

Pulling together: transforming urgent care for the people of Scotland

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

Summary Report

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 to not only advice but 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 under strain for some time now, 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 provide this expert advice and to lead the Review.

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 that reads "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

Purpose: This Summary Report has been prepared to sit alongside the Full Report as a more accessible and concise version: to describe the work, findings and recommendations of the Primary Care Out of Hours Review 'the Review'. Its purpose is to summarise and to guide best use of the extensive and detailed Full Report which should be regarded as a source document.

Background: Out of hours primary care services (OOH services) are under considerable pressure, as is daytime general practice, at this time. Services are fragile, are not sustainable and may worsen rapidly if we do not rise to the occasion.

Transformation: We must secure resilient, high quality and safe out of hours (OOH) services, but we must also think anew about what is best for both urgent and emergency care for the people of Scotland on a 24/7 basis. That requires transformational change across many sectors - it will be neither easy nor quick. We must strive for excellent services, which must be valued accordingly and used responsibly. The Review is cast at a pivotal moment for health and social integration and that has galvanised our thinking and actions.

Appreciation: I have been humbled by the dedication and commitment of very many colleagues during the course of the Review who are too numerous to mention, by the steadfast support of the public who helped us and by my support team,.

Expectations: I am very conscious of the limitations of the Review which reaches out to all care sectors and those we serve. I hope that some recommendations will bear fruit in the short term but others will take much longer to come to fruition.

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 will need to do this well, to do this with resolve and to do this together.



Lewis D Ritchie

Chairman
National Review of Primary Care Out of Hours Services



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

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The Social Care Response Service, Dundee

Our Remit

We were asked 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 OOH 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

Key Definitions

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

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

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



Scottish Ambulance Service taking care to the patient

1 Key Messages

Purpose: This Section provides key messages about Primary Care Out of Hours Services and answers questions about what future services might look like and how that might happen. It differs from the Key Messages section in the Full Report - in order to improve accessibility

Person-Centred 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. We need to both deliver excellent care in partnership with patients and we need to value the staff who provide it.
- Urgent care services for problems and care needs that cannot wait for a routine appointment should be more easily accessible and navigable for all but need to be valued and used responsibly.

Service Demand and Sustainability

- During the one year period 1 May 2014 to 30 April 2015, almost 1 million contacts were made with primary care OOH services.
- 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.
- 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 and other multidisciplinary team members working in both daytime and OOH services.

What will the future look like?

- Future service design and delivery should be based on best meeting the needs of the public and those who deliver services. This should enable tailored advice, support and self care, and where required, direction to the right service, at the right time.
- Patients can no longer expect always to see or receive telephone advice from GPs for urgent care. Future care will be delivered by well trained and well-led multidisciplinary teams. Patients will be seen by the right clinical or caring professional according to need. That could be a GP, an advanced nurse practitioner, a community nurse, a paramedical practitioner, a pharmacist, an allied health professional (AHP) such as a physiotherapist, social services or other team member who might work for the third or independent sector or another agency. GPs must continue to be an essential part of multidisciplinary urgent care teams, providing clinical leadership and expertise.

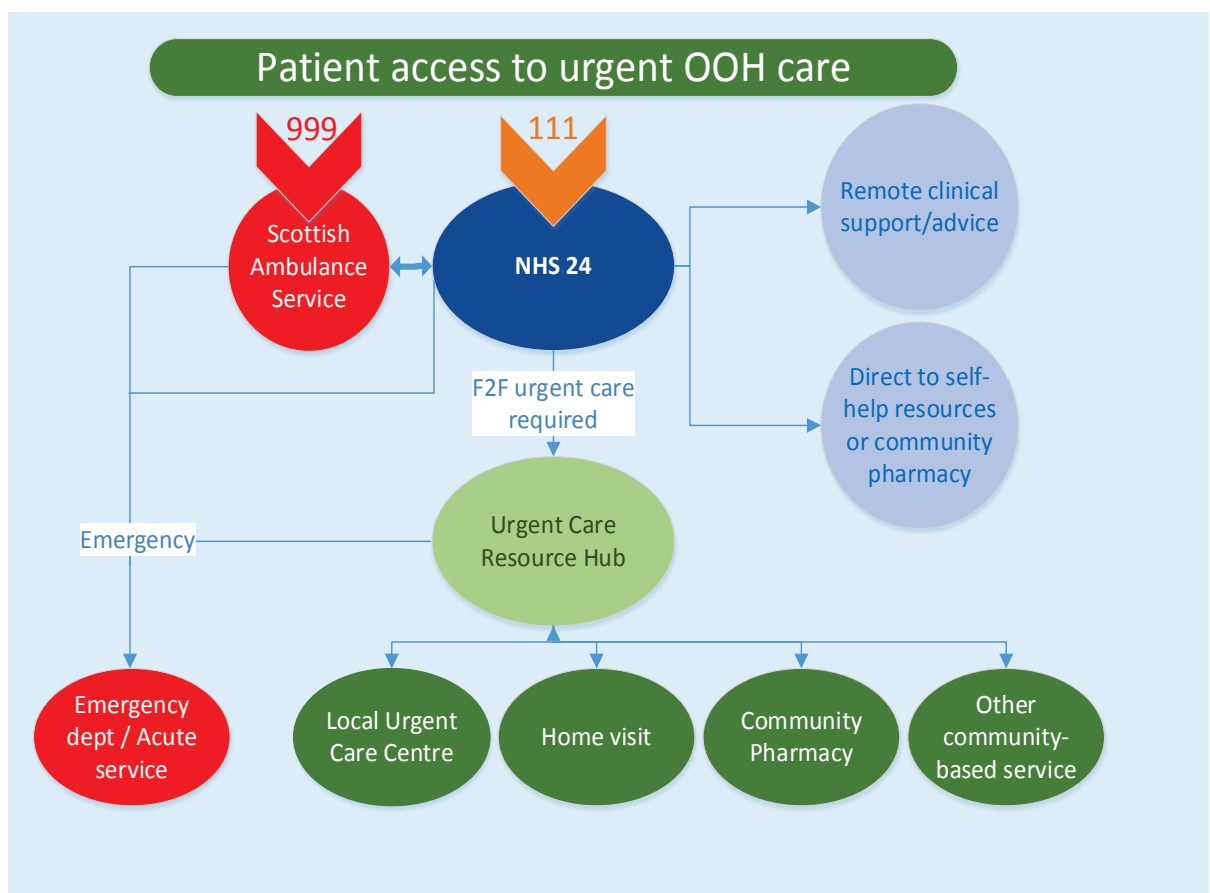


Figure 1 - A new model of out of hours care

How will that be organised?

- At the moment care can be fragmentary and communications can be difficult between professionals to the detriment of best patient care. A new model of urgent care is proposed by developing Urgent Care Resource Hubs – see [Figure 1](#) above. These hubs would provide a coordinating area and locality wide function for multidisciplinary urgent care and should provide remote telephone or video-link support for care professionals from all care sectors. While primarily established for OOH services, they should be considered for 24/7 urgent care coordination. They will need to be piloted and tested to inform future progress.
- An area Urgent Care Resource Hub would normally be networked to several local Urgent Care Centres.
- **Local** Urgent Care Centres (which are presently known as Primary Care Emergency Centres) should be located to facilitate patient access for care, but also for service resilience. They should be fit for purpose for service delivery and training.

How will out of hours care be accessed?

- In the case of genuine medical emergency care that will continue to be by 999 phone call, to access the Scottish Ambulance Service (SAS), or by direct attendance at A&E services.
- In the case of urgent care for a medical problem – care that cannot wait for a routine appointment, when GP practices are closed, by dialling 111 to access NHS 24, as now. NHS 24 will provide the right advice for self care or direction to the right care service – routed to the area Urgent Care Resource Hub nearest to the patient’s location. This Hub will coordinate best care by requesting the patient or carer to visit a local Urgent Care Centre or, if required, by arranging a house call or by direction to another community care service. A house call might be done by an advanced nurse practitioner, by a GP, or paramedical practitioner (paramedic). Some callers will be directed to attend Accident & Emergency services and a small number will have a 999 ambulance dispatched for their immediate assistance.

What will be different?

- NHS 24 and SAS already work closely together, but we have asked them to look again at their care pathways to ensure better coordination of care. This should provide better experience and outcomes for patients and their carers.

- We would expect the public to make greater and better use of local community pharmacies in the future to seek advice and treatment for minor ailments both during daytime and OOH. There is insufficient awareness of the services delivered by community pharmacists and that should change.
- We have looked at a small number of groups of patients with specific needs – children, palliative care patients, frail older people, people with mental health conditions and those who are living in deprived circumstances or who have problems accessing services for a number of reasons. We would expect their care to be improved with better access to services according to need. The work is preliminary only – we suggest that there is much more to do. We identify further work that needs to be considered for prisoner care and for forensic clinical services.
- Increasing use will be made of telehealth and telecare, with remote video-consultations increasing. We have advised that mobile applications ‘apps’ should be developed and evaluated in order to support self care and best use of services.
- We would expect the third sector, already a large and important provider of care – particularly for vulnerable people – to be playing a greater role in future services in collaboration with all other sectors.
- For the care home sector we would expect better remote professional support and improved recording systems.
- We indicate that greater use could be made of the Scottish Fire and Rescue Service, for prevention and care in the community, if available. They are already working closely with SAS to assist cardiac arrest victims as their vehicles carry defibrillators. We have suggested consideration of further expansion of their first-responder role to help clinical care, in the absence of timely ambulance availability.
- In some remote island communities the RNLI lifeboat service may be deployed to evacuate urgent cases when other transport may not be available or unsuitable, particularly in adverse weather conditions. We have asked for a Memorandum of Understanding to be drawn up between RNLI, SAS and HM Coastguard.
- We would expect the specific needs of remote and rural communities to be taken into account particularly for transport and communication issues. Greater use of remote video consultations may help matters.

How can the public and patients be helped to make better access and use of services?

- We have made recommendations about promoting better understanding and use of services. We wish to raise the profile of the meaning of ‘urgent’ and ‘emergency’ to promote responsible use of services. We advise that best

practice should be used to achieve that including learning experience, taking into account international best practice.

- We have particularly looked at how to bolster self care and have recommended promoting person-centred care through better self-management and health literacy.
- We call for greater public involvement in health service developments – those who receive services are entitled to shape them.

What about those who provide the services?

- We have indicated that staff providing services need to be valued more, which is why we say person-centred should refer to both those who receive care and those who deliver it.
- We have made a large number of recommendations about workforce issues and have examined the future roles of GPs, advanced nurse practitioners, district nurses, pharmacists, paramedics, AHPs, physician associates and social care practitioners.
- We have called for urgent primary care workforce planning to be developed at national and local levels – this must be done without delay to rapidly enlarge and enhance capacity.
- We have asked for new one year posts to be created for GPs after completion of three year training and for four year training to be better configured for urgent GP care. We want young GPs to be supported and GPs at all career stages to be encouraged and enabled to work in OOH services.
- We commend the Chief Nursing Officer's Reviews of Advanced Nurse Practitioners (ANPs), creating sufficient capacity and uniform standards and also her District Nursing Review – many district nurses will be retiring shortly so this a pressing matter.
- We have already indicated that community pharmacies should play a greater role for urgent care. Clinical pharmacists will contribute more to both daytime and OOH services. Like ANPs we would expect many more pharmacists to be independent prescribers.
- Paramedical practitioners (paramedics) will play greater roles in delivering care to the community – they are already doing it and like NHS 24 have recently supported some GP practices with staffing difficulties, in daytime hours. Ambulances could be regarded in the future as mobile Urgent Care Centres - that may be more important for remote and rural areas.
- AHPs too will have more prominent roles in OOH services, primarily supporting community rehabilitation and fall pathways, which we have recommended should be accelerated and more uniform throughout Scotland.

- Physician Associates (PAs) have been working in the USA for many years and play important roles working with and for doctors. They should be considered for augmenting the Scottish primary care workforce.
- The roles of social services workers continues to grow – the importance of working closely with clinical colleagues should be fostered by the new model we propose. Again awareness of their roles could be improved as they contribute much to the care of society in the OOH period – including the community alarm system and assistance and preventing falls.
- We also indicate how critical OOH support workers are - they should be appreciated and valued.

How will this happen?

- We have made a number of recommendations about improving quality and safety.
- We have asked for a service specification for OOH services to be developed.
- We would like to support services to promote quality improvement and have asked how that can best be achieved.
- We have made a number of recommendations about securing best use of electronic records and consistent data sharing.
- We have yet to truly unleash the potential of information technology for better and safer patient care and we must strive to achieve that.
- We have called for rapid development of comprehensive primary care workforce plans at national and local levels
- We have suggested that undergraduate schools for health and social care professionals should look at the balance and emphasis of their training - as the changing needs of society and workforce capacity/capability, should be closely aligned

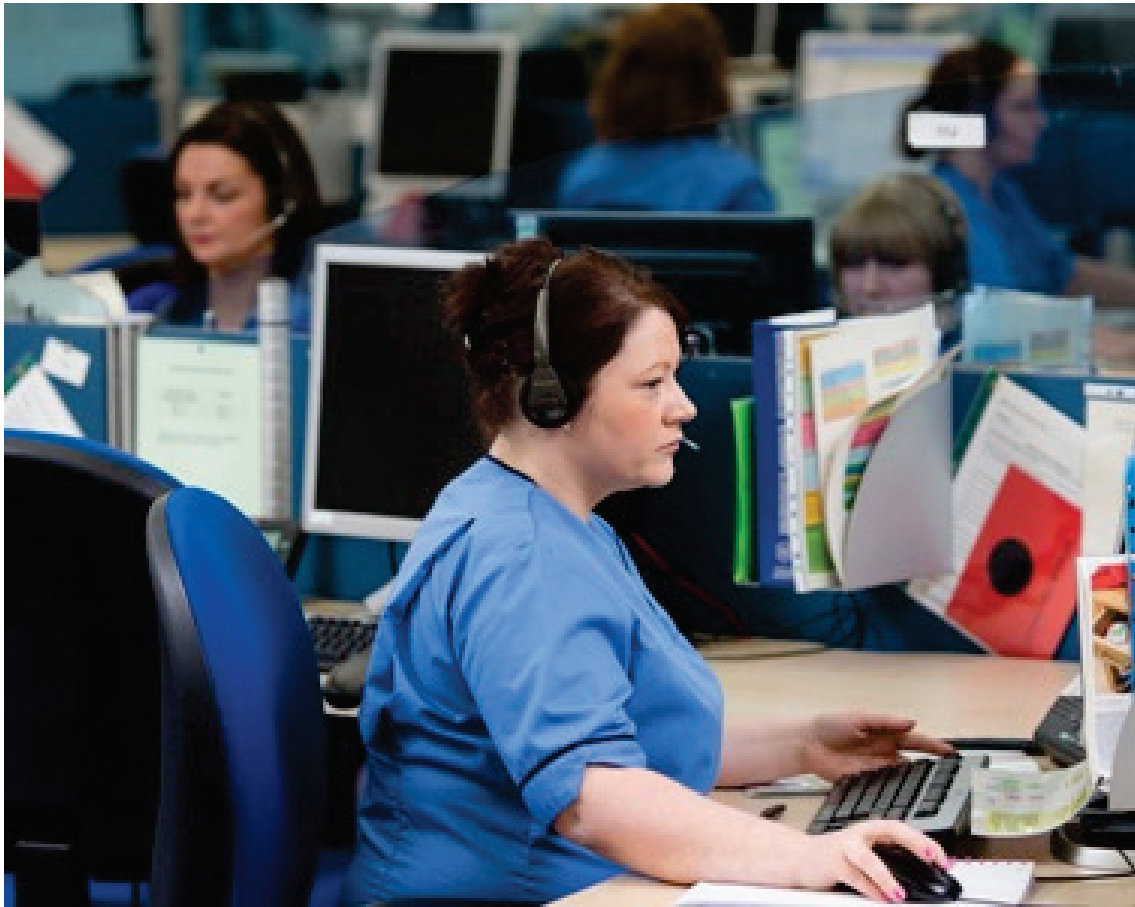
Who will support and ensure these recommendations happen?

- We have spoken to and made recommendations about the third sector, the independent sector, Special Health Boards, Health Bodies and other agencies.
- Throughout the Review we heard about the future importance of Health and Social Care Partnerships and Integrated Joint Boards – that is reflected in our recommendations.
- We commissioned academic research to inform our deliberations and uncovered a lack of good evidence and evaluation of OOH Services We offer some priority areas for future research and have recommended that new models of care, such as proposed by the Review are properly piloted and rigorously evaluated.

- We are conscious of how ambitious some of our recommendations are and also their limitations - while some may be delivered in the short term others will take much longer.
- We would expect these recommendations to be considered carefully but also critically – the canvas is wide, but we need to prioritise and in some cases discard for good or unforeseen reasons.
- We have suggested guiding principles for new 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 have recommended robust planning to be developed at national and local levels to do determine what are likely to be quick wins and what are not. We thought about prioritising our recommendations, but felt that more detailed deliberations would be required, which would fall outwith our allotted timescale for conducting the Review. The recommendations need wider scrutiny and that is our intention, taking into account stringent resource constraints. However, because of current difficulties and serious challenges ahead, we cannot tarry and need to press on with resolve.
 - We need to ensure best use of resources and have offered some proposals regarding financial planning for some of the strategic developments recommended.



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

2 Executive Summary

Purpose: This Section reproduces the Executive Summary from the Full Report, in order to assist accessibility and best use. The Chapters and Annexes referred to are in the Full Report and the OOH Review website is also referred to: <http://www.gov.scot/Topics/Health/Services/nrpcooh>

Chapter 1 – Key Messages

Headline issues addressed by the Primary Care Out of Hours Review are summarised and high level recommendations made.

Chapter 2 – Recommendations:

Describes and summarises the recommendations made by the Review. These recommendations were synthesised from the views of the public, health and social care professionals, of professional organisations and bodies, published literature and research commissioned by the Review.

Chapter 3 – Review Purpose, Process and Engagement

- A Review Group was established to lead 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 as [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 website](#).
- 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 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 ongoing 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 primarily established 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 the 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 AHP, 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 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 commonweal ([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 on to 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, 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.



Community Pharmacy Team at work

3 Recommendations

Purpose: This section reproduces the list of recommendations in the Full Report. The list is lengthy and ambitious, but reflects the need for trans-sectoral transformational, rather than incremental change.

Recommendations 1-4: reflect the need for better, innovative models of care which will improve coordination, communication and more effective multidisciplinary care across the care sectors.

Recommendations 5-7 address the need for patients to know how to make best and responsible use of services, according to need and to support best self-care, where appropriate. The needs of some specific groups are addressed, including accessibility and health inequalities issues.

Recommendations 8-19 reflect the need for compelling and pressing action to shore up and rapidly enhance the capability of an increasingly diverse and multidisciplinary workforce. We must work and learn together more closely and effectively around the needs of patients and carers, in common endeavour. Joint organisational development programmes will be a key component.

Recommendation 20 makes recommendations of how we must improve quality and safety of OOH services, underpinned by a clear service specification.

Recommendation 21 calls for better access to electronic patient records across all sectors to the right information, for the right patient is available at the right time. Confidentiality and security must be assured at all times but we are equally obliged to make best use of information for best patient care.

Recommendations 22-24 addresses potential future roles of Health and Social Care Partnerships and Integrated Joint Boards, Special Health Boards and Public Bodies, the third and independent sectors and other agencies.

Recommendation 25 seeks to how best to promote person-centred care, health literacy and self management.

Recommendation 26 recognises the lack of good research and evaluation into OOH services and urgent community care and emphasises the need for robust evaluation of new developments.

Recommendation 27 robust national planning, replicated locally will be essential to prioritise plans for the development of future OOH and urgent care services.

Recommendation 28 considers finance, best use of resources, value for money and benefits realisation.

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

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 (McLean 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 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, prisoner care and Police Scotland 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.



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



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