional development (CPD) in OOH medical care.

The fill rate for GP specialty training posts has been declining over the past few years throughout the UK and urgent measures are required to raise the profile and importance of the GP role in a number of ways. Medical Schools have a key role to play in this matter.

Recognising the seriousness of the situation the Scottish Government recently moved to increase the number of training places by opening an additional 100 GP training places on top of the 305 already allocated for 2015. If successfully recruited to, this should bolster GP recruitment for both daytime and OOH services, in due course.

## OOH Commitment from GPs

One of the RCGP and SGPC joint principles submitted was:

“ It is a core professional value that GP care in the community is available at anytime and it is essential that GPs remain a central part of OOH services to ensure holistic, coordinated patient care”.



This is endorsed by the Review and resolute efforts should be made, as a matter of urgency, to recruit and retain GPs to work in OOH services, as they remain core and essential to OOH service provision.

This imperative is not GP specific, but about comprehensive skill mix and workforce planning – for all staff working in OOH services ([Recommendation 8](#)).

## Summary

The evidence considered here provided a clear and compelling case for urgent measures to be taking to enhance GP capacity in OOH services but also for daytime care ([Recommendation 11](#)). This is also reflected in other recommendations related to workforce and training and holds good for all other workforce groups considered by the Review.

## Future Contribution of the Nursing Workforce - Recommendation 12

### Evidence

Submission by the Chief Nursing Officer endorsed by Scottish Executive Nursing Directors (SEND) and the Royal College of Nursing (RCN) Scotland available on the [Review website](#). Three recent publications from the RCN informed deliberations:

1 *Nurse Innovators: Clinical Decision Makers in Action* (2015)

2 *Going the Extra Mile: Improving access to Community Healthcare for Older People in Remote and Rural Health Care in Scotland* (2015)

3 *The nursing contribution to seven day care: community nursing and advanced nursing practice* (2014)

A systematic literature review: Substitution of doctors by nurses in primary care (Laurant et al, Cochrane Database of Systematic Reviews, 2005) which suggested that appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients. Other reviews of advanced nursing roles have been similarly positive. An evaluation of advanced nursing practice in Ireland (Nursing Council for the Professional Development of Nursing and Midwifery, 2010) showed strong evidence that such roles improve patient outcomes by, for example, providing earlier diagnosis and intervention, timely access to care, promoting self-management and increasing patient satisfaction. Similarly, an evaluation in primary care trusts in England (Action Shapiro, 2009) , showed that nurses with advanced training, carried out more holistic assessment of patients and increased patient satisfaction; resulted in better engagement of patients in 'hard-to-reach' groups; improved continuity of care; reduced waiting times; and shortened length of stay for hospital patients.

### Advanced Nurse Practitioners

Advanced Nurse Practitioners (ANPs) have a significant and growing contribution to make in delivering sustainable and consistently high quality OOH care. The term Advanced Nurse Practitioner (ANP) used by RCN Scotland refers to any nurse who is working at an advanced level of nursing practice, irrespective of their official role or job title. There is no single definition or terminology which collectively describes all those nurses who work at an advanced level of practice and the variety and lack of consistency of roles and terminology can be confusing

RCN has identified key characteristics of advanced nursing practise including:

- Making professionally autonomous decisions for which they are accountable
- Receiving, assessing and diagnosing patients with undifferentiated and undiagnosed problems
- Having the authority to admit, discharge and refer patients
- Ordering investigations and providing treatment individually or as part of a team

- Supporting patients to self-care, manage and live with illness
- Working collaboratively across professions and disciplines
- Providing clinical leadership

In her submission, the CNO noted that modern health care system in Scotland is waking up to the potential of clinicians from across professions to deliver robust clinical decision making and manage high levels of risk in a truly joined up way that improves patient outcomes and experience. Advanced Nurse Practitioners (ANPs), as autonomous decision makers, are already proving their worth in leading and delivering high quality, cost effective services across acute, intermediate and community care, including in the out of hours period.

However, the evolution of ANP roles has been local and organic, resulting in inconsistencies of role and education, as well as significant gaps in the availability of services which have progressed piecemeal across Scotland. Capitalising on the contribution of ANPs will mean a radical reconfiguration of teams and this may well challenge traditional expectations. In this context, the public, professional colleagues and nurses themselves need to have greater confidence in, and better understanding of, the ANP role in Scotland. This must be addressed in the short term to support the refreshed workforce needed to improve OOH care.

In order to achieve that objective, the CNO has also instigated a Review of Advanced Nurse Practitioners. This is due to report in April 2016. The RCN Report: *Nurse Innovators: Clinical Decision Makers in Action* provides an excellent description of current ANP activities and innovation across Scotland and further examples of good practice of physical and mental health collaborative projects can be found in: *The nursing contribution to seven day care: community nursing and advanced nursing practice*. The CNO cites two models of good practice in her submission to the Review, at NHS Grampian and NHS Ayrshire & Arran, covering the island of Cumbrae, available on the [Review website](#).

The NHS Grampian OOH model employs a significant number of ANPs. In the main centre in Aberdeen, ANPs work alongside GPs, with team members from SAS, community psychiatric and district nurses, Marie Curie nurses and on-site pharmacy service. In the rural care centres some have GPs and ANPs on duty; others are staffed solely by ANPs who rely on video and telephone links to the main centre. Every ANP in NHS Grampian service is either an independent prescriber or preparing to become one. Recruits must have a minimum five years post-registration experience at senior staff nurse or charge nurse level, and most come in from A&E, surgical, intensive care and general practice. They must complete a master's programme at Robert Gordon University (accredited by the RCN), as well as successfully completing the British Association of Immediate Care (BASICS) training

and passing Objective Structured Clinical Examination (OSCE) appraisal of their skills.

In NHS Ayrshire and Arran, on the Isle of Cumbrae, OOH services are provided by an ANP-led team operating from a base at the island's Lady Margaret Hospital. The highly experienced ANPs commute from the mainland and maintain their critical clinical skills by continuing to work in other NHS Ayrshire & Arran hospitals. They work alongside locally based nursing staff to provide urgent and emergency health care, supported by ambulance technicians and a paramedic. They also provide cover for patients in the community hospital's ward, where local people are typically admitted for palliative care, rehabilitation or treatment for infections. They also make OOH home visits, usually to tend to the needs of frail older people

During the national engagement programme a number of examples of nursing innovation in OOH care were seen and discussed, including Community Unscheduled Care Nurses (CUCNs), in NHS Western Isles.

Figure 7.4 Community nursing staff by specialty and age group 2015

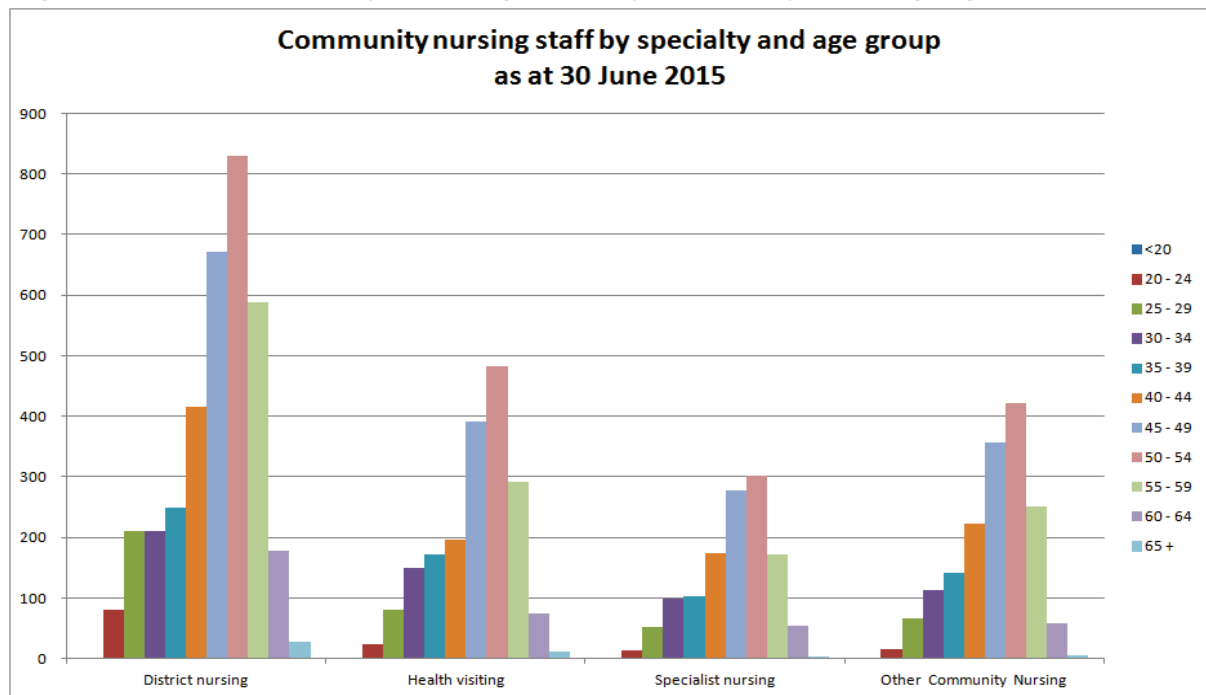


Figure 7.4 above shows the age profile of the community nursing staff working for the NHS in Scotland in 2015. The picture shows very significant challenges of an aging workforce, where the 50-54 years age group is the largest cohort for all community nurse categories. In particular for district nursing, this varies by Health Board area and is worse in some rural areas.

The Chief Nursing Officer's (CNO's) submission to the Review recognises these workforce challenges and she has also instigated a Review of district nursing contributions, including a specific focus on their role in OOH services. The role of district nurses is essential to support 24/7 community healthcare. The CNO review is seeking to underpin a nationally consistent district nursing role, where nurses have the capacity, capability infrastructural support and access to resources, enabling to meet patient need. The CNO's review of district nursing is expected to report in April 2016.

## Summary

Recommendations underpin the CNO Reviews of Advanced Nurse Practitioners and District Nursing which should help to support future OOH and urgent care services. Agreed definitions, standards for training and career development, recruitment and retention, and comprehensive workforce planning are proposed ([Recommendations 8 and 12](#)).

## Future Contribution of the Pharmacy Workforce - Recommendation 13

### Evidence

Joint submission by Community Pharmacy Scotland, NHS Scotland Directors of Pharmacy and the Royal Pharmaceutical Society Scotland - available on the [Review website](#).

*Prescription for Excellence, A Vision and Action Plan for Pharmaceutical Care in Scotland* (2013). Recent publications by Fielding et al, Watson et al and Paudyal et al, found similar outcomes for treating minor ailments in GP, emergency department and community pharmacy settings but at substantially lower costs for pharmacy consultations.. Greater awareness and use of community pharmacies for treating minor ailments could shift substantial demand away from daytime/OOH urgent care and A&E services towards community pharmacies.

Community pharmacies throughout Scotland make an essential contribution to care both in daytime and during the OOH period. There has recently been a major funding initiative as part of the 2015 Primary Care Transformation Fund to attach clinical pharmacists to general practices for daytime medicines management support. As this adds capacity to daytime GP services it is possible that that may release clinical capacity to support OOH services. Pharmacists also play a key role in patient care within NHS 24 and with additional prescribing capability would enhance the multidisciplinary urgent care team working OOH hours.

The joint pharmacy submission contained a number of short/medium and long term recommendations about:

#### Enabling best electronic access to community pharmacies

- Extending the use of national community pharmacy patient group directions (PGDs)
- Maximising the use of the Minor Ailment Service (MAS)
- Strengthening use of the urgent care PGD for repeat medicines/appliance; pharmacists with additional skills to provide enhanced services in community pharmacies and the OOH services
- Engagement by pharmacists in anticipatory care planning
- Exploring extended hours opening, including weekend; develop a national direct referral and clinical handover framework
- Encouraging pharmacist prescriber input to GP practices daytime services reducing pressure on OOH services
- Examining potential roles for pharmacist prescribers in both OOH and A&E services
- Expanding pharmacist input into NHS 24

- Reducing negative impact of medicines shortages on patients, pharmacists and GPs
- Enhancing pharmacist assessment and management skills for common clinical conditions
- Ensuring robust workforce planning for the entire pharmacy workforce, to ensure future fitness for purpose

## Summary

Recommendations have been provided which support greater prominence for community pharmacies for urgent care both in daytime and OOH services, enabling electronic patient record access, promoting greater awareness and use of the minor ailments service (MAS), extending community pharmacy patient group directives (PGDs) and enhancing clinical skills including prescribing capability are consolidated in [Recommendation 13](#).

## Future Contribution of the Paramedical Workforce – Recommendation 14

### Evidence

The five year strategic framework of the Scottish Ambulance Service (SAS), *Towards 2020: Taking Care to the Patient*. Publications notably by Snook et al and by Mason et al, have shown that paramedical practitioners (paramedics) with extended skills can provide clinically effective alternative treatment in the community for elderly patients with acute minor conditions, instead of ambulance transfer to an emergency department. This includes a significant role in the management of older people who fall (SAS attends more than 45000 older people who fall each year). There is a growing literature underpinning extended roles for paramedics ‘seeing and treating’ in the community which is applicable throughout Scotland, but may be particularly relevant for remote and rural areas. This role might be reinforced by increasing use of mobile technology/ video-linking , with professional to professional clinical decision support provided remotely. A modern ambulance fully equipped, including information technology and robust digital communications, could be regarded as a mobile Urgent Care Centre.

In their five year strategy, SAS indicated priorities including: improving access for health care; improving outcomes for patients (specifically cardiac, trauma, mental health, respiratory, frailty and falls); evidence a shift in the balance of care, by taking more care to the patient; enhanced clinical skills as a key and integral partner working with primary and secondary care; more collaboration with other partners including the voluntary sector and other blue light services; improving emergency services; strengthening community resilience; expanding diagnostic capability and use of technology. All of these priorities fit well with the needs of future OOH and urgent care services.

Specific example of SAS innovation include the specialist paramedic model in NHS Western Isles, where such paramedics ‘see and treat’ patients, both as part of the OOH community team and working within the minor injuries unit at the local hospital. The enhanced skills of specialist paramedics allows them to operate more autonomously and they are able to access alternative care pathways directly resulting in fewer avoidable A&E attendances They are able to access decision support from GPs and request follow up visits to the patient from the GP – and by so doing, they can ‘treat and refer’.

SAS have committed to developing and re-profiling their workforce and investment in new roles and enhanced skill sets, and recognises that different approaches may be required in urban compared to remote and rural areas..



This translates as:

- All staff working to their full scope of practice, skills knowledge and experience supported by personal development plans
- Increased levels of specialist medical paramedics operating in the community as part of integrated health and social care teams
- Appropriate numbers of specialist critical care paramedics to respond to critically ill patients and providing support to specialist retrieval teams.

## Summary

Recommendations have been provided about paramedic practitioners, which support an increasing role in the community for urgent care. Development of a competency framework for specialist paramedics is advocated, consistent standards and a clear career development pathway for paramedics ([Recommendation 13](#)).

## Future Contribution of Allied Health Professionals and Physician Associates – Recommendation 15

### Allied Health Professionals

#### Evidence

Submission by the National Allied Health Professions Advisory Committee , *Driving Improvement, Delivering Results*, the Scottish Healthcare Science National Delivery Plan 2015-2020 and a systematic review of evidence about extended roles for Allied Health Professionals (McPherson et al). This section deals with Allied Health Professionals (AHPs) other than paramedics.

The roles of AHPs are diverse and they will play increasingly important roles for OOH and urgent care services including:

- Maximising the potential of planned care to pre-empt avoidable urgent care and hospital admission, including anticipatory care planning
- Consolidation and leadership of integrated community rehabilitation teams
- Securing flexible access to AHP services on an urgent basis according to individual need
- Optimisation of skills and expertise with individual practitioners working to maximise use of their skills and the full scope of their practice. This should include independent prescribing capability
- Individuals who fall, requiring urgent assistance and future prevention are a key priority group. AHPs should play a leading role in the implementation spread and sustainability of the *Falls Up and About* pathway, to aid early identification of triggers for repeat falls/attendees (see Recommendation 6 – *Frail and Older People*).
- As urgent care develops it is likely that point-of-care testing (POCT) will increasingly be deployed. AHPs will have an important role in cost-effective implementation and governance.

A specific example of the contribution of AHPs is provided by NHS Lanarkshire's Age Specialist Service Emergency Team (ASSET). This a pilot project allowing older people in North Lanarkshire to remain at home rather than being admitted to hospital. The ASSET team is made up of consultants, nurses, rehabilitation staff, occupational therapists, physiotherapists and a trained psychiatric nurse working closely with the North Lanarkshire Social Work Department to enable patients to receive immediate additional home care if needed.

## Summary

The extended roles of AHPs in OOH and urgent care services should be recognised. In order to achieve optimal contributions they will require timely and secure access to electronic patient records, like other members of multidisciplinary urgent care teams. Their future contribution should be recognised in integrated workforce planning.

## Physician Associates

### Evidence

The role of physician associates (also known as physician assistants) is relatively new to the NHS. These practitioners have the education and training to diagnose, treat and refer autonomously within defined practice boundaries, working for and with doctors. Physician associates (PAs) have been deployed in the US for more than 40 years and further expansion is underway for primary care roles, in particular. They have also been introduced in other countries such as Canada, Australia, the Netherlands and India. PA educational programmes have been underway in Scotland for several years (University of Aberdeen) and follow a detailed national UK curriculum, with most recruits to date assimilated into secondary care settings, when qualified. They must already have a first degree in life-sciences or health and the course itself is a two year full-time, highly intensive postgraduate diploma. Recent research by Drennan et al, comparing the process and outcomes of GP and PA same-day or urgent appointments, found that outcomes were similar at lower cost. They concluded that PAs offer a potentially acceptable and efficient addition to the primary care workforce.

## Summary

Given serious recruitment difficulties for GPs, as described earlier in this Report, PAs should also be considered for early inclusion in the required skill mix going forward. Their shorter duration of training, will allow earlier reinforcement of urgent care teams.

## Future Contribution of Social Services - Recommendation 16

### Evidence

The Workforce and Training Task Group is very aware that the greater balance of the Review has dealt extensively with clinical requirement, skill sets and expertise in future OOH service development. Social services and their workforce are equally important and crucial to the successful future development of OOH services and urgent care - they must be valued and supported, accordingly.

The traditional view of primary care is that it is principally a NHS activity, delivered by clinical practitioners, along with support staff. In the context of Health and Social Care Integration that view is narrow, restrictive and should be extended. The Review therefore has used the following definition of primary care:

Primary care provides access to care at the right time when it is required and secures ongoing care in the community and continuity of relationships, where this is important. In addition to GP practices, primary care services covers: community services – including: district and community nursing, mental health and dental services, community pharmacies, optometrists - and for effective health and social care integration - social care services, third and independent sector provision

The Task Group considered evidence including workshop activities, submissions by Social Work Scotland, Social Care and Chief Officers of Integrated Joint Boards which are available in [Annex D](#) in summarised form and available in full, on the [Review website](#). Strong support for a more inclusive definition of primary care came from all of these bodies, from representatives of the third sector and during the national engagement programme. Key Facts on Social Services are summarised in [Annex D](#).

This inclusive theme is summarised by key messages from Social Work Scotland:

- Current primary care OOH provision and local authority OOH (emergency) social work provision should be better connected.
- Through integration of health and social care and the establishment of Health and Social Care Partnerships there is an opportunity to consider, how in the future, social work and primary care OOH may be better integrated.
- All health and social care services need to focus on building resilience and self care management. This should include contingency arrangements for extraordinary circumstances, which may mitigate the number of crisis interventions required.
- Service users, carers and the broad workforce need to be clear what constitutes urgent care, which may require attention by OOH services. There

is a need to establish frameworks for use of these services where the detail of the provision of services needs to be clearly laid out and understood - including roles, responsibilities and functions of each agency.

- The future needs of the service should support roles to be developed to ensure better patient services, user outcomes and a more flexible service. This has to be considered in the context of multi-disciplinary team - with [social work and social service workers as key partners](#).
- Focusing on supporting staff to integrate cultures and ways of working and increase mutual respect between professions. Only by improving this, will integrated working come to fruition.

The submissions from Social Work and Social Care on behalf of the independent sector both placed emphasis on the importance of the relationship between social care and clinical OOH services and the need for mutual awareness and of valuing staff and supporting their contribution their contribution. Both recognised that integrated and effective urgent care needs to be delivered 24/7 and not just on an OOH basis.

Co-location of health and services would be helpful but not in itself sufficient – co-working and co-production would be key for success. The Urgent Care Resource Hub and Urgent Care Centre model proposed by the Review should provide options for team-based integrated care in environments that are configured for both service delivery and training.

Other examples of integrated working include hospital-at-home schemes which are presently patchy and do not necessarily operate on a 24/7 basis. These schemes appear to be effective at reducing admissions. The ASSET model described earlier in relation to the future AHP workforce contribution, is another example of encouraging multi-sectoral co-working.

## Summary

Two specific social service workforce recommendations were offered by Social Work Scotland regarding key roles supporting individual and have been incorporated into [Recommendation 16](#):

- The Social Service workforce will have key and developing roles in supporting individuals to ensure they receive the most appropriate support in a community setting.
- Along with other members of inter-sectoral teams, they will continue to play key and developing role in the prevention of, and response to falls in the community and other urgent care needs – for example via the community alarm system. In the future this should include other forms of innovative remote monitoring via telecare, video-linking and mobile applications

- Learning and development programmes should be inter-professional for all practitioners and be embedded within formal Performance and Development plans

## Generic Recommendations for Workforce Development and Support

The following additional generic recommendations are made:

### Recommendation 8 – Effective Workforce Planning

### Recommendation 9 – Interdependent Linkages between Daytime and OOH Services

### Recommendation 10 – The Importance of the Working and Educational Environment

### Recommendation 17 – Working and Learning in Professional Partnership

### Recommendation 18 – Valuing Support Staff

### Recommendation 19 – Leadership

Regarding [Recommendation 18 – Valuing Support Staff](#), the national engagement programme and commissioned survey work by the Workforce and Training Task Group clearly demonstrated the essential roles undertaken by dedicated administrative and support staff. They play a vital role in keeping OOH services viable and consistent in a high stress environment. They should be valued and supported, accordingly.



Primary care multidisciplinary out of hours team, drivers, GP, OOH nurse and receptionist, co-located with Emergency Department at Borders General Hospital



## 8 Quality and Safety

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### Aim

The prime objective of the Quality and Safety Task Group was to develop options for recommendations as to how the quality and safety of OOH services can be best measured, assessed and improved.

The full report of the Task Group on Quality and Safety is available on the [Review website](#).

### Recommendation 20 relates to quality, safety and good practice

### Methodology

- The shared work of the Models of Care Task Group taken into account when working up quality and safety issues
- Evidence from the rapid review of international literature at [Annex F](#) and in full on the [Review website](#), was taken into account, as were emerging findings from the public and professional engagement programme.
- Other evidence considered included: *Developing a Quality Framework for General Practice in Scotland* (Joint Report by Healthcare Improvement Scotland and by RCGP Scotland, 2014); *The Provision of Safe and Effective Primary Medical Services Out-of-Hours*. Quality Standards, NHS Quality Improvement Scotland, 2004); *Delivering Quality in Primary Care National Action Plan* - implementing the Healthcare Quality Strategy for NHS Scotland, Scottish Government, 2010 and Progress Report, 2012)

The consensus was that for future for future OOH services there should be should be clear quality standards with supporting measures for improvement and monitoring of services including key measures of patient, carer and staff experience. The services will be supported to improve the care that they provide and will be an integral, visible and sustainable part of local health and care services.



## Summary

Current OOH arrangements are often complicated and fragmented systems. There is an extensive evidence base highlighting the interface issues and 'pathway' risks facing patients and carers.

- A clear model of service delivery should be established, underpinned by a clear service specification

Out of hours services remain poorly understood across Scotland both by the public and by professionals often resulting in people finding it difficult to know where to go with their health and care needs. Currently OOH primary care services are poorly understood and recognised by the public, the media and politicians resulting in confusion, inappropriate contact and misplaced frustration. Specific lack of recognition of these services within Boards results in a 'Cinderella' service with underinvestment and chronic stress in the system.

- A clear understanding of understanding of the scope of OOH services is essential. NHS Boards, Health and Social Care Partnerships and IJBs should place priority on the delivery, improvement support and monitoring of quality of OOH services

The measurement of OOH service provision for improvement purposes and for monitoring of quality is patchy and poorly supported across Scotland. Recent developments, such as those by PHI in developing the OOH dataset are welcomed. The future service model and specification will require significant development of the current Healthcare Improvement Scotland (HIS) standards and indicators. This will include patient, carer and staff experience in addition to key operational measures, such as staffing of rotas.

- Healthcare Improvement Scotland should be commissioned to review the existing OOH standards and indicators in light of the new service models and to support future service specifications. These should include a specific focus on patient, carer and staff experience. They should do this in collaboration with the Care Inspectorate in relation to social care provision.

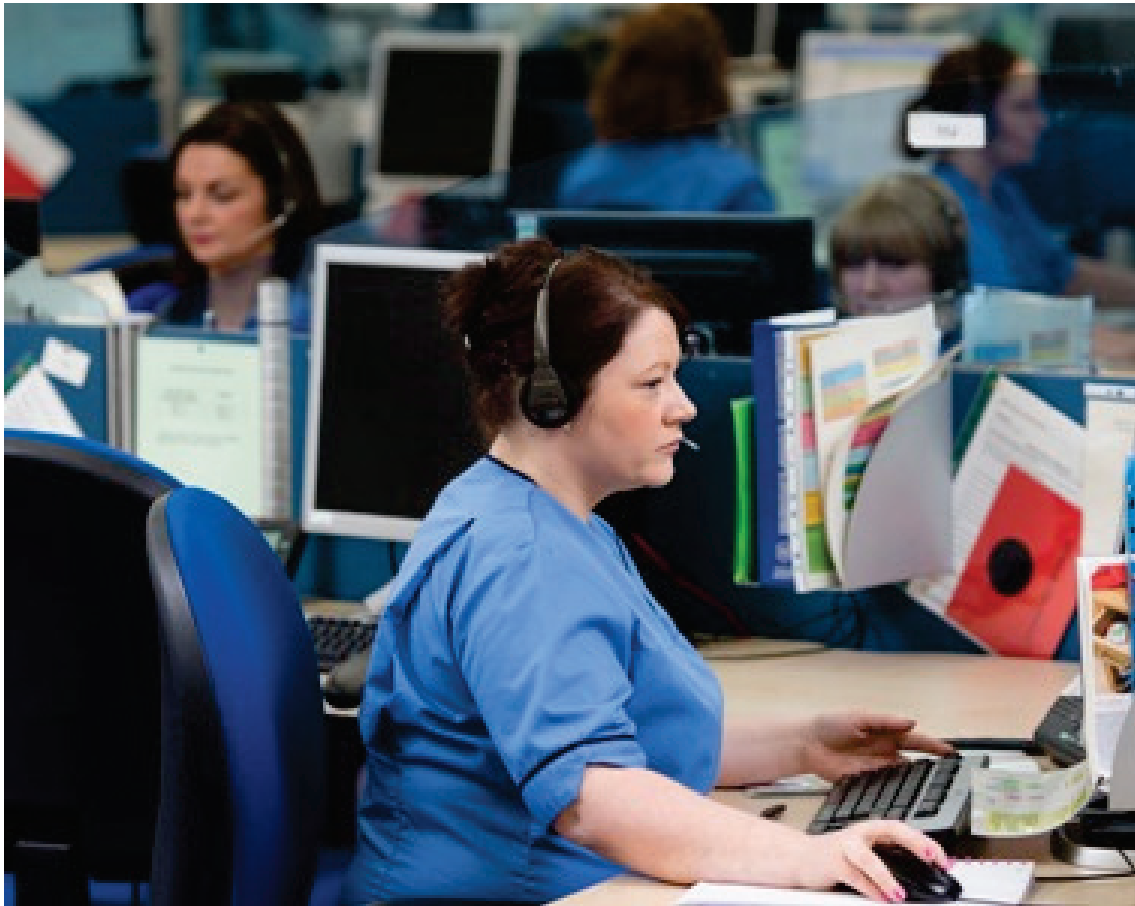
OOH services are not always considered to be an intrinsic part of the health and care system in a systematic manner. The forthcoming HIS Quality of Care Reviews will shape the future of how external scrutiny can best support the delivery of sustainable high quality care across Scotland.

- Healthcare Improvement Scotland should ensure that OOH services are incorporated as a key focus of proportionate and risk based Quality of Care reviews with related improvement support.

It is recognised that having the necessary quality improvement capacity and capability to support services to improve quality is essential. NHS Scotland is known internationally for its commitment to quality and safety and its commitment to build quality improvement capacity and capability. OOH services in Scotland have had limited improvement support to date but where that has been provided, then significant improvements in quality have been achieved.

- All Health and Social Care Partnerships should consider how their existing quality resources can support improvement in OOH services. Healthcare Improvement Scotland, in collaboration, should be commissioned to undertake a scoping exercise of improvement support requirements at local and national level in OOH.

These are translated as [Recommendation 20](#).



Nursing staff, part of a multidisciplinary team at NHS 24, Norseman House

## 9 Data and Technology

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### Aim

The prime objective of the Data and Technology Task Group was to develop recommendations for improved functionality for:

- Communications and data flows to support new ways of working in OOH services.
- Requirements for clinical records, decision support and integrated records
- Complete, accurate and timely information fundamentally underpins safe and effective health and social care
- Clinicians and social care providers require information to be routinely shared if they are to provide optimal care to patients and citizens

The full report of the Workforce on Data and Technology is available on the [Review website](#).

### Recommendation 21 relates to data, technology, mobile and communications infrastructure

### Methodology

In addition to the evidence base, the Data and Technology Task Group took account of the Scottish *eHealth Strategy*, the Caldicott Principles and the Newcastle Declaration as follows:

The seven Caldicott principles must be observed for justified use of patient data, ensuring security and patient confidentiality and the obligations of users. This includes the duty of sharing information, which is as important as the duty of protecting patient confidentiality.

The principles of the *Newcastle Declaration* (2015) should also be taken into account and in particular:

- Complete, accurate and timely information fundamentally underpins safe and effective health and social care
- Clinicians and social care providers require information to be routinely shared if they are to provide optimal care to patients and citizens

A preliminary review of the OOH Information Technology (IT) system (Adastra) was instigated and its findings contributed to recommendations made.

The data and technology challenges for OOH services are the same as those for daytime working. The recommendations offered may have potential to improve all health and social care systems in Scotland on a 24/7 basis. Levels of health literacy, ease of access to data and the information needs of both patients contacting OOH services and staff also emerged as areas for improvement.

The nature of how people access out of hours services, was explored through extensive consultation with individuals with special access requirements. Questionnaires and workshops were arranged with the support of the Health and Social Care Alliance Scotland. Discussions focused on the need for integrated patient records and improvements at the interfaces of care, widening patient and multi-sectoral professional access to securely held electronic records at the right time, irrespective of place or circumstance.

Detailed recommendations by the Data and Technology Task Group are presented in its full report available on the [Review website](#). Some short term priorities, listed as 'quick wins', are already underway or considered to be urgent. The recommendations offered address the following issues:

- Lack of integrated IT systems lead to poor quality of communication, particularly at handovers of care with safety risks
- Patient care plans should be available electronically 24 hours a day to front line services
- Primary Care OOH is not a priority component of the national IT strategy and this is reflected at local levels in terms of resource allocation Lack of national standards and infrastructure for recording and using information. Variation in implementation causes confusion and frustration for clinicians, and an inconsistent service for patients
- People with particular communication requirements are disadvantaged. Standards for accessing support and information are inconsistent and those in place are not adequately implemented

## Summary

- A consistent view is required of all relevant health and social care information necessary to provide optimal OOH and urgent care. Subject to agreed consent, this information should be available securely to the right people at the right time, irrespective of care setting and location
- Consistency of data sharing must be improved and should underpin better person-centred care
- All health and social care stakeholders should agree a common summary of defined data items and updating protocols
- Current referral records and mechanisms are fragmentary and are often still paper based. Referrals from OOH services to all care sectors should be electronic and fully auditable, in order to ensure effective and timely continuity of care
- The NHS NSS National Unscheduled Care Framework presently advises on the procurement of NHS IT systems. In partnership, this framework should now be reviewed in the light of future health and social care integration requirements
- A collective service-led review of OOH IT systems currently in use and related governance arrangements is urgently required in order to deliver national consistency in use and optimisation of individual patient care and information

The Review Group recommended that better use should be made of video and mobile communications and technological innovation:

- High quality and reliable video links should be in place between Urgent Care Resource Hubs and local Urgent Care Centres ([Recommendations 3 and 4](#)). This technology should also be deployed to support practitioners in remote and rural locations, in intermediate care settings - residential care homes and community hospitals, in the Scottish Prison Service and for mobile healthcare delivered by SAS. The technology may also be appropriate for location in the homes of some patients with complex care needs.
- The Scottish Centre for Telehealth and Telecare, in collaboration with the Digital Health & Care Institute, should look to support the development and roll-out of proven technologies at scale, including accredited mobile applications for self-care and access to the most appropriate care services, subject to appropriate evaluation.

All of these recommendations are assimilated as Recommendation 21.



Multidisciplinary Social Services Community Alarm Scheme, Dundee

# 10 Role of Health and Social Care Partnerships and Integrated Joint Boards

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## Evidence

The future role of Health and Social Care Partnerships was a recurring theme of the engagement process and professional submissions. There was general consensus that the leadership roles of Health and Social Care Partnerships and Integrated Joint Boards (IJBs) would be key for securing the successful strategic planning and delivery of future OOH and urgent services.

## Recommendation 22 relates to the future role of Health and Social Care Partnerships and Integrated Joint Boards

### Summary

- Strong leadership for urgent care and OOH services will be required from Integrated Joint Boards (IJBs) and Health and Social Care Partnerships, going forward. They must place sufficient priority on the delivery, improvement, support and monitoring of quality and safety for OOH and urgent care services ([Recommendation 20](#)).
- The strategic planning process of Health and Social care Partnerships and IJBs should look for opportunities for integrated OOH service provision from Local Authorities and the NHS, including co-location opportunities, and the provision of urgent services on a 24/7 basis.
- Future models of care should meet local need and focus on early intervention and prevention. Opportunities should be sought to build on success where best practice has been demonstrated of integrated multi-disciplinary health and social work teams providing 24/7 services. These should include partnership arrangements with the third and independent sectors.
- Joint organisational development plans should focus on supporting staff to integrate cultures and ways of working and increase mutual respect between professions. There is a need for learning and development strategies to be in place that support strong distributive leadership across professions/sectors. These are crucial factors if effective co-working is to become embedded across IJBs and Health and Social Care Partnerships.





Scottish Ambulance Service taking care to the patient

# 11 Role of Special Health Boards and Public Bodies

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## Evidence

Active engagement, including visits and discussions took place with NHS National Services Scotland (NHS NSS), NHS Education Scotland (NES), NHS Health Scotland, NHS 24, the Scottish Ambulance Service and Healthcare Improvement Scotland (HIS), in order to help to define their roles in supporting future OOH and urgent care services in Scotland.

## Recommendation 23 relates to the future role of Special Health Boards and Public Bodies

### Summary

- **NHS National Services Scotland** should play a lead role in interpreting and delivering the Review recommendations from a public health intelligence perspective at national and local levels, in active collaboration with territorial Health Boards. This includes live operational use of intelligence, as well as for strategic planning, service monitoring and development purposes. Work is already in progress on this, including the development of a health and social care dataset at individual patient/service user level to inform local strategic commissioning. This needs to be coordinated across all urgent care sectors, not just the NHS, and conforms to the principle of intelligence-led services ([Recommendations 1,3,21](#)).
- **NHS 24** and the **Scottish Ambulance Service** should be encouraged to work together more closely across all their processes, with a view to improving effectiveness and efficiencies of the patient journey of care in order to deliver best outcomes ([Recommendation 2](#)).
- **NHS Education Scotland** should continue to deliver the lead role in developing training and leadership support for a reconfigured clinical workforce, in order to secure optimal urgent care for the people of Scotland ([Recommendations 8-19](#)).
- **NHS Health Scotland** should lead the delivery of a health inequalities impact assessment process, following assimilation of the recommendations from this Review. This contribution should also inform supported self care and best use

of health and care services, with a view to best patient outcomes and narrowing health inequalities ([Recommendation 7](#)).

- [Healthcare Improvement Scotland](#)\* should strengthen its support for quality improvement approaches and resources applicable to urgent care in the community, in active and synergistic collaboration with the [Care Inspectorate](#)\*.
- The [Scottish Health Council](#) should continue to promote best engagement of the Scottish people in participating and shaping future care services at national and local levels, including self care and best use of urgent and emergency care services ([Recommendation 5](#)).

\*Healthcare Improvement Scotland and the Care Inspectorate are public bodies.



Third sector teams – Alliance and Voluntary Action Scotland

## 12 Role of the Third and Independent Sectors and other Agencies

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Recommendation 24 relates to the future role of third and independent sectors and other agencies

### Evidence - third sector

The third sector is a major provider of health and social care services, which is contributed over 24/7. A report on the activities and impact of the third sector was submitted to the Review and is summarised in Annex D in full on the [Review Website](#).

The contribution of the third sector is summarised in the Key Facts section, [Annex B](#). In addition representatives of the third sector were actively engaged in the Review process as members of groups, during engagement meetings and at workshops.

The third sector plays a vital role in supporting the people of Scotland, particularly the most vulnerable individuals in our society, who are often frequent users of OOH services. Therefore improving these connections has potential to improve personal outcomes, safety and to have a positive impact on inequalities in health. The need to support and understand the contribution of the third sector is now more urgent, as Health and Social Care Partnerships and Integrated Joint Boards and Scottish Government require information to make more effective and efficient use of all community resources and to develop the intelligence required to plan services.

### Evidence – independent sector

The independent sector is also an important provider of residential care services reflected in their submission from Social Care to the Review. This is summarised in [Annex D](#) and available in full on the [Review website](#).

Key Facts about the residential care sector can be found in [Annex B](#).

In addition to this submission, the role of the independent sector in OOH services was discussed in workshops and was also flagged by Social Work Scotland in their submission. Several recommendations were offered to the Review including:

- Care homes should be recognised as a legitimate component part of primary care. The Review included it in its definition of primary care.
- Data improvements, better anticipatory care planning, use of telemedicine links, better professional support for care homes, and greater co-working and collaboration – all feature in Review recommendations.

### Summary – third and independent sector

In addition to the above response to the independent sector’s submission, the following recommendations some of which crossover have been assimilated into [Recommendation 24](#):

- Improve understanding and support for the role of the third sector in OOH services prevention and self management
- Improve national intelligence about the contribution of the third sector to Scotland’s Health and wellbeing in both daytime and OOH services
- Explore models of governance in statutory and non statutory organisations to ensure a person-centred safe and effective service
- Health and Social Care Partnerships and IJBs should explore models of funding to the third sector to ensure their agreed contribution to both daytime and OOH services is sustainable
- Improve systems for communication and for connecting both statutory and non-statutory providers of care

### Scottish Fire and Rescue Service

#### Evidence

There is a robust international evidence base for the use of fire services personnel in medical first response incidents – particularly in the USA. In Scotland there has been a significant decline in fire incidents and a growing interest in prevention and medical co-response with the SAS to cardiac arrest incidents in pilot schemes, as part of Scotland’s *Out of Hospital Cardiac Arrest Strategy (Recommendation 2)*. Further evidence came from the HM Fire Service Inspectorate Report on Emergency Medical Response and the Scottish Fire and Rescue Service (2014), a series of meetings with Scottish Fire and Rescue Service, and a site visit to a first-responder scheme at Maud. This unit also engages in falls pathways and is highly valued by the community it serves.

#### Summary

The future role and assets of the Scottish Fire and Rescue Service should have more prominence in relation to health and social care provision, particularly in their



prevention, co-responder and first responder roles. This has immediacy for community cardiac arrest events, in close partnership working with the Scottish Ambulance Service. The Scottish Fire and Rescue Service is well placed and willing to contribute further to the urgent care and wellbeing of the Scottish people, beyond their traditional roles. Their potential future contributions to prevention and urgent care provision should be carefully considered, defined and valued - including potential involvement in uninjured falls pathways and extension of first-responder roles.

## Royal National Life Boat Institution (RNLI), HM Coastguard and SAS

During the national engagement programme it was noted that in some remote areas of Scotland the evacuation/transport of sick people requiring urgent care or assessment was sometimes difficult. In that instance, RNLI might assist evacuation, in liaison with SAS - where alternative transport arrangements were unavailable or inappropriate, particularly in adverse weather condition. Discussions were held with both RNLI and SAS and it was proposed that where there are working linkages between RNLI, SAS and HM Coastguard, these should be supported by a formal Memorandum of Understanding.

## Scottish Prison Service and Forensic Medical Services

The care of prisoners in Scotland transferred from Scottish Prison Service to the NHS in 2011. When exploring issues of resilience in primary care OOH services, a number of views were expressed concerning the use of common GP personnel for OOH services, prisoner care, Police Scotland healthcare and forensic medical services. Issues of insufficient capacity and lack of resilience were raised. Preliminary discussions were held with Scottish Prison Service and with GPs. The Review was unable to pursue this further in the available timeframe and therefore recommends that further work should be considered of these issues. In particular, further exploration should be considered of the potential of remote telehealth consultation, electronic national record linkage ([Recommendation 21](#)) and quality assurance of OOH services delivered across Scottish prisons ([Recommendation 20](#)). In relation to forensic medical services, a multidisciplinary approach should be considered in keeping with the recommendations for OOH services by the Review, in the context of the National Guidance on the Delivery of Police Care Healthcare and Forensic Medical Services (2013).





# 13 Promoting Person-Centred Care

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Delivering person-centred care is a strategic priority for NHS Scotland and the Scottish Government, and essential to the delivery of our *2020 Vision* for Health and Social Care.

## Recommendation 25 refers to promoting person-centred care

The Review stated that person-centred care was true for both those who received care and those who deliver it. The Review has had a key thread running through it of valuing professional health and social care, administrative, support, third and independent sector, other statutory agency staff and voluntary workers - often working in difficult circumstances, with complex cases in the OOH period. This section focuses on the optimal care, support and wellbeing of the people of Scotland

## Optimising Person-Centred OOH and Urgent Care

The Review gives an opportunity to develop OOH and urgent care services that are responsive to the relational care, self-management and health literacy needs of people, particularly as health literacy is at the heart of our commitment to delivering a safe, effective and person-centred healthcare system.

## Evidence

Individual quality improvements by themselves do little to support self management and there is a growing understanding that a whole system approach that promotes the process of partnership working to plan and coordinate care (care and support planning) is required. Key ingredients include:

- Helping people and their carers to be informed and engaged through education, information sharing, addressing health literacy needs, emotional and psychological support.
- Helping the professionals to be enabling and collaborative, through leadership, communication skills, training and reflective practice.
- An organisational infrastructure that promotes continuity, ease of access, customises time according to need, IT support and service design.
- Rich social support, relationships and sustained resources in our communities that keep people well.

The evidence for these elements comes from the work on the Chronic Care Model which has been redrafted into the House of Care. Embedding these elements into an integrated health, care and community setting is a key piece of work supported by Scottish Government and the Alliance (HCSAS), which aims to promote the adoption of care and support planning, particularly within primary care, for people living with long term conditions. It is also a policy commitment by RCGP (UK) and part of RCGP Scotland's strategy blueprint for Scottish general practice.

- Promoting the integration of all these elements into health and care settings requires transformational change. Where this has been adopted there is also evidence of improved biomedical processes of care and by inference this should have a positive impact on unscheduled care, hospital admissions and effective discharges. It's important to recognise that gains occur when all the elements are in place. Individual interventions, such as a self-management or anticipatory care plan, whilst important, on their own are likely to prove limited.
- The key message is that improving our health and care system that embraces enabling, empowering approaches and promotes collaborative, personalised care and support planning will have a mutually positive effect for people using out of hours services and for those providing their care.

The House of Care Model in itself can be used as an integrative framework to map and checklist many areas of policy and service improvements, such as required for developing OOH services. However, we need to be mindful that at its core is a productive interaction between people and their professional carers.

### What can OOH services do to promote self management and be responsive to people's health literacy needs?

- As professionals, whilst we may wish to be enabling and empowering, we may unwittingly and unintentionally dis-empower people and perpetuate learned helplessness and dependency. Certainly when someone is acutely ill such as a stroke, heart attack or severe pain they willingly and appropriately submit to being passively cared for.
- However, for many OOH contacts our professional responsibility is to help people make sense of their health problem, the health service, and then support them to cope with the demands and expectations that any treatment or further management at home entails.

There is an opportunity to develop OOH and urgent services that are responsive to the self-management and health literacy needs of people. The rationale and

recommendations for these are set out in Scotland's national health literacy action plan [Making it Easy](#). For this the following elements are suggested:

- Organisational management and leadership committed to these aspects of person-centred care
- Enthusiastic health literacy and self-management clinical champions
- Training and support for staff to recognise and cater for people's health literacy needs
- Involvement in design and delivery by service users
- Clear, unambiguous, intuitive processes to access and navigate OOH services
- Clear jargon- free communication
- Accessible to people with different language needs, speech, sight or hearing difficulties
- Checking understanding
- Sharing of personalised and meaningful information, such as results and correspondence (including shared medical record)
- Tailored educational information that is literacy and numeracy sensitive

## Summary

Promoting person-centred care was the opening guiding principle of the Review and is appropriate now that we return to it. OOH and urgent care services should not just be about supply and demand but rather we should be seeking to respond optimally and compassionately to care needs and to support self management and improve health literacy. The Review supports Scotland's national health literacy and action plan, [Making it Easy](#), and the integrative framework of the House of Care. This is assimilated as [Recommendation 25](#) (see also [Recommendations 5,6,7](#)).



Primary care out of Hours Team, Hamilton NHS Lanarkshire clinical support worker, driver, GPs nurse practitioner, senior charge nurse

# 14 Research and Evaluation

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The Review commissioned a rapid systematic review of the international literature, and focus group research from the Scottish School of Primary Care and undertook separate survey work ([Annex F](#)) and in full on the [Review website](#).

## Recommendation 26 refers to research and evaluation

### Evidence

During the course of the course of this systematic review yielding 274 research papers for scrutiny, a paucity of robust evaluation of models of OOH services was found.

### Key areas identified as being crucial in the development of high quality OOH services

- Good communication and information technology, both across OOH service providers but also across the daytime and OOH interfaces.
- Better understanding of how patients view OOH services and the decisions they make in relation to which service they choose to attend.
- Development and evaluation of new professional roles in OOH care, in particular pharmacy, but also other organisations out with health care
- Better engagement with early career GPs, with trainees and with undergraduate medical students to promote the value and professionalism of providing out-of-hours care.
- Improvement in career development and training for other professional groups.
- Single, centralised systems have to be *'future proofed'* to address the contextual realities of different areas, for example patients in remote and rural areas have different needs and capacity to respond compared to those in urban areas. This is also true in relation to socioeconomic deprivation.

### Recommendations for research and evaluation

- Future models of care need to be rigorously evaluated using experimental research designs which will allow both clinical and cost effectiveness to be addressed. The methodology used should include cluster randomised controlled trials and alternative study designs, such as stepped-wedge study designs, to best inform the development of OOH delivery programmes. This research should pay particular attention to the requirements of key groups

with specific needs, including palliative care, mental health, frail older people and individuals with communication and accessibility issues.

- Future evaluation designs should include economic evaluation to assess not only the immediate costs of new models of care, but also the wider impact on other parts of the health and social care system, in relation to health and social care integration imperatives.
- A better understanding is required of the decision-making of patients and carers in terms of: what they know and understand of different parts of the OOH system and what makes them choose one service provider over another (for example phoning NHS 24 versus attending A&E services).
- Co-location, co-working and integration of services should be underpinned and informed by evaluation, including qualitative process evaluation to understand the challenges and facilitating factors for co-location, co-working and integration.

## Summary

The lack of relevant published literature and planned service evaluations in OOH services have significantly hampered understanding of best practice. Future research and development (R&D) support should inform and evaluate new models of OOH and urgent care services, including economic assessment ([Annex F](#)).





Scottish Fire and Rescue Service and First Responder Team, Maud

# 15 National Implementation Plan and Local Guidance

Recommendation 27 refers to a national implementation plan and local guidance

## Evidence

The Review has proposed 28 recommendations covering new models of care, workforce - including increased multidisciplinary capacity and capability, quality and safety, data and technology, responsibilities and leadership and enhanced roles for statutory authorities, third and independent sectors and other agencies. These are ambitious - but reflect extant and looming challenges of demographic change, increasing multimorbidity, complexity and rising service demands. The recommendations offered reflect the imperative of transformational rather than incremental change. Careful reflection on the recommendations is therefore essential for all stakeholders at national and local levels. This is amplified by financial constraints and the need to maximise benefits, as discussed in [Chapter 16](#). Set in the context of early and evolving health and social care integration, implementation of the recommendations in the Review will require inter-sectoral collaboration of a very high order. Careful, considered and resolute preparation of quality assured implementation planning is vital.

## Summary

1. A national implementation plan is recommended, including performance impact, key indicators and timescales. This should include support for local implementation guidance, including a service specification, as local ownership is key for success.
2. The plan should also take account of related work streams already in place and underway, including: the National Clinical Strategy, the Task Force on Sustainability and Seven Day Services, the National Unscheduled Care Programme, the Chief Nursing Officer's Review of Advanced Care Practitioners and District Nurses, the Public Health Review and the eHealth Strategy.





Crew of the Lerwick Lifeboat on service

# 16 Finance and Best Use of Resources

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## Finance

Over the next decade it is unlikely that health funding will grow at the same rate as the increase on demand for services. All of our services will therefore need to deliver increased efficiency and productivity in order to deliver the safe, high quality care required. Increased investment in primary care generally and OOH services specifically will need to demonstrate best value for money in the context of this overall pressure on budgets. Similarly, we will need to consider and identify areas of disinvestment to allow for a higher proportion of overall health and care spend to be allocated to primary care services.

## Recommendation 28 refers to finance and best use of resources

The Review highlights a range of areas where financial investments will be required and risks will arise including:

- The proposed new Urgent Care Resource Centres primarily envisage drawing upon existing staff working in the OOH period. As detailed models start to develop in individual Board areas it is likely that investment in new multidisciplinary teams will be required but will vary considerably across Boards.
- It is realistic to assume that further investment in eHealth will be required, aligned with national eHealth strategies to improved consistency and efficiency of systems to support the working of teams.
- The future increasing roles of multidisciplinary teams within OOH and other primary care urgent care services is seen as contributing significantly to our future service delivery solutions: GPs, Advanced Nurse Practitioners, Paramedical Practitioners, other AHPs, community nursing staff - including mental health, physician associates, social services workers, support staff and other workers. Investment on a national basis for training of practitioners is essential to ensure future workforce models can be effectively and efficiently delivered.
- The proposed closer alignment of NHS 24 and SAS ([Recommendation 2](#)) and the services they provide must consider the resource implications, avoidance of potential duplication and pursuit of efficiencies. Any investment in roll-out

of the SAS strategy: *Towards 2020: Taking Care to the Patient*, should ensure maximisation of service benefits

- It is likely that the changes envisaged for local Urgent Care Centres (formerly PCECs) may require some capital investment as physical modifications to accommodation are required to deliver the new service models. This should be recognised as a priority through Boards capital programmes and the Capital Investment Group. The service benefits of co-location and co-working should be fully explored and assessed.

## Summary

Recognising significant financial challenges in the next 10 years it will be particularly important that all services produce increased efficiency and productivity in order to deliver safe, high quality person-centred care. Increased investment in primary care OOH and urgent care services specifically will need to demonstrate best value for money and areas of disinvestment pursued. Particular areas for resource allocation are identified and where maximising service benefits will be essential.

# 17 Conclusions

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The onset or worsening of illness can occur at any time of the day, any day of the week. Irrespective of the time and place, the people of Scotland deserve a high quality service which fully meets their needs and does so reliably and at all times.

The commission of the Cabinet Secretary for Health, Sport and Wellbeing was to secure person-centred, sustainable, high quality and safe primary care during the out of hours (OOH) period - when general practices are closed. Present OOH services are under considerable pressure, remain fragile and are not sustainable.

From the outset, it was recognised that the Review would be challenging as it is set at a pivotal moment in our health and social care integration journey – early days and many miles to travel. Equally, looming large are unprecedented demographic challenges, increasing multi-morbidity, complexity, workforce and financial constraints.

In order to navigate our way, we chose deliberately to define a set of guiding principles, a compass for the road ahead. These principles were that future primary care OOH services should be:

- **Person-centred** - for those who receive and those who deliver services
- **Intelligence-led** - making the most of what we know about our people and their needs
- **Asset-optimised** - making the most of all available assets and resources
- **Outcomes-focused** - making the best decisions for safe and high quality patient care and wellbeing

In addition to these guiding principles, such services should be:

- **Desirable** – high quality, safe and effective
- **Sustainable** - resilient on a continuous basis
- **Equitable** - fair and accessible to all
- **Affordable** - making best use of public funds

We took the view that an inclusive and transparent approach along the way would be the right thing to do. This started with the definition for primary care which should rightfully include social services, the third and independent sectors, other agencies and voluntary carers. We also took the view that we should not go alone and so our Review process was inclusive – many professional colleagues and the public have travelled with us, as part of our engagement process. Our direction of travel had to be clear at the outset, in order to fulfil our remit and therefore incremental change was not sufficient and transformational change was required and that while

addressing our remit in relation to OOH services we need to think anew about 24/7 urgent care services.

28 Recommendations and a number of sub-recommendations are presented for consideration and reflection at national and local levels. They embrace new models of care, the needs of specific groups, enablement and empowerment, accessibility, health literacy, inequalities and the promotion of person-centred care. Workforce issues occupy a number of our recommendations - capability, capacity, challenges and the need for unprecedented primary care workforce planning at national and local levels with a key focus on valuing and supporting staff throughout their careers. Better quality and safety are essential for optimising patient care and this will be underpinned by better use of and access to electronic records, telehealth, telecare and mobile applications caring for our patients and the people of Scotland, supporting self-care where appropriate and ensuring best access to services when needed. A number of recommendations are made about the future roles of the third and independent sectors and other agencies, the leadership roles of Health and Social Care Partnerships and Integrated Joint Board, and the support roles of Special Health Board and Territorial Boards. Recommendations for research and evaluation are mooted and there is a strong emphasis on shared inter-sectoral planning at both national and local levels with the key imperative of ownership. The final recommendation addresses finance and best use of resources.

These recommendations have been set out as foundational. They will certainly need to be scrutinised, reviewed, challenged and updated in the light of evaluation and new intelligence - but hopefully they will reap some rewards ahead for the people of Scotland, for patients in need, for carers and for their loved ones.

# References

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The bibliography below is representative, rather than an exhaustive list of the range of literature and publications which have been referenced in the compilation of this report. Please visit the Review web space where a more comprehensive list of reference materials will be available.

**Quality Strategy:** A strategy for improving the quality of care patients receive from the NHS in Scotland. The Quality Strategy aims to deliver the highest quality healthcare to the people of Scotland to ensure that the NHS, Local Authorities and the Third Sector work together, and with patients, carers and the public, towards a shared goal of world-leading healthcare.

<http://www.gov.scot/Publications/2010/05/10102307/0>

**National Conversation: Creating a Healthier Scotland - What Matters to You?:** The Scottish Government is inviting you to have your say on what a healthier Scotland should look like in the next 10 to 15 years and the steps that could be taken to make this vision a reality. From August 2015 to Spring 2016 we will be holding a national conversation on improving the health of the population and the future of health and social care services in Scotland

<http://healthier.scot/>

**Health and Social Care Integration:** Integration of health and social care is one of Scotland's major programmes of reform. At its heart, health and social care integration is about ensuring that those who use services get the right care and support whatever their needs, at any point in their care journey.

Main page on SG website: <http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration>

Integration Narrative: <http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Narrative>

Roles, Responsibilities and Membership of the Integration Joint Boards:  
<http://www.gov.scot/Publications/2015/09/8274>

**Getting It Right For Every Child (GIRFEC):** GIRFEC is a consistent way for people to work with all children and young people and the bedrock for all children's services and professionals in adult services who work with parents or carers.

Main page on SG website: <http://www.gov.scot/Topics/People/Young-People/gettingitright>

SG Publications: <http://www.gov.scot/Topics/People/Young-People/gettingitright/publications>

Wellbeing: <http://www.gov.scot/Topics/People/Young-People/gettingitright/well-being>

**Mental Health Strategy:** The Scottish Government's mental health strategy to 2015 sets out a range of key commitments across the full spectrum of mental health improvement, services and recovery to ensure delivery of effective, quality care and treatment for people with a mental illness, their carers and families.

<http://www.gov.scot/Publications/2012/08/9714>

**Health Inequalities:** Reducing inequalities in health is critical to achieving the Scottish Government's aim of making Scotland a better, healthier place for everyone, no matter where they live. While the health of the country as a whole is improving, the fact is that some inequalities are widening. That requires concerted action across government.

Main page on SG website: <http://www.gov.scot/Topics/Health/Healthy-Living/Health-Inequalities>

Equally Well - Report of the Ministerial Task Force on Health Inequalities:

<http://www.gov.scot/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well>

**Palliative and End of Life Care:** Palliative and end of life care are integral aspects of the care provided by health or social care professionals to people living with and dying from any advanced, progressive and incurable condition. Palliative care is not just about care in the last days and hour of life, but about ensuring quality of life for both the person and their family at every stage of the life-limiting disease process from diagnosis onwards.

Main page on SG website: <http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/peolc>

Caring for people in the last days and hours of their life - National Statement/Guidance:

<http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/peolc/caringinthelastdaysandhoursoflife>

**Workforce Policy:** The Workforce Policy team lead on pay, terms and conditions of service, pensions, education and training and workforce planning. The 2020 Workforce Vision was published in June 2013 and the first Implementation Plan was published in December 2013.

Main page on SG website: <http://www.gov.scot/Topics/Health/NHS-Workforce>

NHS Workforce Policy page: <http://www.gov.scot/Topics/Health/NHS-Workforce/Policy>

Everyone Matters: 2020 Workforce Vision: <http://www.gov.scot/Publications/2013/06/5943>



**eHealth Strategy:** The eHealth Strategy 2014 – 2017 sets a national direction through a common vision and set of key aims. The Strategy maintains a significant focus on healthcare and the needs of NHSScotland, but has been redeveloped to recognise the rapidly evolving environment of integrated health & social care and the need to address not only NHSScotland requirements, but also the expectations and requirements of partnership organisations, and citizens for electronic information and digital services.

<http://www.gov.scot/Publications/2015/03/5705>

**Falls policy - The Prevention and Management of Falls in the Community:** The Framework builds on the model presented in the Up and About resource, and focuses on falls prevention and management and fracture prevention for older people living in the community. The Framework is underpinned by evidence from research and draws on knowledge and experience gained by the falls prevention community in Scotland over the last four years.

<http://www.gov.scot/Publications/2014/04/2038>

**Cardiac Arrest Strategy:** The Out-of-Hospital Cardiac Arrest(OHCA) strategy, which has been developed in collaboration with a range of stakeholders, is a 5 year plan with the aim of ensuring that by 2020 Scotland becomes an international leader in OHCA outcomes. The headline aim is to save an additional 1,000 lives by 2020.

<http://www.gov.scot/Publications/2015/03/7484>

### **Prescription for Excellence, A Vision and Action Plan for Pharmaceutical Care in Scotland (2013)**

A Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation

<http://www.gov.scot/resource/0043/00434053.pdf>

### **Towards 2020: Taking Care to the Patient. The Scottish Ambulance Service.**

[http://www.scottishambulance.com/UserFiles/file/TheService/Publications/Strategic%20Plan\\_Online%20pdf.pdf](http://www.scottishambulance.com/UserFiles/file/TheService/Publications/Strategic%20Plan_Online%20pdf.pdf)

**Shape of Training: Securing the future of Excellent Patient Care** (the Greenaway Report).

[http://www.shapeoftraining.co.uk/static/documents/content/Shape\\_of\\_training\\_FINAL\\_Report.pdf\\_53977887.pdf](http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf)

**The future of primary care: Creating teams for tomorrow (Report by the Primary Care Workforce Commission, Health Education England)**

<http://hee.nhs.uk/wp-content/blogs.dir/321/files/2015/07/The-future-of-primary-care.pdf>

**Scottish eHealth Strategy 2014/17**

<http://www.gov.scot/Resource/0047/00472754.pdf>

**Scotland's National Health Literacy Action Plan – Making it Easy**

<http://www.gov.scot/Resource/0045/00451263.pdf>

**Effectiveness of paramedic practitioners in attending 999 calls from elderly people in the community: cluster randomised controlled trial**

BMJ 2007; 335 doi: <http://dx.doi.org/10.1136/bmj.39343.649097.55> (Published 01 November 2007) Cite this as: BMJ 2007;335:919

**National Audit Office Out of Hours GP Services in England 2014**

<https://www.nao.org.uk/wp-content/uploads/2014/09/Out-of-hours-GP-services-in-England1.pdf>

**Randomised controlled trial of effectiveness of Leicester hospital at home scheme compared with hospital care**

BMJ 1999; 319 doi: <http://dx.doi.org/10.1136/bmj.319.7224.1542> (Published 11 December 1999) Cite this as: BMJ 1999;319:1542

General Practice Funding underpins the persistence of the inverse care law. Mclean G, Guthrie B, Mercer SW, Watt GCM. BJGP in press

**Examining the role of Scotland's telephone advice service (NHS 24) for managing health in the community: analysis of routinely collected NHS 24 data**

Alison M Elliott, Anne McAteer, David Heaney, Lewis D Ritchie, Philip C Hannaford

BMJ Open 2015;5:e007293 doi:10.1136/bmjopen-2014-007293

**Increase in emergency admissions to hospital for children aged under 15 in England, 1999–2010: national database analysis**

Peter J Gill, Michael J Goldacre, David Mant, Carl Heneghan, Anne Thomson<sup>3</sup>, Valerie Seagroatt, Anthony Harnden

*Arch Dis Child* doi:10.1136/archdischild-2012-302383

**Are pharmacy-based minor ailment schemes a substitute for other service providers?**

Vibhu Paudyal, Margaret C Watson, Tracey Sach, Terry Porteous, Christine M Bond, David J Wright, Jennifer Cleland, Garry Barton, Richard Holland

DOI: 10.3399/bjgp13X669194 Published 1 July 2013

**A cohort study of influences, health outcomes and costs of patients' health-seeking behaviour for minor ailments from primary and emergency care settings**

M C Watson et al.

BMJ Open 2015;5:e006261 doi:10.1136/bmjopen-2014-006261

**Physician associates: the challenge facing general practice**

James Parle, James Ennis

DOI: 10.3399/bjgp15X684685 Published 1 May 2015

**Physician associates and GPs in primary care: a comparison**

Vari M Drennan, Mary Halter, Louise Joly, Heather Gage, Robert L Grant, Jonathan Gabe, Sally Brearley, Wilfred Carneiro, Simon de Lusignan

DOI: 10.3399/bjgp15X684877 Published 1 May 2015

**Estimating the burden of minor ailment consultations in general practices and emergency departments through retrospective review of routine data in North East Scotland**

Fielding et al

Family Practice (2015) 32 (2): 165-172. doi: 10.1093/fampra/cmz003

**A systematic review of evidence about extended roles for allied health professionals**

Kathryn McPherson, Paula Kersten, Steve George, Val Lattimer, Alice Breton, Bridget Ellis Dawn Kaur Geoff Frampton

doi: 10.1258/135581906778476544 J Health Serv Res Policy October 1, 2006 vol. 11 no. 4 240-247

**Characteristics of service users and provider organisations associated with experience of out of hours general practitioner care in England: population based cross sectional postal questionnaire survey**

BMJ 2015; 350 doi: <http://dx.doi.org/10.1136/bmj.h2040> (Published 29 April 2015) Cite this as: BMJ 2015;350:h2040

**Support and assessment for fall emergency referrals (SAFER 2) research protocol: cluster randomised trial of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to appropriate community-based care**

Snooks, et al. BMJ Open 2012;2:e002169 doi:10.1136/bmjopen-2012-002169

**The increasing burden and complexity of multimorbidity**

Anna J Koné Pefoyo<sup>123\*</sup>, Susan E Bronskill<sup>24</sup>, Andrea Gruneir<sup>2456</sup>, Andrew Calzavara<sup>4</sup>, Kednapa Thavorn<sup>478</sup>, Yelena Petrosyan<sup>2</sup>, Colleen J Maxwell<sup>49</sup>, YuQing Bai<sup>24</sup> and Walter P Wodchis<sup>1024</sup> .

**BMC Public Health** 2015, **15**:415 doi:10.1186/s12889-015-1733-2

**Factors influencing junior doctors' choices of future specialty: trends over time and demographics based on results from UK national surveys**

Fay Smith, Trevor W Lambert and Michael J Goldacre

Journal of the Royal Society of Medicine; 0(0) 1–10 DOI: 10.1177/0141076815599674

# Glossary

IJB	Integrated Joint Board
HSCP	Health and Social Care Partnerships
COSLA	Confederation of Scottish Local Authorities
SCVO	Scottish Council for Voluntary Organisations
RCN	Royal College of Nursing
SCGP	Scottish Council of General Practitioners
RCGP	Royal College General Practitioners
BMA	British Medical Association
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
eHealth	Electronic enabled health care and advice
BASICS	British Association of Immediate Care Scotland
GP	General Practitioner
MIU	Minor Ailments Unit
Adastra	Patient Records System
PGD	Patient Group Directives
eKIS	Electronic Key Information Summary
ECS	Electronic Care Summary
ACP	Anticipatory Care Plan
SEND	Scottish Executive Nurse Directors
GMS	General Medical Services
NHS	National Health Service
NSS	NHS Services Scotland

NES	NHS Education Scotland
ALISS	A Local Information System for Scotland
A&E	Accident and Emergency
ED	Emergency Department
OHCA	Out of Hospital Cardiac Arrest
COPD	Chronic Obstructive Pulmonary Disease

# Annex A      Review Membership

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## Review Group

Prof Lewis Ritchie <b>(Chair)</b>	Academic GP, University of Aberdeen,
Jeff Ace	Chief Executive NHS Dumfries & Galloway
Prof Mahmood Adil	Medical Director, Public Health & Intelligence, NHS National Services Scotland
Prof David Bruce	Director Postgraduate General Practice <b>Education</b> , NHS Education Scotland
Dr Andrew Buist	Deputy Chair, SGPC of the British Medical Association (Scottish General Practitioners Committee)
Rachel Cackett	Policy Advisor, Royal College of Nursing
Gail Caldwell	Pharmacy Director, NHS Forth Valley
Prof George Crooks	Medical Director, NHS 24
Frank Dunn	President, Academy of Medical Royal Colleges and Faculties in Scotland
Dr Norrie Gaw	Chair, Out-of-Hours National Operations Group/GP NHS Greater Glasgow & Clyde
Gordon Guthrie	NHS 24 Patient Participation Forum
Alan Hunter	Director of NHS Performance, Scottish Government
Brenda Hutchison	Head of Adult and Older People Services, South Lanarkshire Council
Melanie Johnson	Director of Nursing, NHS Lothian



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Katy Lewis	Director of Finance, NHS Dumfries and Galloway
Dr Miles Mack	Chair, Royal College of General Practitioners (Scotland)
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Gill McVicar	Director of Operations, NHS Highland
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Prof David Bruce	Director of Postgraduate GP Education, NHS Education Scotland
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Dr Sian Tucker	Joint Chair National Out of Hours Operations Group
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Professor Martin Marshall	Lead, Improvement Science, Professor of Healthcare Improvement, University College London, <b>London</b>
Dr Alan Jones	GP in NHS D&G for 25 years; ex associate medical director and GP trainer. Now locum GP New Zealand and Scotland.
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Dr Euan Paterson	GP deep end practice GG&C / GP, Macmillan palliative care, <b>Scotland</b>
Dr David Johnstone	Former Chair of RCGP Northern Ireland and a GP in Maine Medical Practice, Co Antrim; Clinical Director of Dalriada Urgent Care, <b>Northern Ireland</b>
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Clare Cable	Chief Executive and Nurse Director, Queen's Nursing Institute <b>Scotland</b>
Professor Brendan McCormack	Head of the Division of Nursing, QMU (senior nursing/nurse education/practice development), <b>Scotland</b>
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Shirley Fife	Nurse Consultant Cancer & Palliative Care Representing Scottish Partnership for Palliative Care, <b>Scotland</b>
Dr Michael Norbury	Inner city GP, <b>Vancouver, BC Canada</b>
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Billy Watson	Chief Executive, Scottish Association for Mental Health, <b>Scotland</b>
Lorna Hall	Interim Director of Sustainable Primary Care, Jersey, <b>Channel Islands</b> (Former Dietician) Director McPhersonHall Consultancy
Ralph Roberts	Chief Executive, NHS <b>Shetland</b>
Stuart Smith	NHS Non-executive (formerly NHS Lothian and NHS 24 non-executive director), <b>Scotland</b>
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#### **Short Life Working Group on GP Out of Hours Contractual Good Practice**

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Scott Anderson	British Medical Association
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Lorimer McKenzie	Health Workforce Division, Scottish Government
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# Annex B Key Facts about Services

## Background

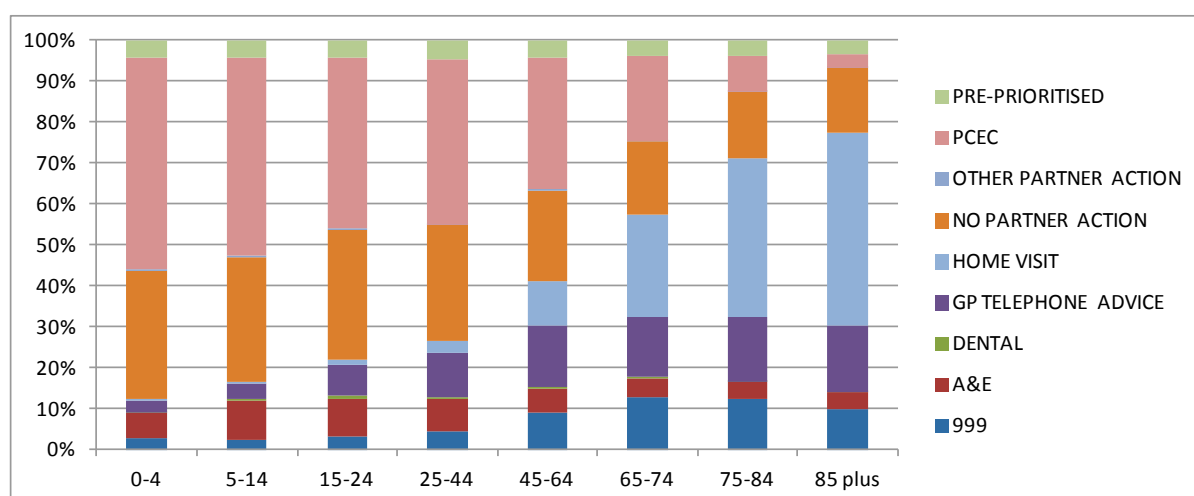
Much of the statistical information requirements for this Review was prepared by Information Services Division (ISD), National Services Scotland. Scottish Government recently commissioned ISD to develop and introduce a dataset to collect information on GP OOH services across Scotland. National data collection began in April 2014. ISD published its [first report](#) for the period 1 April 2014-31 March 2015, in August 2015:

## Use and Provision of Services

**Note:** Data are from 1 May 2014 to 30 April 2015, except where stated - this period was chosen to give the most recent and robust data.

## NHS 24

- There were just under 1.3 million calls to NHS 24 - 25% of callers are given self care advice; 40% are directed to a Primary Care Emergency Centre (PCEC); 12% are visited at home, 10% receive GP telephone advice; 7% are advised to attend Accident and Emergency (A&E) services, 6% are transferred to 999.
- The following diagram presents information on the outcomes of NHS 24 calls (for example home visit, PCEC, no partner action) in the OOH period by age group:

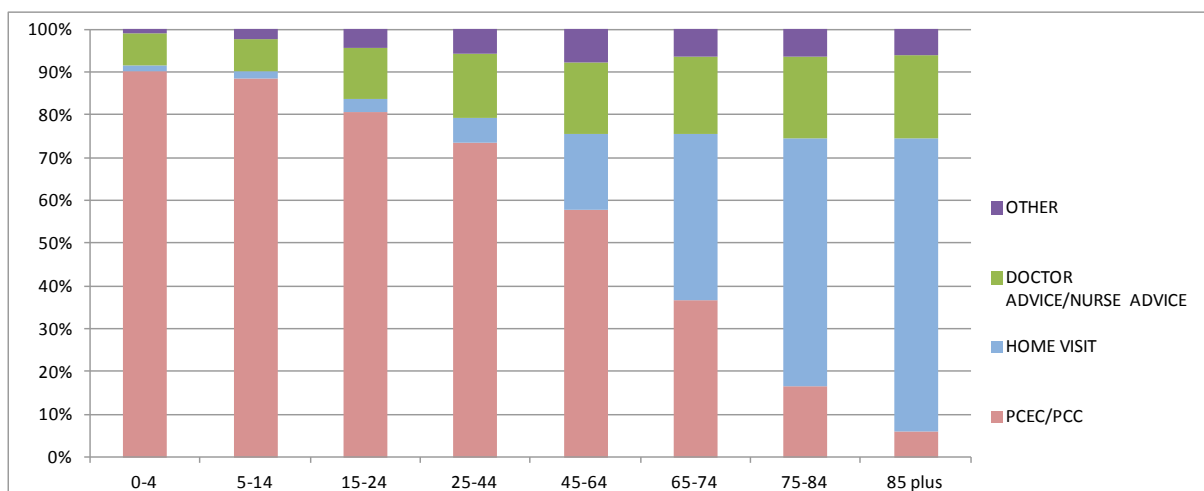


- The demand for NHS 24 services has been steadily increasing with a significant (20%) increase after the introduction of the NHS 111 number.
- 49% of callers to NHS 24 were from the top two most deprived - Scottish Index of Multiple Deprivation (SIMD) - areas.
- NHS 24 operates a number of contact centres, one of which is stand-alone at Clydebank. Contact Centres at Cardonald, South Queensferry and Inverness are co-located with the Scottish Ambulance Service.
- In addition to responding to urgent advice calls NHS 24 also offers a range of health information services providing information on a range of illnesses and conditions and treatments. NHS 24 holds details of pharmacy opening times and GP and dental practices and coordinates the confidential phone-line service Breathing Space for people experiencing low mood or depression. Further details are available on the NHS 24 website, including a self-help guide: <http://www.nhs24.com/explained/services/>

## Primary Care OOH Services (OOH services)

- At present there are 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. This compares to 980 GP Practices in Scotland where daytime services are provided.
- Almost 1 million contacts (997,112) were made with OOH services between 1 May 2014 to 30 April 2015, an average of ~75,000 per month peaking in January 2015 (88,414). This compares with 900,000 ED/A&E attendances in the OOH period amounting to 56% of their total workload.
- Three out of four contacts with OOH services come via NHS 24. 56% of patients are seen at a Primary Care Emergency Centre, 19% have a GP or nurse practitioner home visit; 21% will receive GP or nurse practitioner telephone advice. The remaining 4% are provided by other clinicians including community psychiatric nurses. At present it is estimated that around 20% of all consultations are carried out by nurse practitioners with a wide variation between Health Boards (1%-33%).
- Gender - Female contacts with OOH services account for 59% of all contacts, mirroring contacts with NHS 24.
- Patients aged over 75 years accounted for nearly 20% of the patients treated – this represents 8% of the Scottish Population. Those 75 and over are more likely to receive a home visit. Those aged 4 years and under are most likely to be seen at a PCEC. 48% of people attending PC OOH top two most deprived - Scottish Index of Multiple Deprivation (SIMD) - areas

The following diagram presents the type of consultation (attendance at PCEC, home visits, GP OOH advice call and other) and is based on the last consultation recorded for the patient.



- Home visits are slightly higher in more rural NHS Boards. However there is some variation between NHS Boards in the type of consultations recorded.
- At present there are 64 Primary Care Emergency Centres in Scotland. Most Health Boards have at least one of these centres co-located with emergency departments at acute hospitals or with minor injury units/community hospitals. This compares to 980 general practices in Scotland where daytime services are provided.

## The Scottish Ambulance Service (SAS)

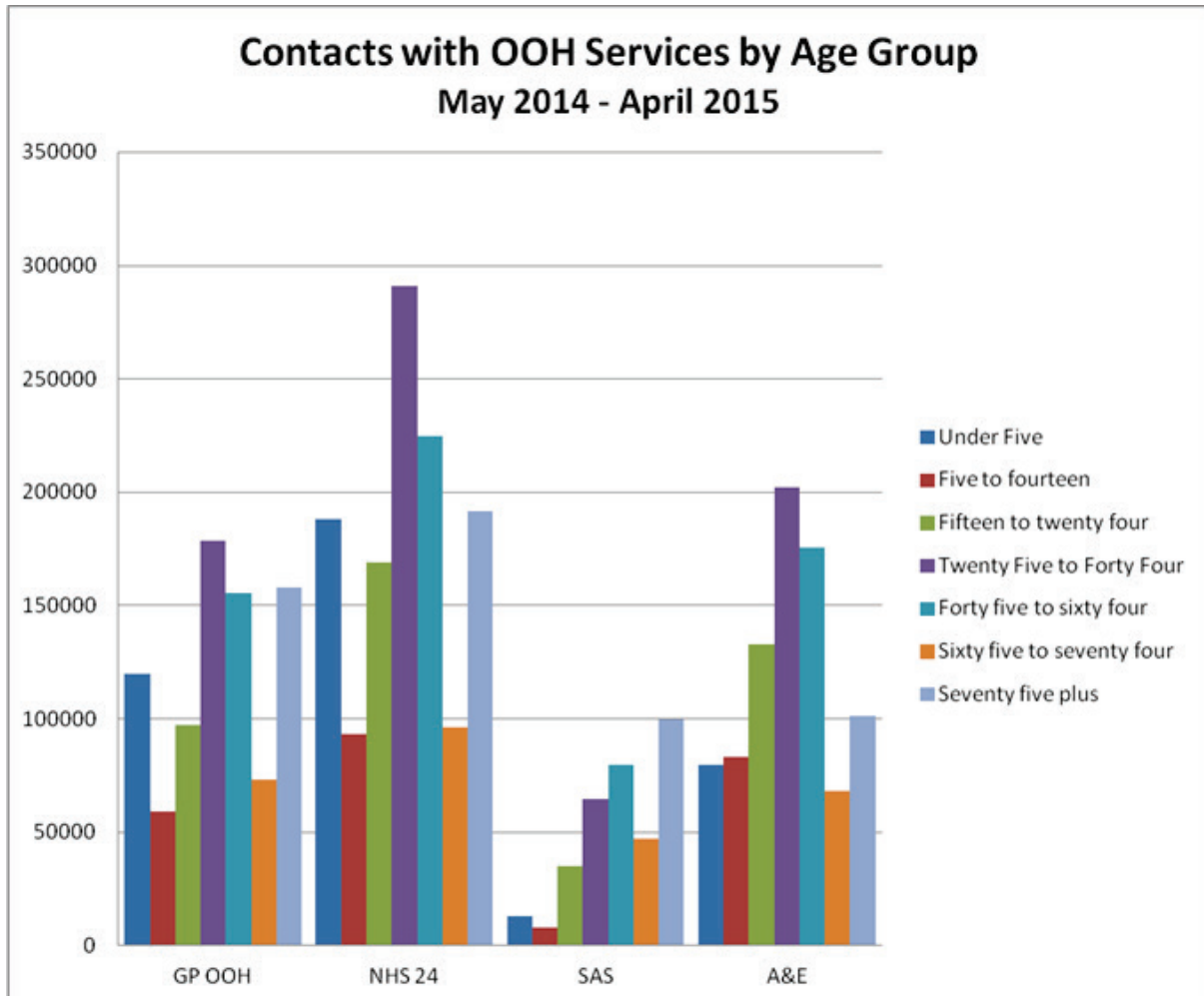
- SAS dealt with 740,631, 999 and GP urgent calls during the financial year 2014/15. Of these around half a million occurred in the OOH period, of which SAS attended 378,879 incidents.
- Of those that they do not attend, the patients may be passed on to NHS 24 and others do not require any input following further triage by SAS. As with other OOH services, demand has been increasing by 11% between 2010 and 2014.
- Just over half of the calls to SAS are initiated by the patient (family member/bystander/care home) and one in five come via NHS 24.
- The majority of people are conveyed to A&E or to a hospital (presently around 75%).
- Increasingly SAS are delivering *See and Treat* services i.e. they will treat an individual at the scene of the incident, rather than take them to hospital. This presently accounts for around 17.5% of calls in the daytime and OOH period. SAS will also transfer about 4% of their calls to NHS 24 or a clinical advisor.
- The over 75 age group account for 26% of patients treated/conveyed by SAS.
- 44% of SAS incidents were in the top two most deprived SIMD areas
- SAS presently operates from three national control centres at Cardonald in Glasgow, South Queensferry and Inverness.

## Accident and Emergency (A&E) Services

- There are around 1.6 million attendances at A&E services (emergency departments and minor injury units) across Scotland annually, ~883000 (54%) occurring in the OOH period. This compares directly with ~997,000 contacts with OOH services.
- The majority (57%) - self refer i.e. they have had no contact with a health care professional prior to their attendance. SAS are recorded as bringing about 26% of people to A&E services, NHS 24 will refer around 5% and around 2% are referred by OOH services.
- The 75 and over age group are more likely to be brought to A&E by an ambulance whereas the younger age groups are more likely to self refer.
- 2 in 3 people (67%) are discharged home from A&E and 27% are admitted to hospital. A small percentage (2%), are re-directed to PC OOH services.
- 52% of people attending A&E were from the two most deprived SIMD quintiles (a similar figure for NHS 24, OOH services and SAS activity).
- People from the most deprived SIMD quintile (29%) made twice as many A&E attendances of those in the least deprived SIMD quintile (14%).
- Proximity to A&E services is a large factor in attending – those who live closer to emergency departments and minor injury units are more likely to attend there to seek help.
- There are 30 emergency departments presently in operation throughout Scotland, as well as 63 minor injury units, community hospitals and health centres which carry out A&E related activity, typically GP or nurse led.

## Contacts with all OOH NHS Services by Age Group

The diagram below provides an age-profile of contacts for primary care OOH, NHS 24, SAS and A&E services, noting in particular the demands of the youngest (<5 years) and oldest age (75+ years) cohorts on primary care OOH services and NHS 24 and the highest use of SAS by people aged 75+ years.





## Population Projections for Scotland

- The population of Scotland is projected to rise from 5.31 million in 2012 to 5.52 million in 2022, and to continue to rise to 5.78 million in 2037 – an increase of 9 per cent over the 25 year period.
- Over the next decade, 28 per cent of the projected increase in Scotland's population can be attributed to natural increase (more births than deaths) while 72 per cent of the increase is due to assuming continuing inward net migration to Scotland.
- Between 2012 and 2022 the number of children aged under 16 is projected to increase by 4 per cent from 0.91 to 0.95 million. It is then projected to increase to 0.96 million by 2037 (a 5 per cent increase compared with the 2012 estimate).
- The number of people aged 75 and over is projected to increase by around 28 per cent in the first ten years of the projection period, from 0.42 million in 2012 to 0.53 million in 2022. It is then projected to continue rising, reaching 0.78 million in 2037 – an increase of 86 per cent over the 25 year period.
- The number of people of working age\* is projected to increase from 3.35 million in 2012 to 3.51 million in 2022 (an increase of 5 per cent). The projected working age population then decreases to 3.48 million by 2037 (an overall increase of 4 per cent from the 2012 estimate).
- The number of people of pensionable age\* is projected to decrease from 1.05 million in 2012 to 1.02 million in 2020 (a decrease of 3 per cent).

\*To see foot note in next page qualifying working and pensionable ages.

Source: National Records Scotland

<http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/population-projections-scotland/2012-based/list-of-tables>

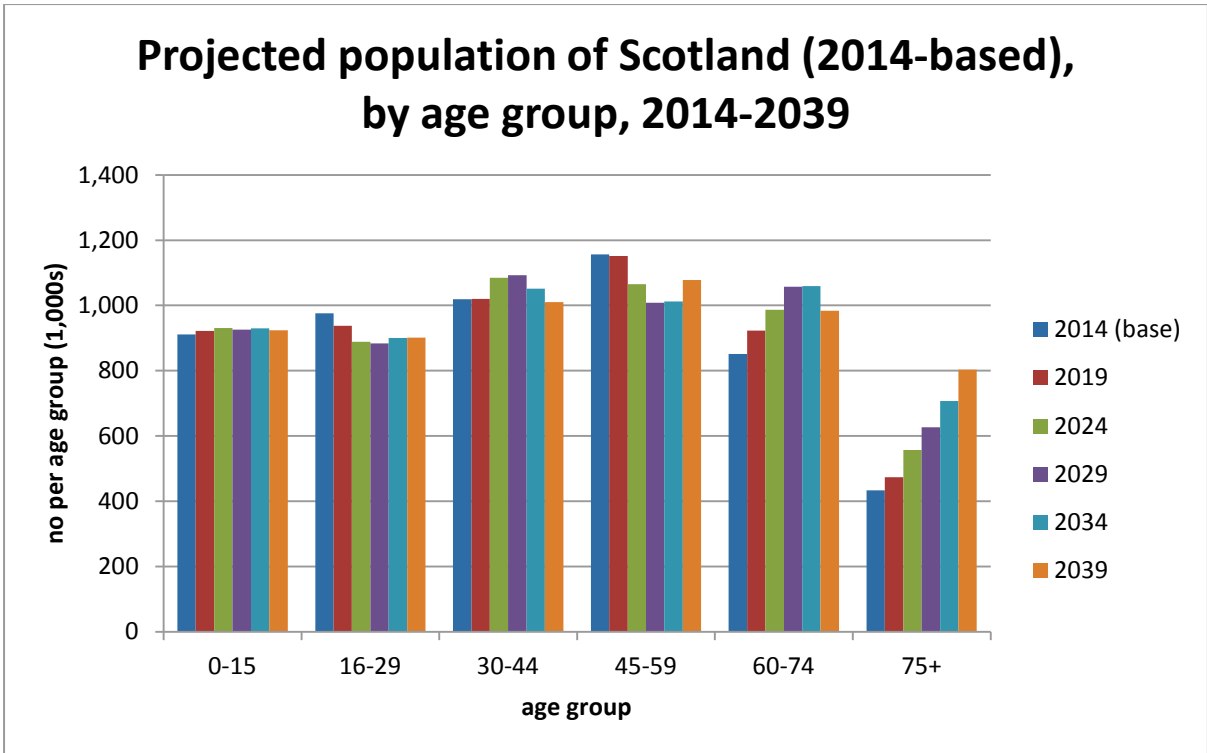
## Projected population of Scotland (2014-based), by age group, 2014-2039

	(1,000s)					
	2014 (base)	2019	2024	2029	2034	2039
<b>All ages</b>						
0-15	911	922	931	926	929	924
16-29	976	938	889	884	900	902
30-44	1,019	1,020	1,085	1,093	1,051	1,010
45-59	1,157	1,151	1,065	1,009	1,012	1,078
60-74	851	923	987	1,058	1,059	984
75+	433	474	557	626	707	803
Median age(years)	41.9	42.4	42.9	43.5	44.3	45.2
Children	911	922	931	926	929	924
	3,377	3,478	3,492	3,525	3,457	3,419
Working ages <sup>1</sup>						
	1,059	1,028	1,092	1,145	1,273	1,359
Pensioners <sup>1</sup>						

### Footnote

1. The figures for working age and pensionable age and over, take into account the changes in the State Pension Age (SPA) as set out in the 2014 Pensions Act. Between 2014 and 2018, the state pension age will rise from 62 to 65 for women. Then between 2019 and 2020, it will rise from 65 years to 66 years for both men and women. A further rise in state pension age to 67 will take place between 2026 and 2028. Between 2044 and 2046, SPA will increase from 67 to 68. The UK Government plan to review state pension age every five years in line with life expectancy and other factors. (Not all figures will sum due to rounding)

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## Potential Impact of Population Change on Future Service Demands for the OOH Period

The figures here have been sourced from ISD and are unpublished. Please note these are estimates only based on current service use and must be carefully recalibrated with the passage of time. Service demand patterns may change by factors other than population change and indeed emphasises the importance of resilient new models of community based urgent care for this particular age-group, not only by number but by complexity – with many having multiple chronic conditions.

- Currently the over 75 years age group and the under 1 year age group are high volume users of OOH services.
- The projections show that the majority of age groups who use services in the OOH time period, will increase slightly or remain fairly stable over the next 20 years. This includes the under 1 year age group.

## Service projections for the over 75 age group

The over 75 age group using services in the OOH period is projected to increase by ~32% by the year 2024 and ~66% by the year 2034 as follows:-

- PC OOH services – the over 75 age group had ~170,000 contacts in 2014. This is projected to increase to ~224,000 in 2024 and ~283,000 in 2034
- A&E – the over 75 age group had ~99,000 attendances in 2014. This is projected to increase to ~131,000 in 2024 and to ~165,000 in 2034.
- NHS 24 – the over 75 age group called NHS 24 ~188,000 times in 2014. This is projected to increase to ~247,000 in 2024 and ~312,000 in 2034.
- SAS - the over 75 age group had ~101,000 incidents responded to by SAS in 2014. This is projected to increase to ~133,000 in 2024 and ~169,000 in 2034.
- Emergency admissions to acute hospitals (all time periods - not just OOH as time of day of admission is not collected) – the over 75 age group had ~149,000 emergency admissions in 2014. This is projected to increase to ~197,000 in 2024 and ~248,000 in 2034.

## Community Pharmacy

- There are currently some 1,250 community pharmacies located across Scotland offering a range of services and healthcare advice to patients and the general public.
- Service developments, implemented within community pharmacy, have led to pharmacies becoming an important access route for people reinforcing pharmacies role as a first point of care. This is particularly important in the OOH period.

## Minor Ailments Service

The Minor Ailment Service (MAS) allows eligible individuals to register with and use a community pharmacy as the first port of call for the treatment of common illnesses on the NHS.

- A patient registers with the community pharmacy of their choice in order to use MAS. Once registered, they can present at any point with symptoms and the pharmacist, having ascertained whether the patient is still eligible to use the service, will treat, advise or refer them to another health care practitioner where appropriate.

- At 31 March 2015, nearly 18% of the population of Scotland were registered for the Minor Ailments Service, a total of 913,483 people.
- Over 2.1 million items were dispensed under the Minor Ailments Service, accounting for 2.2% of all items dispensed by community pharmacies in Scotland. This service is only available to a subset of the population.

### The National Patient Group Direction (PGD) of the Urgent Supply of Repeat Medicines and Appliances

- PGD are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for prescribing treatment.
- By using the national PGD for the urgent supply of repeat medicines and appliances pharmacists can provide a supply of the patient's medicine for up to the equivalent of the quantity of medicine normally prescribed for the patient.
- Over the period 1 April 2014-31 March 2015, community pharmacies supplied 266,614 items using the national PGD (compared to 997,112 OOH service contacts in the same period). It is likely that the absence of this service would lead to a significant increase in OOH services contacts.

### Direct Referral of Patients to OOH Service Services

- Pharmacists who wish to refer patients to OOH services or other local health service, complete a Direct Referral Form Template.

### Health Protection Scotland

Health Protection Scotland (HPS) is the national centre for communicable disease and environmental hazard epidemiology, control and prevention. It has a critical interface with Scotland's OOH primary care services.

- HPS is the centre of key knowledge relevant to the control and prevention of communicable disease and environmental hazards. It has the role to communicate information and disseminate alerts to a variety of agencies including OOH services.
- HPS gathers this knowledge from a number of areas, local NHS Board intelligence and interrogation of various datasets.

- HPS is responsible for the training of the local NHS Board health protection workforce. OOH services are provided information and intelligence by HPS and can respond to queries from OOH primary care personnel.
- HPS runs a 24/7 operational support and advisory service which is designed to support Health Protection teams in NHS boards. However, in certain instances, particularly those relating to serious incident responses such as Pandemic Flu, HPS coordinates national multi-agency, multi-disciplinary responses which have a direct interface with OOH services.
- Information and intelligence are frequently transmitted between HPS and NHS 24 to ensure optimal awareness of urgent public health issues such as patterns of communicable disease including influenza/influenza-like illness.

## Social Services

### Background

- Across Local Authorities OOH (emergency provision) is variable in terms of the model of service provision. Some Local Authorities provide this service on an individual basis, others do so on a shared basis with service level agreements in place. The operating model and the service provision (this includes the operating hours), will differ. The interface with primary care OOH services will also differ across localities.
- Within local authority OOH provision there will be qualified Social Workers within the team. The primary function of the OOH services is to deal with urgent and emergency situations that arise OOH i.e in evenings, over weekends and on public holidays when not all social work provision is available. Within the teams there is a focus on statutory provision in terms of safeguarding and protection both in terms of Children and Families and Vulnerable adults which may require interventions within the legislative framework of Child Protection, Adult Support and Protection, Adults with Incapacity and Mental Health legislation. The teams also provide support in terms of accessing social care/nursing care OOH where this is required, for example, where a frail older person has an event that requires an emergency response. Professional staff within the local authority OOH teams require to work with OOH primary care teams to discharge the functions described above. The links with primary care OOH services work well in many instances but there can also be challenges. One particular challenge is the variability that local authority OOH teams experience when seeking to access mental health provision from health colleagues.

## Care Setting

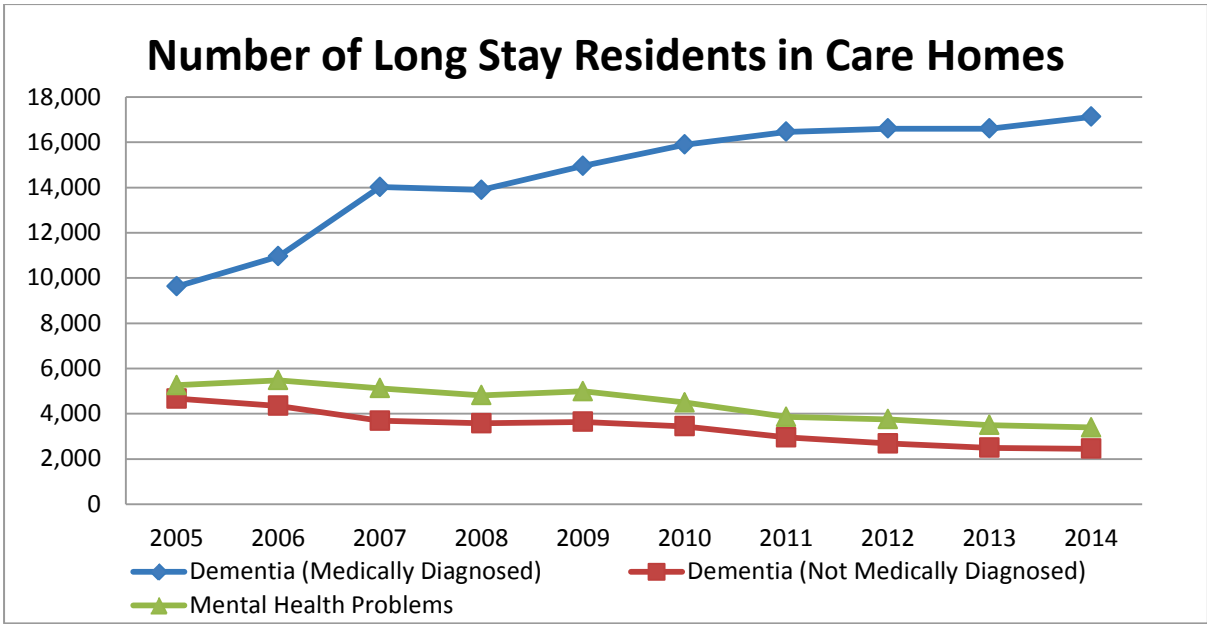
- The majority of older people live in their own home (or with family). Of people aged 65 and over 3.3% were living long term in a care home in 2014. Amongst people aged 85 and over most live at home, with about one person in six living in a care home.
- By 2014 around 16,500 people aged 65+ were living in residential care. A further 15,000 received a package of home care of between 5 and 10 hours per week, and 18,500 a package of under 5 hours.
- In 2014, 111,940 people in Scotland were in receipt of telecare (community monitoring) provided by their local authority. The national statistics reporting the provision of these services show a steep age gradient in provision: 3.5% of people aged 65-74 and 13% of people aged 75-84, escalating to one person in three aged 85.

## Residential Care

The Care Home Census publishes information on numbers of care homes, residents and registered places at Scotland level. Residential care may be required for adults who are unable to remain safely in their own home due, for example, to frailty in old age or disability. Local Authorities may provide funding for residential care depending on assessment of need and financial situation. Care homes may provide long stay, short stay and/or respite care. They may be run by Local Authorities/NHS, private companies (independent sector) or the third sector; they are all registered with and regulated by the Care Inspectorate.

Please note these figures are as at 31 March 2015:

- 36,193 adults were in residential care homes.
- 42,026 places were available in 1,216 care homes for adults in Scotland.
- 73% (892) of care homes provided care to older people.
- 58% (701) of care homes providing 31,566 places to 27,064 residents were run by the private sector.
- 28% (337) of care homes providing 5,780 places to 5,212 residents were run by the third sector.
- 15% (178) of care homes providing 4,680 places to 3917 residents were run by Local Authorities or NHS Boards.
- 89% of long stay residents in care homes are aged 65 and over.



Selected demographic information is collected for long stay residents only. The above figures show the trend in the number of long stay residents in care homes for selected mental health conditions. The number of long stay residents with a medical diagnosis of dementia has almost doubled over the last ten years.

### Trends in Residential and Hospital Care

- Compared to 2008/09, by 2013/14, each day on average around 1,300 ‘fewer than projected’ people aged 65 and over were in hospital following an emergency admission.
- When the differences against the 2008/09 position in both the emergency hospital bed use and the use of care homes are taken together, it is possible to conclude that on average about 5,300 fewer older people *per day* were in a hospital or care home by 2014. In other words, older people spent almost 2 million more days and nights at home in 2013/14, than would have been expected had the 2008/09 rates for institutional care continued.
- These differences indicate the important role of prediction of trends for future service demands but also the importance of continuous monitoring to ensure the robustness of future forecasting.



## Third sector

### The role of the third sector in health and social care

The Third sector is a major provider of health and social care services, which is contributed over 24 hours – both the daytime and OOH period. The wider activity of the third sector keeps people connected, promotes health and wellbeing and is organised in distinctive ways:

- Many third sector organisations are community-based, which provides them with a detailed “bottom-up” understanding of the issues affecting people’s lives and an ability to reach and relate well to people in need.
- Third sector governance is voluntary. While board members of third sector organisations will have to declare an interest or a conflict of interests, their stake in them is cause-related, rather than financial.
- Any surpluses generated by third sector organisations are reinvested in their good cause, rather than distributed for private gain.
- Generally, third sector organisations are flexible and can respond quickly to emerging or changing needs.

### Examples of third sector activity:

- Prevention, supporting self-care and self-management
- Supporting people with learning difficulties, long-term conditions
- Counselling, mental health and recovery support
- Addiction services - alcohol and drugs
- Children’s and older people’s services
- Palliative care
- Provision of health and social care services
- Supporting people who are lonely, befriending
- Cognitive and physical impairment
- Provision of aids and adaptations, care and repair schemes
- Supporting carers
- Shopping services
- Community food and health initiatives, patient transport, volunteer driver schemes
- Accommodation, housing and tenancy support
- Advocacy, advice and information
- Human rights, social enterprise, volunteering

## The third sector workforce

55% cent of the sector is employed in social care or health, with a further 17% employed in housing, which has vital link with health. The Third sector workforce is growing, which demonstrates the interest in community-led, third-sector enabled response to the complex issues, which affect many lives of people living in Scotland.

## The size and shape of the sector

The third sector in Scotland is made up of around 45,000 organisations, large and small – charities, community groups, social enterprises and voluntary organisations. They have a collective annual income of £4.9 billion and deliver a range of good causes with support of 1.3 million volunteers, 180,000 trustees and 138,000 paid staff. There are more third sector organisations in rural than in semi-urban communities in the central belt. This difference is likely due to the thinner spread of public services, the limited size of market for the private sector and the need for people to do more for themselves and each other. The Shetland Islands, the Western Isles and the Orkney Islands have the highest number of charities per 10,000 of population, while North Lanarkshire, South Lanarkshire and Falkirk have the lowest number.

**See also:** The Scottish Council for Voluntary Organisations (SCVO)  
<http://www.scvo.org.uk/>

A Local Information System for Scotland (ALISS)  
<https://www.aliss.org/>

# Annex C Key NHS Financial Data

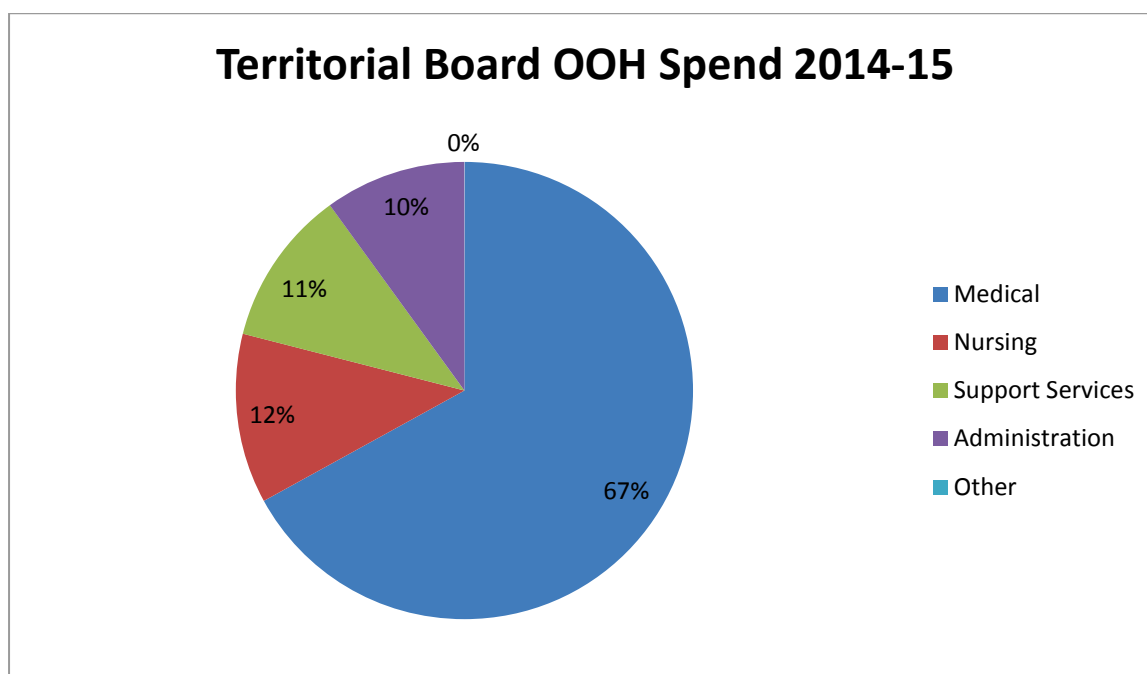
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## Aggregated Costs

The annual cost reported by Scotland's territorial Boards in 2014/2015 was £81.8 million, which saw a significant rise of 6% from the previous financial year. NHS 24 incurred costs of £40.4 million, giving a total of £122.2 million invested in supporting OOH care across Scotland. By comparison, expenditure on daytime general practice services - only one component of primary care funding - amounted to £767 million. Direct pay costs of £70.5 million from Regional Boards and £28.5 million from NHS 24 account for 81% of the total service costs. Direct non-pay costs were 13% with allocated (overhead) costs from territorial Boards making up the remaining 6%.

## Territorial Board Costs Breakdown

Medical costs of £46.8 million are two thirds of the pay costs incurred by territorial Boards, as shown in the chart below. Medical costs can be further broken down into salaried GPs of £12.5 million (27%), sessional GPs of £30.6 million (65%) and GP locum/agency costs of £3.8 million (8%).



The 6% annual rise in costs incurred by Boards has been spread over all the main pay areas, with exception of support services, which saw a 1% inflationary rise. Between 2012/13 and 2013/14 there was also a 3.9% cost increase across Scotland. When analysing medical pay in more detail, GP locum/agency costs (£3.8 million)

have increased by 15% from the previous financial year, following on from a substantial 180% increase between 2012/13 and 2013/14.

## NHS 24 Costs Breakdown

The NHS 24 Service is predominately based on Trained Nurse staffing costs of £15.2 million, call handler, physiotherapy and pharmacy staffing costs of £12.0 million and non-pay technology and infrastructure costs amounting to £11.9 million.

# **Annex D Evidence Submitted by Professional Groups and Organisations**

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## Royal College of General Practitioners Scotland and the Scottish General Practitioners Committee of the BMA: Joint Submission

The Royal College of General Practitioners (RCGP) Scotland and the Scottish General Practitioners Committee (SGPC) of the British Medical Association (BMA) welcomed the Review and were very encouraged by the progress that had been made.

Separate additional submissions from RCGP Scotland and SGPC are available on the [Review website](#). In considering what recommendations should be made, they jointly believed that the following principles should be considered:-

- There must be clarity on the scope and purpose of primary care OOH services
- Primary care OOH services should be seen as a valued core NHS service and must be resourced adequately
- OOH services should have a clear identity as the urgent '*green light*' service as opposed to an emergency '*blue light*' service
- Triage of patient demand should be optimised to ensure best use of available resources, with patients referred to self-care and non-urgent services when safe to do so
- OOH care should be delivered by a multidisciplinary team (MDT) of which the general practitioner is a key member
- All MDT members should be working up to the top of their skill set (licence to practise)
- As the senior clinical decision maker in primary care, fully trained GPs are vital and should, when clinically appropriate, be available to all patients with urgent OOH clinical needs
- Staff working in the OOH period should feel safe and supported, with adequate facilities
- Services involved in patient OOH care should have integrated IT systems that allow appropriate sharing of patient information in a secure environment
- The training of junior doctors to be general practitioners should include sufficient and well supported exposure to OOH to develop competence and should take place within a learning environment
- GPs in their first five years following completion of specialty training, should be enabled and encouraged to develop confidence working in the OOH period
- Doctors working in OOH services should have the opportunity to partake in local GP cluster quality activity and be able to influence service development through their IJB.

“It is a core professional value of general practice that GP driven care in the community is available at any time. RCGP Scotland and SGPC see it as essential that GPs remain a central part of the OOH service to ensure holistic, co-ordinated patient care”.

## Chief Nursing Submission endorsed by Scottish Executive Nurse Directors (SEND) and the Royal College of Nursing (RCN)

The submission from the Chief Nursing Officer Scotland (CNO), endorsed by SEND and RCN, made recommendations for addressing the future of care across the spectrum of health and social services, both daytime and OOH services, offering a number of examples of good practice.<sup>1,2</sup>

1. <http://www.rcn.org.uk/aboutus/scotland/professionalissues/nursinginnovations>
2. <http://www.rcn.org.uk/aboutus/scotland/professionalissues/remotelandruralscotland>

The full submission from the CNO is available on the [Review website](#).

The CNO indicated that:

“Nursing is already making a significant contribution in this context across primary, intermediate and acute care.... To maximise this potential we need to learn from and scale up on initiatives where we are seeing tangible benefit for our patients through enhanced nursing roles”.

Her three key recommendations are as follows:

1. **Advanced Nurse Practitioners:** The potential of advanced nurse practitioners (ANPs) must be urgently realised

The CNO noted that: “The evolution of ANP roles has been local and organic resulting in inconsistencies of role and education as well as significant gaps in the availability of services ...the public, our professional colleagues and nurses themselves must have greater confidence in and better understanding of the ANP role in Scotland”.

A further 13 recommendations were proposed for short term implementation and three for the medium term.

2. **Community Nursing:** Reducing OOH demand and improving outcomes through community nursing

The CNO noted that: “Splitting in (daytime) and OOH service development hinders a focus on joined-up services that improve patient outcomes”.

While community nursing service already offer an invaluable core health service across communities in Scotland, that service is not universally available on a 24/7 basis and the nursing workforce is ageing fast. The CNO’s shared vision is for urgent action to ensure the sustainability of a vibrant, 24/7 community nursing service able to coordinate round-the-clock community nursing. In order to secure that aim, the



CNO has commissioned a review of district nursing which is already underway and due to report in April 2016.

A further five recommendations were made for short term implementation and eight for the medium term.

**3. Nursing Staff Support:** The right support must be provided for nurses to be competent, confident, informed and well resourced

The CNO noted that: “In the OOH period, where the primary focus will be on delivering complex, urgent care with significant amounts of lone-working there is a particular need to ensure nurses are well-supported to deliver safe, high quality care”.

A further three recommendations are made for short term implementation and four for the medium term.

The CNO has established a Transforming Nursing Group which will act as the main governance body to ensure that these recommendations are implemented effectively and quickly.

## Community Pharmacy Scotland, NHS Scotland Directors of Pharmacy and Royal Pharmaceutical Society of Scotland - Joint Submission

This is the first time that all the major professional Pharmacy organisations in Scotland have produced a joint Pharmacy statement, which proposed:

“The pharmacy profession welcomes the opportunity to contribute to the National OOH Review and to offer solutions to address the challenges of providing care both OOH and in hours. There is much to build on as pharmacy already contributes to primary care through the community pharmacy service, particularly the Minor Ailment and the Chronic Medication Services. In addition pharmacists providing services to GP practices are delivering direct patient care in this setting. Pharmacists are also working strategically in and across primary and secondary care to ensure effective pharmaceutical services...

...We consider that a collective response from Community Pharmacy Scotland (contractor body), the Royal Pharmaceutical Society Scotland (professional body) and Directors of Pharmacy (senior pharmacy leaders for NHS Boards) provides reassurance to the National Primary Care OOH Review that the profession is very much committed to playing a full and active part in improving health outcomes for the people of Scotland...”

The full submission from the Scottish pharmacy community is available on the [Review website](#).

### Key Pharmacy Recommendations

- **Electronic Record Access:** The principal enabler is to ensure available information is utilised effectively. This requires as a minimum, that community pharmacies are given universal access to the Emergency Care Summary (ECS) and the Key Information Summary (KIS), as appropriate. This will enable them to play their full part in patient care during the OOH period.
- **Extending the Minor Ailment Service (MAS):** There should be greater use of the Minor Ailment Service by the whole population, making pharmacy the first port of call for these conditions and a national awareness raising programme of this service. This would ease pressure on healthcare services both for daytime and OOH services.
- **Resources to match extended roles:** To appropriately resource increased contributions of pharmacists and pharmacies

Against these three key recommendations, the joint Pharmacy submission makes 15 further detailed recommendations for implementing in the short, medium and long term, in relation to:

- Enabling best electronic access to community pharmacies
- Extending the use of national community pharmacy patient group directions (PGDs)
- Maximising the use of the Minor Ailment Service (MAS)
- Strengthening use of the urgent care PGD for repeat medicines/appliance; pharmacists with additional skills to provide enhanced services in community pharmacies and the OOH services
- Engagement by pharmacists in anticipatory care planning
- Exploring extended hours opening, including weekend; develop a national direct referral and clinical handover framework
- Encouraging pharmacist prescriber input to GP practices daytime services reducing pressure on OOH services
- Examining potential roles for pharmacist prescribers in both OOH and A&E services
- Expanding pharmacist input into NHS 24
- Reducing negative impact of medicines shortages on patients, pharmacists and GPs
- Enhancing pharmacist assessment and management skills for common clinical conditions
- Ensuring robust workforce planning for the entire pharmacy workforce, to ensure future fitness for purpose.

## National OOH Operations Group Submission

The National OOH Operations Group in their position statement offered the following recommendations:

- The OOH service should be valued as an essential element of the whole NHS
- Adequate resourcing including staff and finance
- A realistic workforce plan for now and the future
- Wrap around multidisciplinary team including both health and social care, with skill mix and encompassing robust arrangements to achieve this
- Structured involvement with the Integrated Joint Boards
- Standardised educational requirements and clinical competencies for nurses, pharmacists and extended role for paramedical practitioners working in an OOH setting
- Support of secondary care colleagues especially the Emergency Department
- A robust, effective and consistent entry point for patient care with accurate and pragmatic triage
- Fast and efficient IT systems to facilitate communication
- Appropriate buildings and facilities
- In-built quality improvement methodology
- A clear description of purpose and remit of the OOH services

The full submission of the National OOH Review Group is available on the [Review website](#).

## Allied Health Professionals' Submission

The following submission was provided by the National Allied Health Professions Advisory Committee:

- To support a linked daytime/OOH approach, it is essential to maximise the potential of planned care in order to pre-empt avoidable urgent care. This includes consolidation of integrated community rehabilitation teams. Such measures should help to enable Allied Health Professionals (AHPs) to work at the 'top of their licence'. This should also facilitate flexible access to services on an urgent basis, according to individual need.
- To inform the development of future OOH service models and the optimal contribution of AHPs it will be important to secure shared, reliable, secure and timely access to electronic patient records.
- Configuration of future OOH workforce development plans should include the contribution of AHPs, as a key integral component.
- Individuals who fall, requiring urgent assistance and future prevention are a key priority group. It is suggested that AHPs play a leading role in the implementation spread and sustainability of the *Falls Up and About* pathway, to aid early identification of triggers for repeat falls/attendees
- The revision of the General Medical Services contract (due to be implemented in 2017), should take account of the important impact of AHPs in their service contribution to the wider primary care team.
- AHPs should look to maximise additional skills and expertise, such as independent prescribing capability, in order to optimise their contribution to OOH and urgent care,

## Summary of Clinical Professional Views

Drawing from individual and joint submissions from clinical professionals:

- **Negative perception:** In the past, OOH services have been regarded as overtime or *'bolt on'* to the main business of the NHS.
- **Identity and purpose:** Going forward, they must have a clear identity, purpose and valued as being essential - at the heart of the care services in Scotland.
- **Person-centred:** They must be built on the needs of patients and be flexible – one size does not fit all.
- **Expectations and best use:** At a time when both in-hours GP and OOH services are under pressure, it is essential that best use of OOH services are made by the public and expectations are realistic.
- **Access and triage:** Have a robust and consistent point of access by patients whose needs are then effectively triaged.
- **Integration:** They must be clearly integrated with the wider health and social services, with strategic leadership from Health and Social Care Partnerships and IJBs.
- **Care pathways:** The interface between OOH and acute services is particularly crucial – local care pathways need to be developed in tandem, be understood and effectively implemented – this is particularly important for OOH and A&E services.
- **Multi-professional contributions:** Recognition of the contributions of individual professionals is key: GPs, nurses, pharmacists, mental health practitioners, allied health professionals, social services workers and other professionals providing care or support services, going forward, as new models of care are developed.
- **Optimal working:** The skills and expertise of all professionals working in OOH services must be optimised – with individual practitioners working to maximise use of their skills and the full scope of their practice.

- **Non-medical prescribing:** Should be extended and optimised.
- **Teamwork and leadership:** Effective 'wraparound' multidisciplinary teamwork and leadership are essential, including comprehensive induction programmes.
- **Workforce planning:** Robust workforce planning is required at national and local levels.
- **Training environment:** OOH services must be regarded as excellent training as well as delivery environments.
- **Competencies:** Standardised educational requirement and clinical competencies must be in place for all clinicians working in OOH services.
- **Support staff:** The contribution of non-clinical support staff is crucial and must be clearly valued and recognised.
- **Quality improvement:** Continuous quality improvement is necessary – delivering and assuring safe and high quality services.
- **Facilities:** OOH services should be housed in facilities that are fit for purpose – taking into account [1] clinical and educational requirements; [2] the safety and wellbeing of both the public and staff.
- **eHealth:** OOH services should be underpinned by robust IT systems, shared electronic records (including ECS and EKIS), and videoconference/ telemedicine infrastructure to facilitate communication and coordination of care.
- **Contractual practice, terms and conditions:** Good contractual practice should be shared nationally. Terms and conditions should fully reflect the specific requirements of OOH services, going forward.
- **Resources:** Robust resource planning and appropriate funding allocation.

## Social Work Scotland Submission

Social Work Scotland welcomed the opportunity to have representation on the National Review Group. The review presents the opportunity to build on success where best practice exists through integrated multi-disciplinary health and social work/care teams (including OOH) providing 24/7 services in partnership with the third and independent sectors and carers. Health and Social Care Partnerships under the auspices of Integrated Joint Boards (IJBs) will require to have organisational development plans in place that support the delivery of future models of care. These will focus on supporting staff to integrate ways of working and increase mutual respect across professionals to ensure we deliver the best service we can in Scotland. Their full submission is available on the [Review website](#).

Social Work Scotland indicated:

“The review of OOH primary care provision cannot be considered in isolation and service redesign has to link with in-hours service provision from both a primary care and acute perspective. In considering how the shape of urgent and emergency care might look on a 24/7 basis it is acknowledged that all those delivering health and care services via NHS, Local Authority, third sector, carers and the independent sector have had the opportunity to contribute to the review process. As we move forward towards the integration of health and social care, all of these stakeholders will have a key role to play in delivering person-centred services on a multidisciplinary/multi-sectoral basis.”

## Key Messages from Social Work Scotland

1. All health and social care services need to focus on building resilience and self care management among those services that care for people with health needs. This should include contingency arrangements for extraordinary circumstances. This may prevent the volume of crises interventions required.
2. Service users, carers, the workforce and members of the public need to be clear what constitutes urgent care which may require attention by OOH services. Therefore, there is a need to establish frameworks for use of these services wherein the detail of the provision of services needs to be clearly laid out and understood (including roles, responsibilities and functions of each agency).
3. An urgent move to assess the future need for roles to be developed to ensure better patient services, user outcomes and a more flexible service – for example, more work is needed to develop advanced nurse practitioners, to review and develop the role of the district nurse and community nursing teams and to capitalise on the contribution of pharmacists and paramedical



practitioners. This has to be considered in the context of multi-disciplinary teams with social work and social care key partners.

4. Focusing on supporting staff to integrate cultures and ways of working and increase mutual respect between professions. Only by improving this will integrated working come to fruition. Joining up IT systems that ensure efficient, safe and timely communication between staff from different organisations will support positive outcomes for patients/service users OOH.

## Links between Primary Care OOH Services and Local Authority OOH Provision

- It is recognised that currently primary care OOH provision and local authority OOH (emergency) social work provision could be better connected.
- Through integration of health and social care and the establishment of health and care partnerships there is an opportunity to consider, how in the future, social work and primary care OOH may be better integrated. It would be important to consider further the potential of co-location in terms of health and social care 'hubs' but this in itself will not bring about change. In considering how OOH provision might look in the future and also the daytime element, it would be important to design models of service delivery that improve outcomes for people who use services with integrated patient/service user pathways and support packages that reflect multi-agency working with greater flexibility to utilise resources more effectively.

## Links between Primary Care OOH Services and Local Authority Care Home Provision

- The care home sector is an important area for OOH primary care provision as Local Authorities both provide and commission care home placements. This includes nursing care.
- There are positive aspects to the current OOH provision to care homes and the review provides the opportunity to build on this.
- The strengths and challenges in terms of current OOH provision to care homes from a local authority perspective can be summarised as below:-

## Strengths

- Quality care requires a whole-system approach placing the service user/patient at the centre of all activity. Therefore the term "OOH" is not

helpful as we work towards delivering person-centred care for vulnerable persons and their carers/family members across 24 hours.

- Within the care home environment, the staff skill mix ensures safe and effective care alongside appropriate, multi-disciplinary clinical decision making at all times throughout the 24 hour period. Staff are supported by experienced managers and professional colleagues to deliver safe and effective care.
- We have used service users' experience of OOH services and listened to their feedback and where necessary have acted to ensure services remain responsive and of a high quality.

## Challenges

- A significant challenge will be to ensure the full spectrum of services needed are available at any given time, recognising that the current scope of within and out with hours are based on contractual definitions, rather than patient/service user health care needs. A frequent difficulty is effective communication and there are challenges to ensure that patient/service user information flows simply and securely between providers and professions across 24 hours.
- There needs to be a far greater emphasis on anticipatory care planning, as currently many of those accessing OOH services have long-term conditions where better planning for changes in known conditions could prevent urgent care intervention. Anticipatory care planning requires to be available to all key staff delivering services at all times and should remain the property of the patient/service user and not the provider of service.
- People at the end of life should be able to access services directly over the 24 hour period without recourse to NHS 24 to ensure swift and effective care. This should come with extended admission protocols to allow 24/7 admission to hospice care. Extending the practice of 'just in case' medicines and protocols would support service users/patients to remain within care homes.
- Palliative care patients should have extended access to community nursing and ANP support, with nurses able to verify expected deaths in the community
- Care homes should be able to access a wider set of community supports to reduce avoidable admissions of older people from the sector OOH.
- Hospital-at-home services were recognised as a positive, multi-disciplinary contribution to improving care in the community and delivering the 2020 vision. However provision must now be available in all areas of Scotland with extended hours of operation and the full involvement of social care services to provide effective, high quality and person-centred care for older people around the clock. This will also require clarity on who is accountable for acute medical interventions in the community and, if this service is to be within the

remit of the OOH primary care team, it will also require those professionals to have both the capacity and underpinning knowledge to deliver.

- All localities require to have an effective falls response service to assist people in a crisis and avoid unnecessary admissions. They should also provide co-ordinated follow-up services to prevent further falls or injuries wherever possible.

## Links across Primary Care Daytime and OOH Provision and Local Authority Community Based Services Operating 24/7

- There are a range of examples across local authority and health partnership areas of integrated health and social care teams who provide support to vulnerable people in both daytime and OOH services to keep people at home thus avoiding unnecessary hospital admissions. One of the challenges is raising awareness with GPs and other primary care clinicians that these services exist and building their confidence that these are credible alternatives to hospital admissions, particularly OOH where the default position is often hospital or care home admission. There is a need for better communication with primary care clinicians in order that they better understand the community based services that are available where social work, health and other partners have a range of community supports and early interventions in place with the aim of reducing unplanned emergency events. The benefits of such teams have to be positively accentuated, whereby nursing, AHP and social care staff work together to ensure that the person receiving the service is provided with a seamless service eliminating referrals and improving coordination between professionals both at the time of crisis and support following that crisis.
- When the model of care described above is provided over 24/7, it supports primary care clinicians both working in daytime and OOH to maintain people at home, avoiding potential hospital admissions. It has been recognised that factors within daytime general practice provision, such as lack of availability to appointments, impacts on other parts of the health care system (for example: OOH, NHS 24, A&E and acute hospital services). However there is also an impact on the social care sector in that if an individual cannot access the health care support they need this may impact on the level of support required from a local authority perspective for example: social care or mental health service provision.
- There has to be recognition that to widen the models of care described above across partnerships will require the appropriate resources. The issue of resources is both financial and people having the right levels of staff, with the right skills, in the right place. The dialogue has to continue in terms of shifting the balance of care and the balance of resources from acute hospital services

to community based provision both in terms of professionals moving from a hospital setting as well as budget re-allocations. The role of other health care professionals including the Scottish Ambulance Service also have a pivotal role to play in such integrated community support teams and this requires further exploration in terms of role and functions.

- The development of the virtual ward model (hospital-at-home) is operational across a number of partnerships across the country and described above in terms of the benefits. In citing this as a model of good practice in maintaining people at home in a virtual ward model with clinical input, there is a caveat in that due cognisance has to be given to the cost/benefit analysis of this model of service compared to other models of integrated community support prior to any decision to introduce or expand.

## Future Provision

- The establishment of Health and Social Care Partnerships and IJBs brings opportunities to determine future service provision across all sectors.
- This presents opportunities to further consider models of care for both daytime and OOH service provision. The Health and Social Care Partnerships and IJBs will be required to have in place a Strategic Commissioning Plan for Adult Health and Social Care and this will act as important leverage in terms of how future services are commissioned and delivered.
- Health and Social Care Partnerships and IJBs will have a key role in determining the financial profile across community based services and the unscheduled care element of acute described above. In order to further develop integrated multi-disciplinary teams that are designed to meet local need this will require budgets to be in the right place with potential disinvestment from some of the current arrangements to support reinvestment in community based services across local authority, NHS, third and independent sectors. This is as relevant for OOH care as it is for in daytime provision.
- The development of future models of care has to be predicated by the use of robust data across not just local authority and health but all stakeholders.
- Health and Social Care Partnerships and IJBs will require robust workforce planning in place and organisational development strategies in place that support the delivery of future models of care. This provides a real opportunity to have an organisational development (OD) approach that supports a better understanding of roles and functions across not just health and social work but the third and independent sectors. This will also allow for an examination of role/ task/location across professions/sectors to determine where there is a need to do thing differently. This would include a range of staff, for example

GPs, AHPs, home care, district nursing, pharmacists with a view to ensuring that where there is the potential to up skill any sector of the workforce undertake more enhanced roles we train and support them to do so. This will enhance capacity to create teams that get the right services to people at the right time both daytime and OOH services. This extends to the role of the third and independent sectors in terms of the important contribution they make to delivering services. Effective integrated workforce planning is crucial.

- Joint organisational development plans have to focus on supporting staff to integrate cultures and ways of working and increase mutual respect between professions. There has to be learning and development strategies in place that support distributive leadership across professions/sectors. These are crucial factors if integrated working is to come to become embedded across all care sectors
- There is also an opportunity to look at undergraduate professional training and further integration of social work and health faculties in universities to ensure learning programmes promote an understanding of cross sector roles, function, and the need for integrated service provision in communities.
- Effective communication is a key area in future service provision and the work of the review group in looking at data and technology as integrated teams need to be supported effective linked and fit for purpose IT systems with information shared appropriately and seamlessly across health and social care as well as other stakeholders. This is crucial for safe and effective OOH provision.
- Future development and utilisation of telehealth and telecare will be important to supporting people to be more independent in their communities, promoting self management and reduce reliance on services which includes OOH provision.

## Recommendations offered by Social Work Scotland

1. There is an opportunity to explore further local authority OOH services provision with that of NHS primary care OOH services to explore opportunities for co-located and integrated service provision. This should be part of the strategic planning process within Health and Social Care Partnerships and IJBs.
2. Strategic commissioning plans for adult health and social care require to be developed. This will act as important leverage in terms of how future services are commissioned and delivered. Future models of care have to meet local need and focus on early intervention and prevention. There is an opportunity to build on success where best practice exists in terms of integrated multi-disciplinary health and social work teams (including OOH) that provide 24/7 services often in partnership with the third and independent sectors and carers. A platform for shared learning across sectors would be beneficial.

3. Robust workforce planning needs to be in place and organisational development strategies that support the delivery of future models of care. There is an opportunity to have an organisational development approach that supports a better understanding of role/task across professions/sectors to determine where there is a need to doing things differently. This would support the development of multi disciplinary/sector teams with the potential to up skill the workforce to undertake more enhanced roles, where appropriate, and with the training and support to do so. This will enhance the capacity to create teams that get the right supports to people at the right time and this extends to the role of carers, third and independent sectors, given the important contribution they make to supporting people in communities.
4. Joint organisational development plans have to focus on supporting staff to integrate cultures and ways of work and increase mutual respect between professions. There is a need for learning and development strategies to be in place that support strong distributive leadership across professions/sectors. These are crucial factors if integrated working is to come to become embedded across care sectors.

## Chief Officers of Integrated Joint Boards Submission

In their submission, the Chief Officers of Integrated Joint Boards (IJBs) indicated that Integration of health and social care has been a long term policy direction and in 2015/16 has been coming into reality across Scotland. By 31st March 2016 all partnerships will have brought together the planning and commissioning of health and social care under a joint arrangement (Body Corporate or Lead Agency). In many partnerships operational delivery will either be integrated or moving towards being integrated.

General Medical Services, including OOH services, are part of the delegated functions for all Bodies Corporate. Therefore OOH primary care services will be a component of all partnerships' strategic plans. In some cases operational management of OOH services will also be delegated to partnerships.

Some of the challenges facing OOH services (particularly medical recruitment and retention) are not always possible or desirable to address at a single partnership level since they require regional or national action. However some challenges, such as closer working with other care services, require local action at partnership level.

### Proposed Principles

- The primary location of the planning for OOH GP services should be the IJBs. This should be balanced against the need for consistency within territorial Health Boards that have multiple partnerships and the need for solutions to problems that can only resolved on a national basis.
- OOH primary care services have important connections and opportunities for improvement with OOH social care services. We believe that the Review should recommend greater local integration with social care services and other NHS OOH services for example district nursing and mental health services.
- There has been an upward spiral and competition of pay rates set locally over the last few years. Payment rates for doctors working in OOH services should be set nationally. Consideration should also be given to the potential for variation locally (within nationally agreed limits) to address capacity in hard-to-fill areas.



## Third Sector Contribution

Future caring systems must place a high value on improving the connectedness between individuals, systems and sectors. The third sector is a major provider of 24/7 health and social care services in Scotland; fifty-five per cent of the sector is employed in social care or health and the sector has collective annual income of £4.9 billion (Health and Social Care Alliance). One third (~£1.6 billion) of the sector's income is for activity in health and social care. It is therefore vital that the statutory and the third and independent sectors in Scotland pool resources, and co-produce the caring and efficient systems required for the future.

The full third sector contribution is available on the [Review website](#).

The inclusive process adopted by the National Review of OOH Primary Care Services is a good example of the spirit of collaboration required to make sustainable improvement in health and social care services. The Review is an opportunity to celebrate the dedication and talent of people working in both the statutory and non statutory sectors, but also to consider opportunities for doing things in a different way. Key features of our future caring systems should be that they place a high value on inter-connectedness, which applies at all levels, between individuals, systems and sectors. There is untapped potential in developing a more reciprocal approach, where effort and benefits are equally shared between people living in our communities and those who provide care and support, no matter which sector they work for.

The Christie Commission made recommendations about managing demand and enabling people to do more for themselves and each other, which are relevant to improving OOH care. An important theme in the report was that effective services must be designed with and for people and communities – not delivered 'top down' for administrative convenience:

“Working closely with individuals and communities to understand their needs, maximise talents and resources, support self-reliance and build resilience and prioritising preventative measures, to reduce demand and lessen inequalities.” This is a good description of the type of services which the third sector have a long history of providing and which have an impact in OOH care.

There is an increasing awareness of the potential benefits of co-production and person-centred design in many areas of Scottish public services and the third sector through networks such as the Co-Production Network, movements such as ULab, the Scottish Council for Voluntary Organisations' (SCVO) Digital Participation programme, Health and Social Care Academy of the Health and Social Care Alliance, opportunities exist for different staff disciplines and sectors to develop joint



approaches to improving health and wellbeing, promote prevention and self-management. Participation in its widest sense, is presently being discussed in Scotland through the National Conversation on Health and Social Care services in 2015. This has relevance for the Review, as it is an opportunity for people to put forward their views and ideas on how to sustain a 24/7 service which remains free at the point of delivery. Opportunities and strengthening existing relationships with the third sector should be harnessed and will enable solutions beyond traditional health service approaches to promote improvement of OOH services. These approaches will involve engaging people who use OOH services and strengthening multi-disciplinary, multi-professional and multi-sector collaboration.

The third sector plays a vital role in supporting the people of Scotland, particularly the most vulnerable individuals in our society, who are often frequent users of OOH services. Therefore improving these connections has potential to improve personal outcomes, safety and to have a positive impact on inequalities in health. The need to support and understand the contribution of the third sector is now more urgent, as IJBs and Scottish Government require information to make efficient use of all community resources and to develop the intelligence required to plan services. We suggest that developing the local and national collaborative infrastructures required can be addressed by implementation of the following recommendations which are considered in greater detail within the full Third Sector report submitted to the Review:

- Improve understanding and support for the role of the third sector in OOH services prevention and self management
- Improve national intelligence about the contribution of the third sector to Scotland's Health and wellbeing in both daytime and OOH services
- Explore models of governance in statutory and non statutory organisations to ensure a person-centred safe and effective service
- IJBs should explore models of funding to the third sector to ensure their contribution to both daytime and OOH services is secure
- Improve systems for communication and for connecting both statutory and non-statutory providers of care.

## Independent Sector Contribution

This is an extract of a submission from Donald Macaskill, Joint National Workforce Lead for Scottish Care. (see: <http://www.scottishcare.org/about/>) The full submission is available [online](#).

As the population of Scotland continues to age, more and more individuals will seek to use OOH services. The independent sector strongly believes that it has a positive role to play to ensure that the experience of care and support can be as person-centred, effective and holistic as possible. To achieve this, there needs to be much more co-ordinated and strategic partnership and working across the statutory third and independent sectors. The provision of OOH support is best delivered at a local community level, by integrated teams involving staff from all sectors, able to respond to local needs and circumstances. People are best supported as close to their home environment as possible and wherever possible that admission to hospital should be made as a clinical choice and not because it is the only resource available. We recognise that the success of OOH provision will necessitate a re-prioritisation of resources and a commitment at the point of planning, commissioning and procurement to enable local OOH provision and partnerships across all the sectors. We hope that the Review will contribute to this process.

The following recommendations were offered to the Review for consideration:

- It is important that care homes and care at home/housing support services are recognised as being part of 'primary care' in its widest sense and that they offer potential solutions to some existing and developing challenges.

This will be develop in importance as integration continues to take root and will necessitate joint local planning and review of local OOH provision which should of necessity include both the independent and third sector providers in an area. In particular IJBs should explore the distinct contribution which use of care homes and care at home/housing support could offer for local OOH provision.

- There is a significant lack of data on the independent sector's activity in the OOH period which makes it challenging if not impossible to capture the local and national contribution. Work needs to be undertaken to identify best practice and the lessons learnt from local work.

The establishment of appropriately funded local pilots to test the potential of using care homes and home care provision to contribute to ensuring a reduction in unnecessary hospital admission and reducing delayed discharge. Such testing would include the exploration of developing appropriate communication and data systems

to enable GPs to have access to a wider range of options which are alternatives to hospital admission. As part of this the configuration of 'rapid response' care home beds and intensive home care for up to 48-72 hours offers both immediacy of access and local treatment. We believe that a responsive OOH provision requires that all care options, including step-up care homes and care at home provision should be available to those making decisions to place individuals

- Overall there needs to be a more robust improvement in anticipatory care planning and a sense of real partnership between the independent, third and statutory sectors.

There are some specific areas which impact most directly upon the independent sector, notably in relation to tissue viability; in awareness and treatment of delirium (there are still issues of misdiagnosis as dementia). All three would be aided by a more joined up, localised approach to OOH support and treatment which involved care at home and care homes and which would prevent unnecessary hospital admissions for some of the most vulnerable of our citizens. Related to this is a more comprehensive location of direct services, for example locating rehydration facilities in a care home to prevent unnecessary admission.

- Work should be undertaken to explore the strategic and routine use of telemedicine links between primary care, secondary care and social care,

This should assist the reduction of unnecessary duplication and intervention especially for older individuals who may have limited capacity and comprehensibility – for example: tests could be conducted by nursing staff in a care home and reviewed by a GP or consultant to avoid unnecessary movement of residents from care home to hospital.

- There is merit in exploring the potential use of existing models of personal information, for example One Page Profiles, already used by many care homes as a mechanism for personal information passports. The use of such person-centred information tools would assist in the reduction of unnecessary re-assessments and to ensure a more focused and holistic support of individuals as they navigate between different parts of primary care.

Related to this, the lack of any national and comprehensive system to pool data from statutory and non-statutory sectors, inhibits real collaborative working and creates yet more obstacles for people seeking support and care. Sharing common datasets between all sectors has potential to positively impact on OOH services.

Developing a reformed OOH provision will require the development of integrated information and data systems that ensure staff have access to all relevant information to ensure a seamless care pathway for individuals.

- The age of those we care for has increased significantly with an attendant complexity of medical conditions, as well as an increase in dementia. This will require greater professional support for care homes.

For care homes, this means residents coming in later, with higher levels of dependency and closer to end of life. For care at home and housing support, it means supporting people, with higher levels of need to live and die in their own homes, whilst maintaining as much quality of life as possible. The provision of palliative and end of life care is OOH provision acknowledges the significant role care homes and care at home services play in palliative provision. In practice this will require a more robust OOH support to care homes and care at home providers in relation to palliative and end of life care, medical emergencies etc. in order to ensure the continuity of care plans and that individuals are able to exercise the maximum degree of control and choice in relation to their care and support in OOH periods.

- There requires to exploration as a matter of urgency with the regulatory bodies to ensure the ability of care home and care at home/housing support providers to engage in and develop new models of intermediate care, step up and step down provision.

Providers often make the observation that they would like to engage in much more innovation in regard to intermediate care but feel they are hampered by the legislation relating to registrations and changes to service provision through the Care Inspectorate.

- Greater co-working and collaboration will be essential going forward

It is important that work is undertaken to increase the awareness and training of clinical staff to include social care options and in particular the contribution of the third and independent sectors. This will necessitate a properly funded workforce development and planning strategy which involves all partners.

See also: Social Care – the voice of the independent care sector in Scotland website at: <http://www.scottishcare.org/index/>

# **Annex E      Report Submitted by NHS Health Scotland on Health Inequalities**

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## Contribution from NHS Health Scotland on Health Inequalities

### Introduction

We welcome the opportunity to respond to your request to contribute to the National Review of OOH Primary Care Services. This contribution addresses OOH services from the perspective of inequalities, specifically health inequalities.

This contribution is summarised here – the full contribution from NHS Health Scotland is available on the [Review website](#).

This review, and the area of public services that the review addresses, is a crucial and rare opportunity to tackle inequalities in access, experience and outcome for people who often face the greatest challenges in their circumstances and have the greatest and most complex needs, at important times of their lives.

We realise that pressures on OOH services are substantial and rising, and that the anticipated trends of demography, public and professional expectation have hit services with full force, when resources in social care and other supporting services are less abundant, and those people and communities with fewest resources are under further strain. The NHS is a universal provider of healthcare, free at the point of need for the whole population. Its contribution to the health of the population is substantial, although it does not act alone; it is dependent on the contributions of many stakeholders, the general health of the population and determinants of health that are mainly beyond the scope of healthcare.

### Key messages:

- Health and social care services and professionals have an important contribution to make to reducing health inequalities.
- Changes to out of hours primary care provision have the potential to increase or decrease health inequalities, depending on how they are implemented. Elements of the style of service more likely to decrease health inequalities are contained in key points and recommendations that follow.
- The principle of proportionate universalism should be applied to OOH developments – in other words, OOH services should be designed in the full knowledge of the needs of whole local populations, co-produced and delivered with service users in proportion to levels of need.
- Resources spent on crisis management mean that less is available elsewhere in public services to take more cost-effective, preventive measures. Helping people to access resources to prevent escalation or deterioration of their health problems should be a key feature of OOH service design.
- Barriers to access as a result of cost, geography, additional support needs, institutional settings or features of service design should be minimised as much as possible.

- There are particular risks of increasing inequalities in relation to telephone-based access; the evidence we do have suggests that uptake is likely to be influenced by a range of socio-demographic factors, including deprivation.
- There are also inequalities issues in relation to centralised primary care out of hours centres, particularly in remote and rural areas or where the reimbursement of travel costs is inconsistent.
- The evidence in relation to inequalities in access to, use of and outcomes from OOH services in Scotland is currently very limited and needs to be improved.

In particular, tackling inequalities in access to and uptake of primary care is a key focus for the NHS in reducing health inequalities. This includes ensuring equitable experience of services and targeted support for the most disadvantaged and those at particular risk of poor health outcomes. Key actions which can help to mitigate health inequalities include:

- Training to ensure that the primary care and wider public sector workforce is sensitive to the needs of all social and cultural groups, and can build on the personal assets of service users as well as being able to identify risks and areas of deficit- for example poor health literacy. Health literacy is especially important in relation to appropriateness of self-referral, concordance with treatment, and uptake of secondary and tertiary treatment services
- Linking of services for vulnerable or high-risk individuals.
- Provision of specialist outreach and targeted services for particularly high-risk individuals.
- Ensuring that services are provided in locations and ways which are likely to reduce inequalities in access (i.e. linked to public transport routes and avoiding discrimination by language and internet access).<sup>i</sup>

These key messages from NHS Health Scotland regarding health inequalities find an echo throughout the report and in particular to people with specific needs which is addressed in the Models of Care Task Group. These messages should be seen in the light of the guiding principles set out in the Chairman's Introduction for the future development OOH services which should be seen as desirable, sustainable, equitable and affordable. They must also be taken account of in the development of a service specification for OOH services.

# **Annex F      Commissioned Research**

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## Commissioned Research Evidence

To underpin the work of the Review, a rapid systematic literature review and qualitative study was commissioned via the Scottish School of Primary Care and undertaken by Professor Catherine O'Donnell and colleagues, General Practice & Primary Care, Institute of Health and Wellbeing, University of Glasgow.

A full report of the research work undertaken is available on the [Review website](#).

This research work aimed to a) identify the key literature on OOH care services, b) focus on the structure, use and evaluation of OOH primary medical care, c) sought to identify gaps in the knowledge base and d) analyse the literature in order to inform the development of future OOH services. The research examined primary clinical care but also key interfaces, including community, social care and A&E services. The literature review included those countries with health care systems broadly similar to that of Scotland or where there might be new types of service development potentially transferable to Scotland. There has been a number of service models developed in the last 10 to 15 years, operating in OOH periods (for example NHS 24, NHS Direct, walk-in clinics). The scope of the literature review therefore covered:

- UK and appropriate international settings, mainly Europe, Australia, New Zealand and the US.
- Primary medical care (excluding dentistry and social work out-of-hours services).
- Services which impact on primary medical care, including: out-of-hours telephone-based services such as NHS 24, NHS Direct and the NHS 111 service.
- A&E/emergency department initiatives designed to interface with primary care services.
- Community-based or social work services designed to interface with primary care services.

### Aims of systematic review of peer-reviewed literature

- To identify the peer-reviewed literature focussed on the structure, use and evaluation of OOH primary care services
- To identify gaps in the knowledge base with respect to OOH services
- To help to define what quality OOH services should look like in the future

In summary, the research work report is presented in five sections:

**Section 1:** outlines the key definitions used in the research

**Section 2:** reviews the international literature on OOH primary care

**Section 3:** summarises the wide set of literature on demand, use and outcomes

**Section 4:** reviews the published literature in relation to the Review Task Sub-Groups

**Section 5:** reports on a series of interviews conducted with new and more experienced GPs

**Section 6:** summarises this evidence and outlines our own recommendations for future research and evaluation in this area.

## Overall summary and recommendations

The evidence identified by this rapid systematic review indicates a preponderance of quantitative research. The relative ease of collecting quantitative data on demand, use and outcome, indicates that around one quarter of the 274 papers included in this review dealt with such issues. Indeed, over all the research areas, the use of quantitative data and observational methods such as case/record review, routine data and questionnaires predominated. Despite the importance to policy makers of knowing which models are more effective in terms of meeting patient need, only four randomised controlled trials were identified. There were also very few studies which conducted an economic analysis of the costs associated with OOH care.

Much of the research studies have focused on GP-led models of care, or on nurse-led telephone triage. Other issues, such as the future role of pharmacists in OOH care provision, and links to social care and third sector organisations are conspicuously under-researched.

While there has been some work researching the issues faced by service providers – mainly GPs – in caring for palliative care patients, other patient groups are very much overlooked. There was little or no evidence in relation to meeting the needs of elderly patients, particularly frail elderly, patients with dementia, patients with particular communication needs, such as the deaf community, or patients whose first language is not that of the host country. Such gaps need to be addressed

## Key areas identified as being crucial in the development of high quality OOH services

- Good communication and information technology, both across out-of-hours service providers but also across the daytime and OOH interfaces.
- Better understanding of how patients view OOH services and the decisions they make in relation to which service they choose to attend.
- Development and evaluation of new professional roles in OOH care, in particular pharmacy, but also other organisations out with health care

- Better engagement with early career GPs, with trainees and with undergraduate medical students to promote the value and professionalism of providing out-of-hours care.
- Improvement in career development and training for other professional groups.
- Single, centralised systems have to be '*future proofed*' to address the contextual realities of different areas, for example patients in remote and rural areas have different needs and capacity to respond compared to those in urban areas. This is also true in relation to socioeconomic deprivation
- Co-location and integration of services will have to be rigorously evaluated, including process evaluations to understand the impact and challenges this brings to different professional groups.

## Recommendations for research and evaluation

Future models of care need to be rigorously evaluated using experimental research designs which will allow both clinical and cost effectiveness to be addressed. The methodology used should include cluster randomised controlled trials and alternative study designs, such as stepped-wedge study designs, to best inform the development of OOH delivery programmes. This research should pay particular attention to the requirements of key groups with specific needs, including palliative care, mental health, frail older people and individuals with communication and accessibility issues.

Future evaluation designs should include economic evaluation to assess not only the immediate costs of new models of care, but also the wider impact on other parts of the health and social care system, in relation to health and social care integration imperatives.

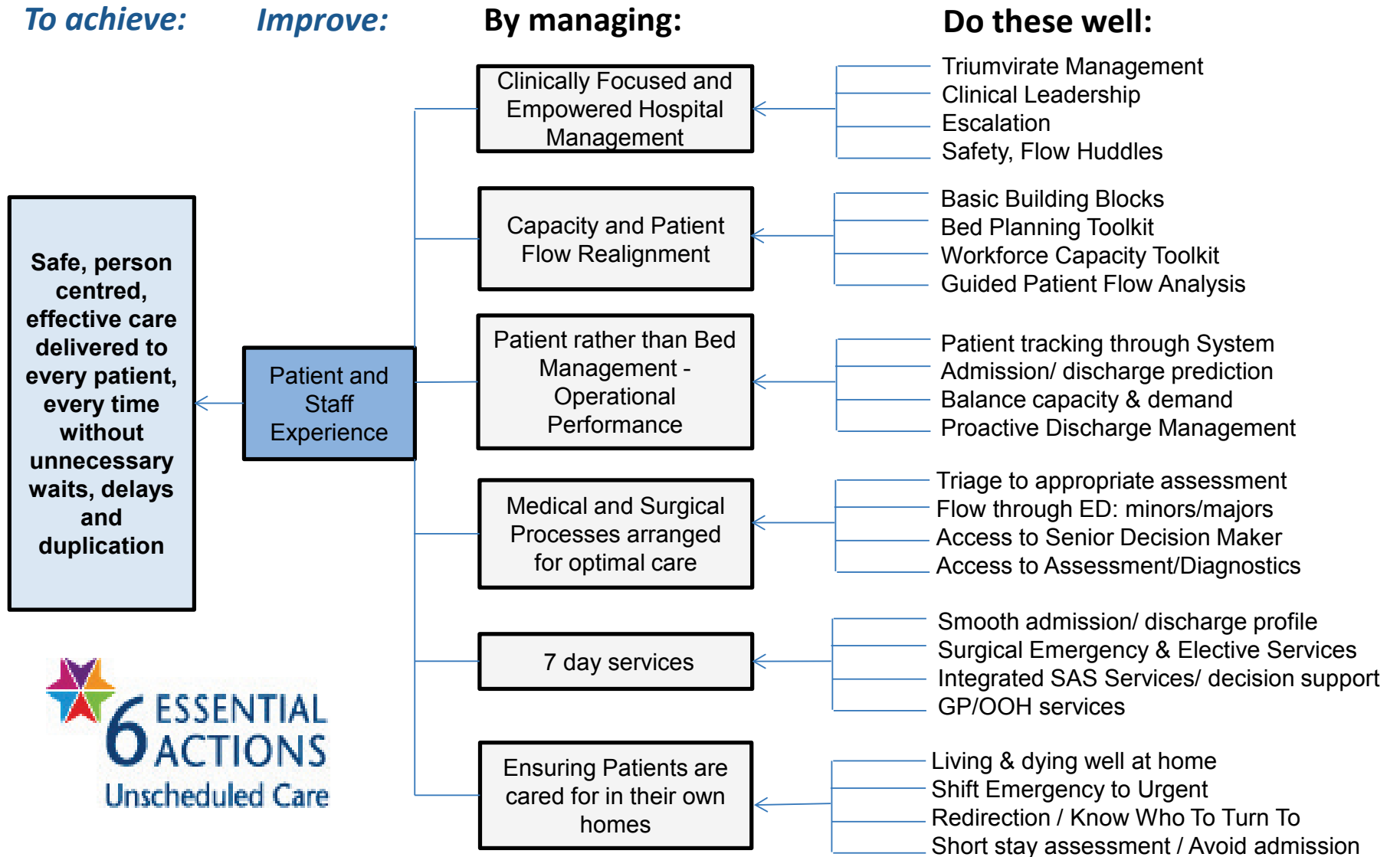
A better understanding is required of the decision-making of patients and carers in terms of: what they know and understand of different parts of the OOH system and what makes them choose one service provider over another (for example phoning NHS 24 versus attending A&E services).

Co-location, co-working and integration of services should be underpinned and informed by evaluation, including qualitative process evaluation to understand the challenges and facilitating factors for co-location.

# **Annex G      Improving Unscheduled Care**

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# Improving Unscheduled Care Performance



# Annex H      Integration Principles

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## Health and Social Care Integration Principles

Under the provisions of the Public Bodies (Joint Working) (Scotland) Act, regard must be paid to the integration principles as follows:

1. By NHS Boards and Local Authorities, when drawing up their integration scheme
2. By Integration Authorities, when preparing their strategic plan
3. By any organisation which carries out an integration function (i.e. delivers a service commissioned under the strategic plan)
4. By Healthcare Improvement Scotland and the Care Inspectorate, in carrying out scrutiny and improvement functions relating to integrated care

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

Are integrated from the point of view of service-users

- Take account of the particular needs of different service-users
- Takes account of the particular needs of service-users in different parts of the area in which the service is being provided
- Take account of the particular characteristics and circumstances of different service-users
- Respects the rights of service-users
- Take account of the dignity of service-users
- Take account of the participation by service-users in the community in which service-users live
- Protects and improves the safety of service-users
- Improves the quality of the service
- Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
- Best anticipates needs and prevents them arising
- Makes the best use of the available facilities, people and other resources

For more information see: <http://www.gov.scot/Resource/0046/00466005.pdf>

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<sup>i</sup> <http://www.healthscotland.com/documents/23047.aspx>



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