

Greater Glasgow and Clyde NHS Board

Board Meeting
Tuesday 28th June 2016

Paper No: 16/43

Director of Planning and Policy

GP OUT OF HOURS SERVICES: CHANGES TO DRUMCHAPEL SERVICE.

Recommendation:

The Board is asked to:

- note the outcome of engagement on the relocation of the Primary Care Emergency Centre (PCEC) at Drumchapel Hospital to Gartnavel General Hospital;
- agree that the GP OOH services transfers to GGH as part of the transfer of all services from the site;
- note other work in progress to reshape GP OOH services;
- note the context of the outcome of the National Review of Out of Hours care.

1. INTRODUCTION AND PURPOSE

- 1.1 The Board considered a proposal to transfer the Primary Care Emergency Centre (PCEC) at Drumchapel Hospital to Gartnavel General Hospital at the February meeting and agreed that we should establish public engagement on that proposal. The paper to the February Board noted that the earlier decision to transfer Older People's services from Drumchapel Hospital meant that we needed to relocate the PCEC from the hospital. The proposal was that the service transferred to Gartnavel General Hospital.

2. CURRENT SERVICE

- 2.1. To set the context for this proposal the current GP Out of Hours Service provides the following:
 - A Home Visiting Service - this extends into Lanarkshire to cover Camglen and to Highland to cover Helensburgh and the Lochside.
 - A telephone advice service - this is provided from the Hub at Cardonald by the GP advisor who has a wide role in co-ordinating the service.
 - A pre-prioritised call service to support NHS24 - this is provided from the Hub at Cardonald
 - 10 Primary Care Centres which see patients who are directed by NHS24, Emergency Departments or self present. The service offers a patient transport service to and from these centres for patients who do not have their own transport.
 - The service is currently adjacent to Emergency Departments at Queen Elizabeth University Hospital, and Royal Alexandra Hospital and overnight at Inverclyde Royal Hospital.

- The service is co-located with Minor Injury Units at Stobhill ACH; Victoria ACH and Vale of Leven.
- There are two services in the West of the city, one at Drumchapel Hospital and one at Gartnavel General Hospital.

| Primary Care Emergency Centres | 2014/15 | 2015/16 | %age diff |
|---------------------------------------|----------------|----------------|------------------|
| Drumchapel | 12168 | 12354 | 2% |
| Easterhouse | 12297 | 12905 | 5% |
| Gartnavel | 8067 | 7220 | -10% |
| Greenock | 5366 | 5369 | 0% |
| Inverclyde | 619 | 599 | -3% |
| Lomond | 12387 | 12612 | 2% |
| Queen Elizabeth University Hospital | 9042 | 9600 | 6% |
| Renfrewshire | 14024 | 13985 | 0% |
| Stobhill | 18447 | 19708 | 7% |
| Victoria | 28496 | 29729 | 4% |
| Total PCEC by Final Outcome | 120913 | 124081 | 3% |

- 2.2. The GP OOH service is under consistent pressure due to the increasing lack of availability of GPs willing to participate in the GP Out of Hours service. This is further exacerbated at holiday periods where we experience higher levels of demand. We are regularly making short notice closures of centres when we do not have GP cover.
- 2.3. The current Drumchapel GPOOH services are open from 6pm to midnight Monday to Friday and 8am to midnight Saturday, Sunday and Public Holidays. Access to the Primary Care Out of Hours service is via telephone triage with NHS24. The GP Out of Hours service offers patient transport to pick up and return patients from their home to the centre.
- 2.4. 28% of attendances to Drumchapel PCEC are patients who arrive without having phoned NHS 24 and 72% come via NHS24. Of these referrals 4% required to be seen within 1 hour, 9% within 2 hours and 65% within a 4 hour period. 84% of the patients were treated by a Doctor and 16% by a Nurse. Children (0-15 years) accounted for 32% of attendances.
- 2.5. A postcode review of attendances to both Centres in the West has been undertaken 20% of the attendances at Drumchapel PCEC come from the Drumchapel postcode area.

| PCEC WEST GLASGOW - BASED AT GGH | | | Proportion of Current area flow | |
|----------------------------------|--------------------------------------|--------------------------------|---------------------------------|-------------|
| Postcode | Area | Proportion of overall activity | GGH | DRUM CHAPEL |
| G11 | Partick | 5% | 13.0% | 0.4% |
| G12 | Hyndland/Kelvindale | 5% | 12.0% | 0.5% |
| G13 | Jordanhill/Knightswood/Yoker | 13% | 6.0% | 18.0% |
| G14 | Scoutston/Yoker | 6% | 8.0% | 5.0% |
| G15 | Drumchapel | 13% | 1.0% | 20.0% |
| G20 | Maryhill/Woodside/Kelvinhill/Ruchill | 8% | 17.0% | 1.0% |
| G23 | Summerston | 2% | 3.0% | 0.6% |
| G3 6/7/8 | Woodlands/Kelvingrove/Yorkhill | 4% | 11.0% | 0.1% |
| G40 | Bridgeton/Calton/Dalmarnock | 1% | 2.0% | 0.0% |
| G4 9 | Port Dundas | 1% | 2.0% | 0.0% |
| G60 | Old Kilpatrick/Bowling | 2% | 0.2% | 3.0% |
| G61 | Bearsden | 8% | 1.0% | 12.0% |
| G62 | Milngavie | 3% | 0.6% | 5.0% |
| G81 | Dalmuir/Faifley/ Duntocher | 17% | 2.0% | 27.0% |

3. RATIONALE FOR CHANGE

- 3.1. The OOH service uses a small area at Drumchapel Hospital, all other services will be withdrawn from the hospital building over the next few months. Retaining a small service in the building for a few hours a week would not be viable or enable a sensible future use of the site
- 3.2. This leaves the Board with a decision to make about the future location of the service. The proposal on which the Board agreed to engage was the transfer of the service to provide a single west Glasgow service at Gartnavel General. That proposal was based on a number reasons which are set out in the rest of this section.
- 3.3. Our initial analysis indicated that Gartnavel general is an accessible site for this catchment area. In the light of concerns raised about access a more detailed analysis was undertaken by representatives from the Stakeholder Reference Group and Patient and Public Involvement Team. This looked at public transport and accessibility, comparing journeys to Gartnavel Hospital and Drumchapel Hospital, from various points in the catchment areas served by both. The report found that Gartnavel General Hospital was easier to reach by bus and train than Drumchapel Hospital. This analysis is at Attachment 1 to this paper.
- 3.4. Merging the two West services at Gartnavel General Hospital provides the clinically desirable colocation with wider acute services and would create a service which is more durable to cope with demand than two smaller services. The service would be staffed by both GPs and Nurse Practitioners and would be supported by the Home Visiting GP.
- 3.5. The consolidation of the services into a single service with larger staff numbers gives greater resilience to the GP staffing issues which are regularly experienced across GP OOH enabling us to reduce the number of unplanned closures, which are a major issue for the service and for patients.
- 3.6. The transfer would affect on average 23 patients a night, 64 patients on a Saturday and 63 patients on a Sunday who currently attend the Drumchapel service.

- 3.7. Any patient who is asked to visit the PCEC and does not have their own transport will be collected from and returned to their home. This fact combined with the analysis of access to both sites we have undertaken confirms that there is no significant disadvantage to patients from this proposed transfer;
- 3.8. This relocation gives the service the opportunity to:
- deliver a sustainable workforce at GGH to ensure a responsive and flexible service with a range of staff with the right skills available to meet all expected urgent clinical conditions;
 - improve clinical safety including by delivering colocation with acute services having access to on-site support for patients who become unwell.
- 3.9. In addition to these positive improvements for West Glasgow, this change would also allow us to redeploy staff to create nursing support at the RAH centre, which is currently without that input. This is contributing to major issues in securing GP cover. Transferring a nursing resource will significantly improve the working environment.
- 3.10. A final benefit of the proposal is that it enables us to begin to address the financial challenges caused by changes to the tax treatment of GPs working in out of hour's services and the need to increase remuneration to get GPs to provide sessions. The service has a substantial underlying deficit which has been non recurrently covered. HSCPs will need to work with the Board to address this position; this proposal provides an opportunity to contribute savings through a reduction in support service costs by reducing the number of sites from which the service is operational.

4. ENGAGEMENT PROCESS

- 4.1. The service is located in Glasgow City but serves a wider population, we therefore discussed with the Chief Officers of Glasgow City, West Dumbarton and East Dumbarton the approach to engagement. The engagement process reflected our shared view that the proposal to move GP OOH service from Drumchapel Hospital to Gartnavel General Hospital, would have a limited impact on patients, offers an improved and more robust service, with minimal accessibility issues and is a reasonable response to wider changes at the Hospital and pressures on the service.
- An easy to read, plain English accessible information leaflet was produced. This set out the proposal, the main reasons behind it and how people in the service catchment area could get further information or provide comment.
 - The leaflet and an accompanying letter was emailed or sent out by post to approximately 200 contacts. This included:
 - all community groups on NHSGGC involving people database within the PCEC catchment area;
 - all councillors with constituents within the catchment area of the PCEC;
 - all community councils from within catchment area of PCEC;
 - all contacts on Glasgow Council for Voluntary Services West Glasgow health related interests on its database within the PCEC Catchment area;
 - East Dunbartonshire Voluntary Action for distribution to their database of 200 community contacts.

- Information about the proposal, the leaflet and Board Paper was made available on the NHS Greater Glasgow and Clyde website. Notification of the proposal, the engagement and a link to the webpage was made on NHSGGC's Twitter account.
- An article was written for NHSGGC Staff Newsletter which has 16,000 copies printed and distributed throughout acute and community premises, plus an online link is emailed to all GGC email addresses.
- Two open information and awareness sessions were held in West Glasgow on 31 May 2016 with poster presentations detailing the proposal, how to access OOH services and comparing the accessibility across the sites.
- Given the service is based in Drumchapel the views of local GPs were sought.

5. KEY ISSUES RAISED ABOUT THE PROPOSAL

5.1 This section outlines and responds to the issues raised in the engagement.

Deprived area: concerns were raised about the transfer of a service from a deprived area. A full EQUIA has been undertaken the key issue identified was access to the GGH site, the mitigation to this concern has two elements:-

- a detailed transport assessment (Attachment 1) confirms that for most of the catchment population GGH is more accessible than Drumchapel Hospital;
- transport is provided for patients who cannot make their own arrangements.

Clinical case for change: the basis of the clinical case for change was challenged by some respondents; the Clinical Director for the service has confirmed the points below are important:

- the pressures on the current services have increased; the lack of GPs willing to provide cover has led to regular closures of sites. Consolidation at GGH makes best use of the clinical workforce by creating more sustainable clinical staffing and ensures a resilient service;
- the service is best provided on a site with a wider range of clinical services and facilities.

Information for patients: the importance of clear public information on the revised location and opening times was highlighted including the opportunity to use voluntary organisations to explain how to access the service and to clarify that transport is provided if required.

Capacity: Knightswood Community Council raised concerns about the capacity of the service to deal with increased numbers on one site. The single clinical service will have similar resources to the two current services and will therefore be better able to cope with peaks and troughs in workload.

Car parking at GGH: The Claythorn Community Council queried the availability of car parking at GGH. There is substantial car parking on the GGH site which is reserved for staff during the day, we need to ensure this is clearly signed for patients out of hours;

West Dunbartonshire HSCP have made the following response:

While we welcome the process of consultation that the Health Board and Glasgow City Health & Social Care Partnership are currently engaged in, we are unclear about the why this specific proposal is being consulted upon in advance of the completion of the recently initiated GGC-wide review of primary care out of hours provision. Nonetheless, with respect to the Drumchapel Service, our view is that the current arrangements are well-regarded locally and that the proposed change would have a detrimental impact on access and reduce local provision of services. As such, the agreed response of our Partnership Board is that we do not support the proposal to move the Out of Hours Service from Drumchapel Hospital to Gartnavel Hospital. The Partnership Board also wanted clarity on the proposals for the future of the Drumchapel site and have asked for information to be taken back to them on this subject as soon as possible.

The HSCP response does not indicate what their concerns are, for the population they serve there it is difficult to see any adverse impact of a move of the service, accessibility is increased.

A response was received from an individual West Dunbartonshire Councillor indicating that GGH was more accessible for his constituents but noting that his preference was for a new service at the GJNH.

East Dunbartonshire and GCC HSCPs have not indicated any concerns about the proposal.

6. WIDER AREAS OF REVIEW

6.1 The February Board paper noted the wider review of GP OOH services. The focus of that review is to deliver sustainable and clinically appropriate services taking cognisance of the imperative to reduce demands on this service, in the light of GP workforce challenges; the aim to collocate GP OOH services with wider acute services and the financial pressures we need to address. The key current areas of review and current position are described below:

- **Increasing colocation:** in addition to this proposal we are working to transfer the Greenock service to the IRH to achieve a similar colocation.
- **Alternative care pathways:** we are working with NHS 24 to implement changes to care pathways which will reduce pressure on the service.
- **Nursing homes:** to reduce the numbers of time consuming home visits which put pressure on the service we are changing the interface with nursing homes to reduce demand.
- **Visits cars and centre:** we are working on development of changes to the relationship between centre based and home visit services which make better use of clinical resources.
- **Configuration:** we are assessing the potential for further changes in the configuration which enable us to address the continuing service and financial pressures on the service.

There is nothing within these areas of review which is at odds with or suggests the proposed change in West Glasgow should not proceed. Our consideration of these changes for GP OOH services does not comprehensively address the recommendations of the national review led by Sir Lewis Ritchie. The recommendations of that review are Attachment 2 to this paper. The consideration of the Ritchie review will be led by HSCPs and covers a much wider range of services.

7. CONCLUSION

7.1 There are a number of conclusions from our work on this proposal:

- it is not viable for the OOH service to remain on the Drumchapel site when the main hospital services transfer to GGH;
- there is clear clinical case for transfer to GGH which would offer a reliable and clinically sustainable service;
- the transfer to GGH is in line with the wider work we have undertaken and is not at odds with the national strategic direction;
- the GGH site has better transport access for the catchment population and for patients who require transport, for clinical or financial reasons, transport is provided.
- patients who cannot access a centre will continue to be provided with home visits;
- We have addressed the issues raised in the engagement process.

The alternative to consolidating the service at GGH would be to open a replacement service elsewhere in the catchment area. In the light of the clinical advice, the workforce and financial pressures; and the fact we can address equalities, and access concerns through an amalgamation onto one site, it is difficult to make a case for a new standalone provision of the service.

TRAVEL AND ACCESS ASSESSMENT FOR DRUMCHAPEL HOSPITAL AND GARTNAVEL GENERAL HOSPITAL

Summary

Having compared transport provision and accessibility issues, relating to journeys to Gartnavel Hospital and Drumchapel Hospital from various points in the catchment areas served by both, it was found that **Gartnavel General Hospital is easier to reach by bus and train than Drumchapel Hospital.**

A part of this assessment explored issues that might be faced by people with restricted mobility or those unfamiliar with the area. This physical accessibility audit was undertaken by a manager from NHS GGC's Patient Experience Public Involvement Team, trained in doing accessibility audits, together with a member of the Stakeholder Reference Group, a resident in Drumchapel.

Table 1: Comparison of Gartnavel Hospital and Drumchapel Hospital Bus Access

| | Gartnavel Hospital | | Drumchapel Hospital | |
|-------------------------------|--------------------|--------|---------------------|--------|
| | Stop A | Stop B | Stop A | Stop B |
| Bus shelter | ✓ | ✓ | ✓ | X |
| Real time information | ✓ | X | X | X |
| Raised Kerb | ✓ | ✓ | X | X |
| Designated road crossing | ✓ | ✓ | X | X |
| Is the route to entrance flat | ✓ | ✓ | X | X |
| Distance to hospital | 418m | 70m | 321m | 419m |
| Buses per hour | 15 | 5 | 8 | 10 |
| Total buses | 20 | | 18 | |

Table 2: Comparison of Gartnavel Hospital and Drumchapel Hospital Train Access

| | Gartnavel Hospital Hyndland Station | Drumchapel Hospital Drumchapel Station |
|-------------------------------------|--|---|
| Accessible | ✓ | X |
| Designated road crossing | ✓ | X |
| Distance to hospital | 480m | 801m |
| Is the route to entrance flat | ✓ | X |
| Direct service from catchment areas | 6 | 2 |
| Trains per hour at station | 28 | 8 |

Table 3: Comparison of Gartnavel Hospital and Drumchapel Hospital Bus Travel

| Catchment Area | Gartnavel Hospital | | Drumchapel Hospital | |
|----------------|--------------------|--------------------------|---------------------|--------------------------|
| | Buses Required | Journey* Time in Minutes | Buses Required | Journey* Time in Minutes |
| Clydebank | 1 | 32 | 1 | 24 |
| Knightswood | 1 | 20 | 1 | 32 |
| Bearsden | 1 | 23 | 3 | 50 |
| Kelvindale | 1 | 13 | 2 | 73 |
| Drumchapel | 1 | 26 | 1 | 12 |
| Hyndland | 1 | 8 | 1 | 49 |
| Scotstoun | 1 | 24 | 1 | 25 |
| Maryhill | 2 | 39 | 2 | 44 |

*Times given are average maximum times

Table 4: Comparison of Gartnavel Hospital and Drumchapel Hospital Train Travel

| Catchment Area | Gartnavel Hospital | | Drumchapel Hospital | |
|----------------|--------------------|--------------------------|---------------------|--------------------------|
| | Trains Required | Journey* Time in Minutes | Trains Required | Journey* Time in Minutes |
| Clydebank | 1 | 14 | 2 | 31 |
| Knightswood | 1 | 8 | 2 | 30 |
| Bearsden | 1 | 10 | 2 | 24 |
| Kelvindale | 2 | 16 | 2 | 31 |
| Drumchapel | 1 | 10 | - | - |
| Hyndland | - | - | 1 | 10 |
| Scotstoun | 1 | 6 | 2 | 34 |
| Maryhill | 2 | 18 | 2 | 33 |

*Times given are average maximum times

Drumchapel Hospital by Bus

The Drumchapel Hospital site has one point of access on 129 Drumchapel Road. Access to Drumchapel Hospital travelling by bus is by one of three bus stops that serve the hospital (these are illustrated on Figure 1):

- Bus stop A is located on Drumchapel Road and is 321m (351 yards) from the main entrance. The stop has a shelter, but does not have real time information or a raised kerb. The walk to the hospital is described as uphill, and requires 1 road crossing which is not designated.
- Bus stop B is located on Drumchapel Road and is 419m (460 yards) from the main entrance. It does not have a bus shelter, real time information or a raised kerb. The walk to the hospital is described as uphill, and requires 1 road crossing which is not designated

Figure 1: Drumchapel Hospital Bus Stops

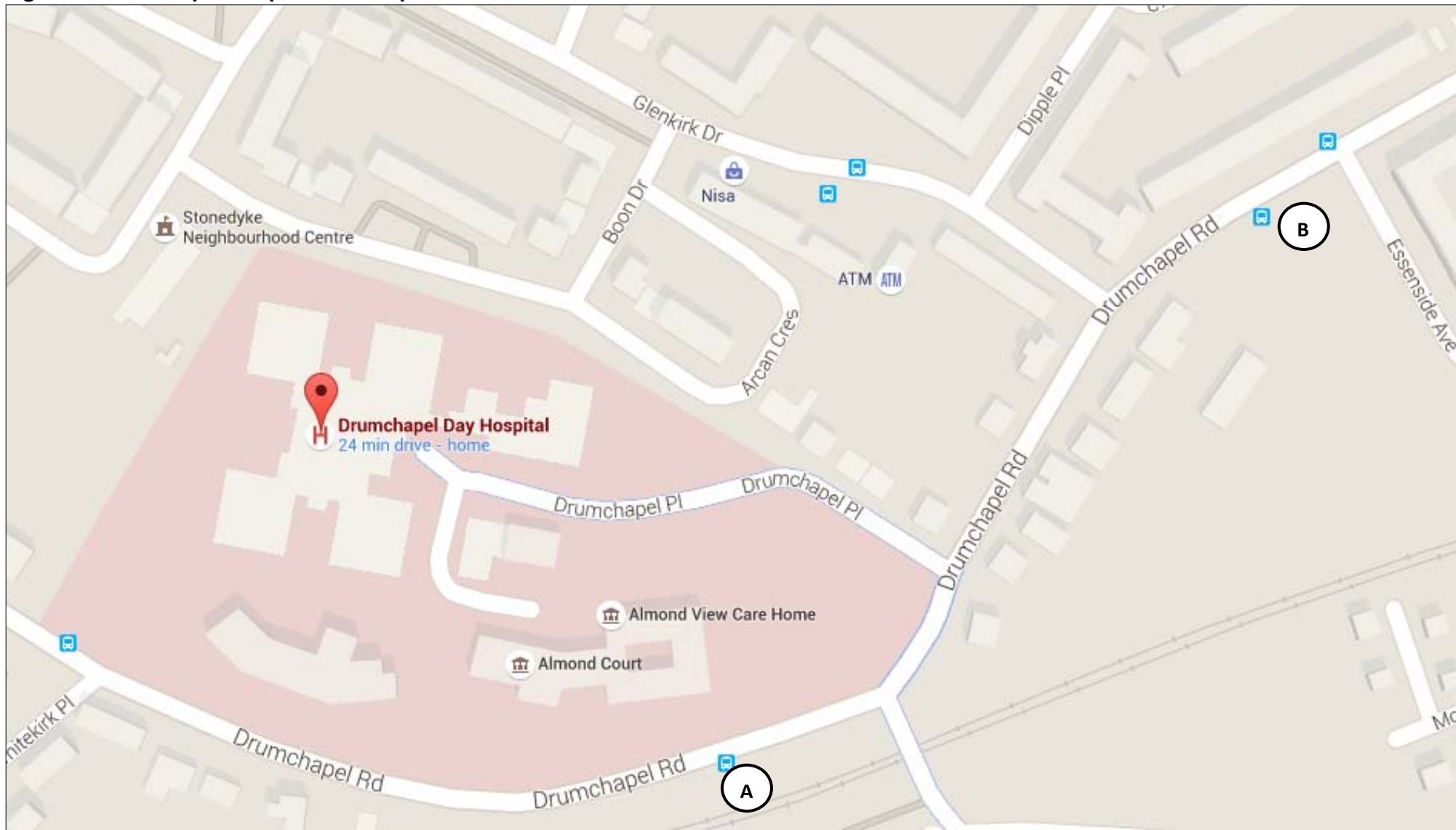


Table 5: Drumchapel Hospital Bus Information

| Bus Stop | Service | Route | Frequency | Catchment areas served |
|----------|--------------|---|------------------|--|
| A | First 3 | Govan to Drumchapel | Every 10 minutes | Knightswood Drumchapel Scotstoun |
| | First 16 | Queen Elizabeth University Hospital to Drumchapel | Every 30 minutes | |
| C | First M 60 | Clydebank to Drumchapel | Every 14 minutes | Clydebank Drumchapel |
| | Avondale 200 | Clydebank to Drumchapel | Every 10 minutes | |

Gartnavel Hospital by Bus

The main entrance to Gartnavel General Hospital is on 1053 Great Western Road. Access to Gartnavel General Hospital travelling by bus is by one of two bus stops that serve the hospital (these are illustrated on Figure 2):

- Bus stop A is on Great Western Road travelling east towards the city centre and is 418m (459 yards) from the main entrance. The stop has a shelter, real time information, and a raised kerb. The walk to the hospital is described as flat and very well signposted once on the Gartnavel site. No non-designated road crossings are required.
- Bus stop B is within the Gartnavel General Hospital site 70m (76 yards) from the main entrance. The stop has a shelter, a raised kerb, but does not have real time information. There on the very short walk to the entrance that is described as flat. No non-designated road crossings are required.

Figure 2: Gartnavel Hospital Bus Stops

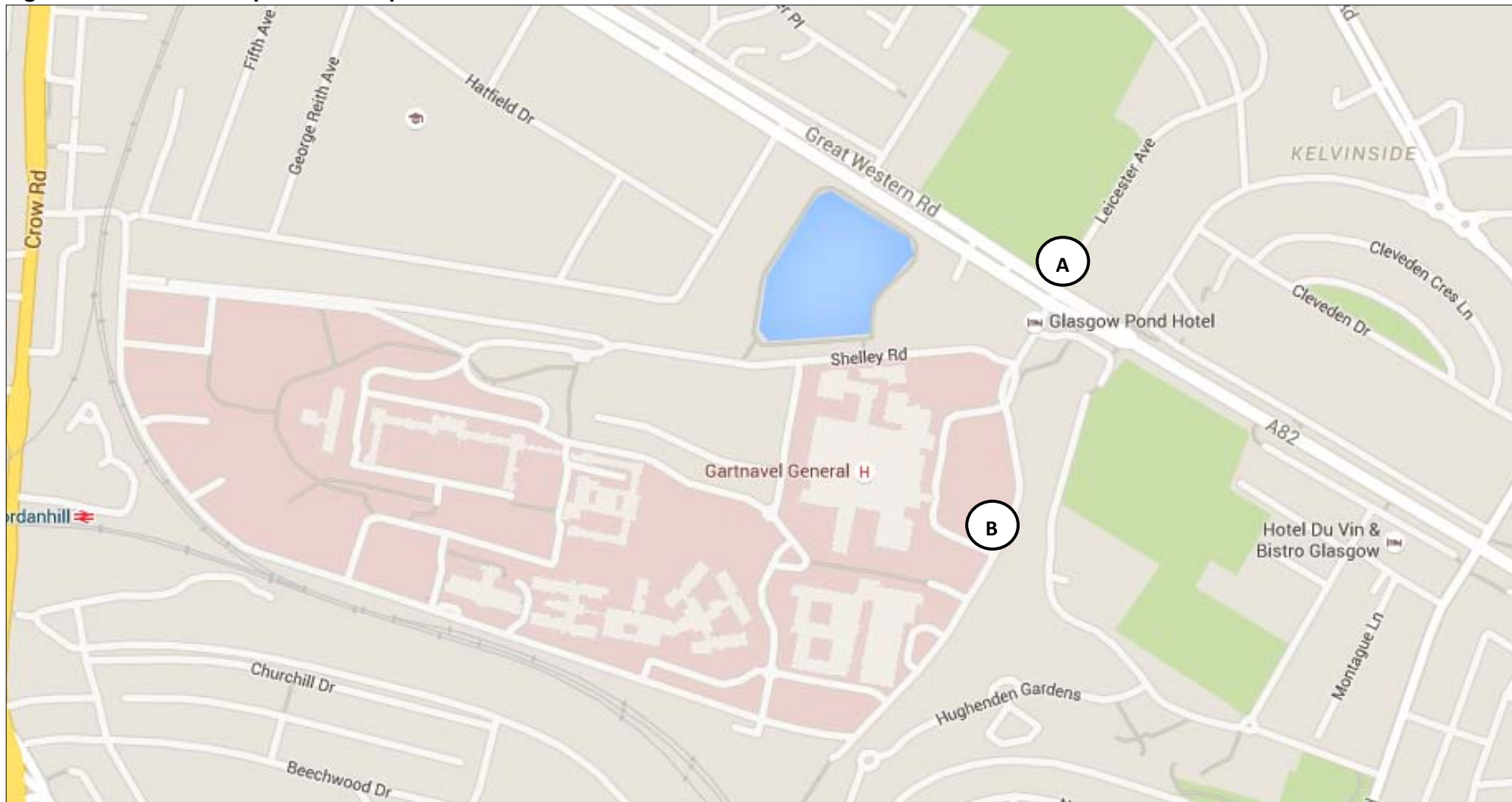


Table 6: Gartnavel Hospital Bus Information

| Bus Stop | Service | Route | Frequency | Catchment areas served |
|----------|--------------|---------------------------|------------------|---|
| A | First 6 | Clydebank | Every 8 minutes | Clydebank Knightswood Drumchapel Scotstoun Bearsden |
| | First 6a | Drumchapel to City Centre | Every 10 minutes | |
| | Citybus 15 | Milngavie to City Centre | Every 40 minutes | |
| B | McGill's 11 | Gartnavel to Clydebank | Every hour | Clydebank Knightswood Bearden Kelvindale Hyndland |
| | McGill's 118 | Hardgate to Gartnavel | Every hour | |
| | McGill's 141 | Partick to Gartnavel | Every 45 minutes | |
| | First M11 | Clydebank to Gartnavel | Every 30 minutes | |

Drumchapel Hospital by Train

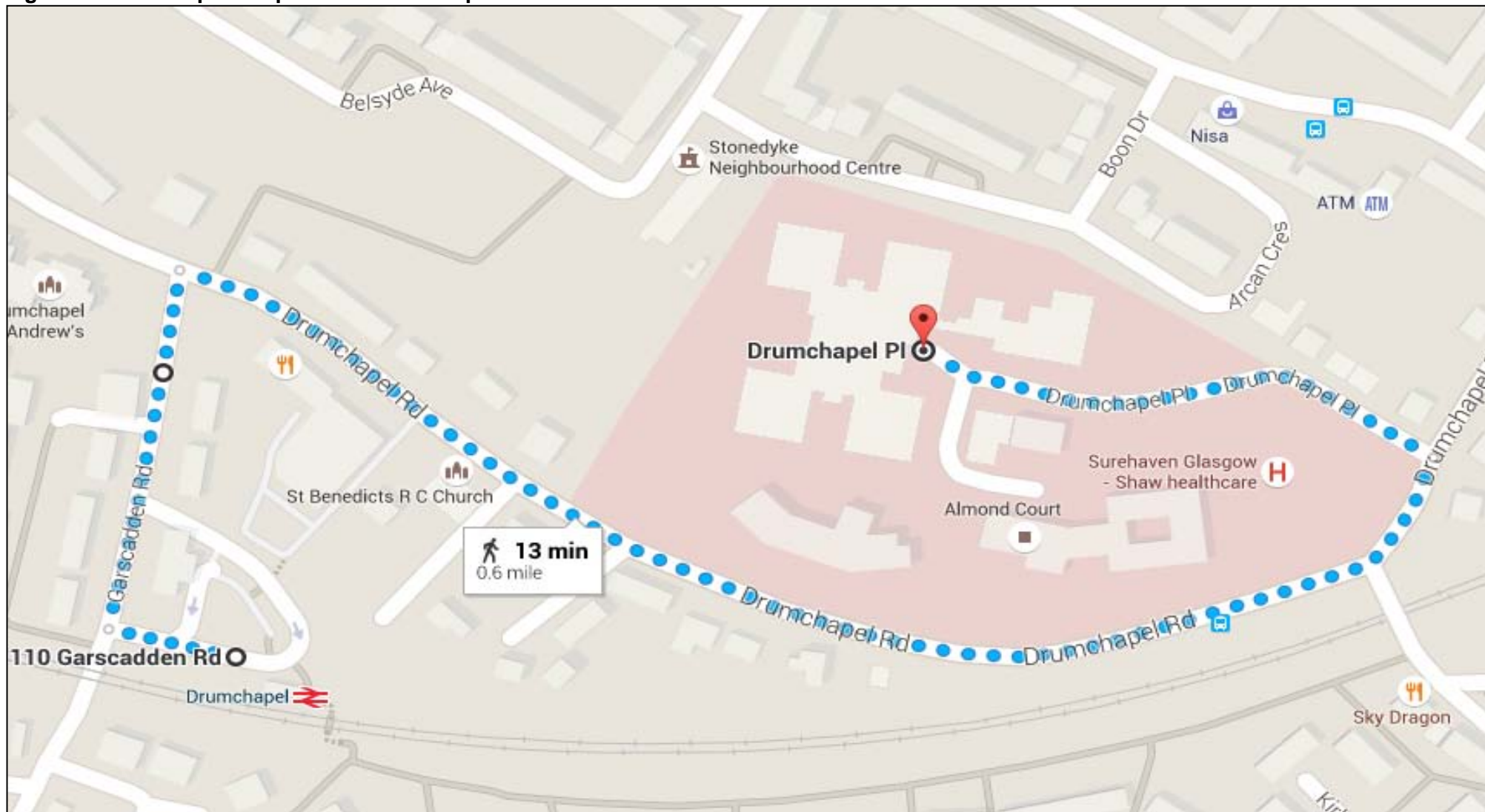
The nearest train station to Drumchapel Hospital is Drumchapel station located on Garscadden Road (illustrated in Figure 3). The main entrance to Drumchapel Hospital is 801m (880 yards) away from Drumchapel station. There is no signage for Drumchapel Hospital at the train station. From the eastbound platform it is not possible to have step free access out of the station. The walk from Drumchapel station to Drumchapel Hospital is uphill. Three non-designated road crossings are required.

There are 8 trains per hour at Drumchapel station, 4 per hour eastbound and 4 per hour westbound. The train routes are:

- Dalmuir to and from Larkhall
- Balloch to and from Airdrie
- Helensburgh to and from Edinburgh
- Dalmuir to and from Motherwell/Whifflet

Two of the catchment areas have a direct train Drumchapel station with the other 6 requiring a connecting train.

Figure 3: Drumchapel Hospital and Drumchapel Train Station



Gartnavel Hospital by Train

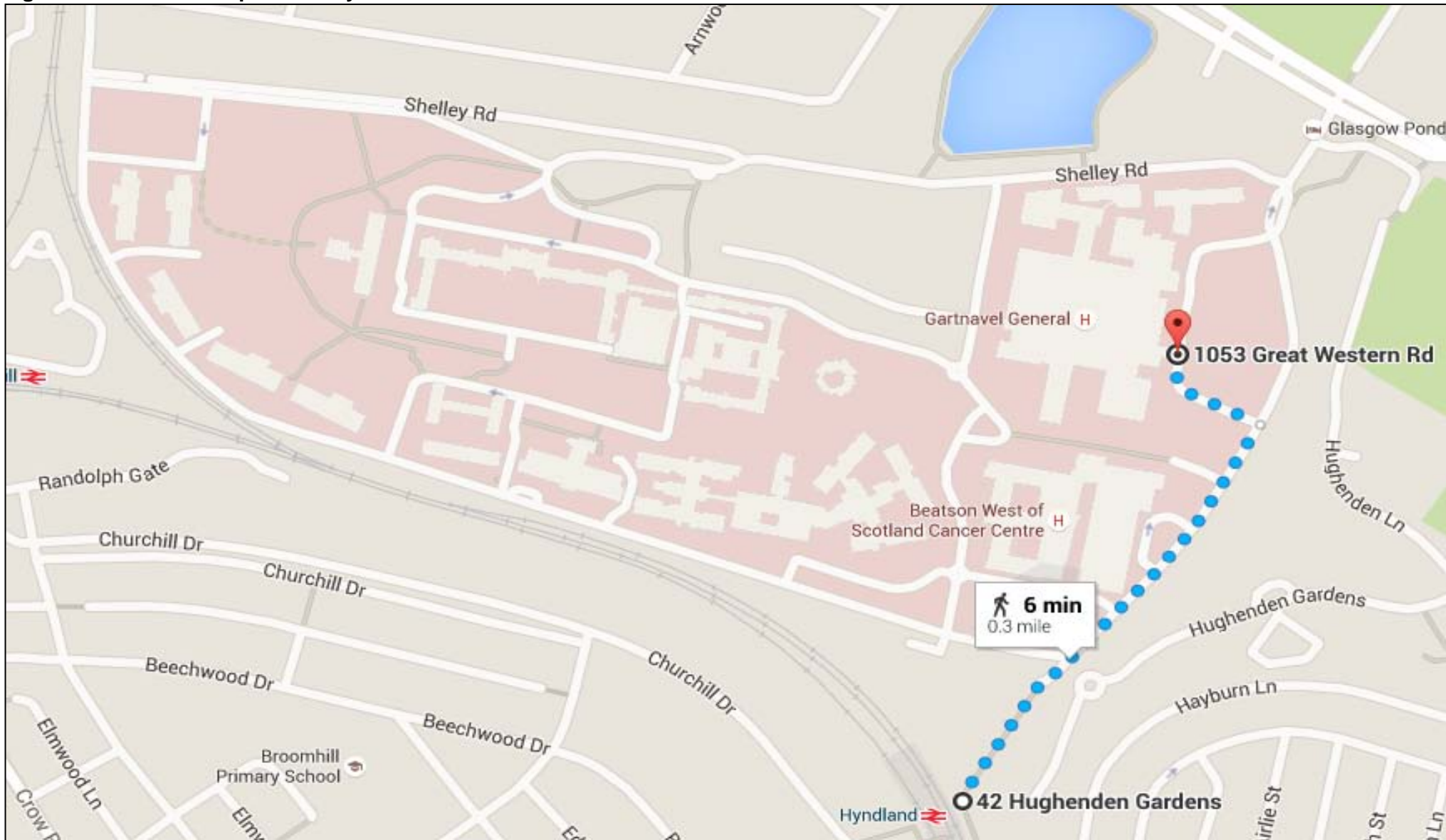
The nearest train station to Gartnavel Hospital is Hyndland station and is connected to the grounds of Gartnavel Hospital (illustrated in Figure 4). The main hospital entrance is 480m (528 yards) away. The walk from station is well signposted, flat, and on hospital grounds.

There are 28 trains per hour at Hyndland Station, 14 per hour eastbound and 14 per hour westbound. The train routes are:

- Dalmuir to and from Motherwell
- Dalmuir to and from Larkhall
- Balloch to and from Airdrie
- Helensburgh to and from Edinburgh
- Milngavie to and from Edinburgh
- Dalmuir to and from Lanark
- Dalmuir to and from Carstairs
- Milngavie to and from Cumbernauld
- Hyndland to and from Edinburgh
- Helensburgh to and from Edinburgh
- Dalmuir to and from Airdrie
- Garscadden to and from Edinburgh
- Dalmuir to and from Edinburgh

Six of the catchment areas have a direct train to Hyndland station with the other 2 requiring a connecting train.

Figure 4: Gartnavel Hospital and Hyndland Train Station



RITCHIE REVIEW RECOMMENDATIONS

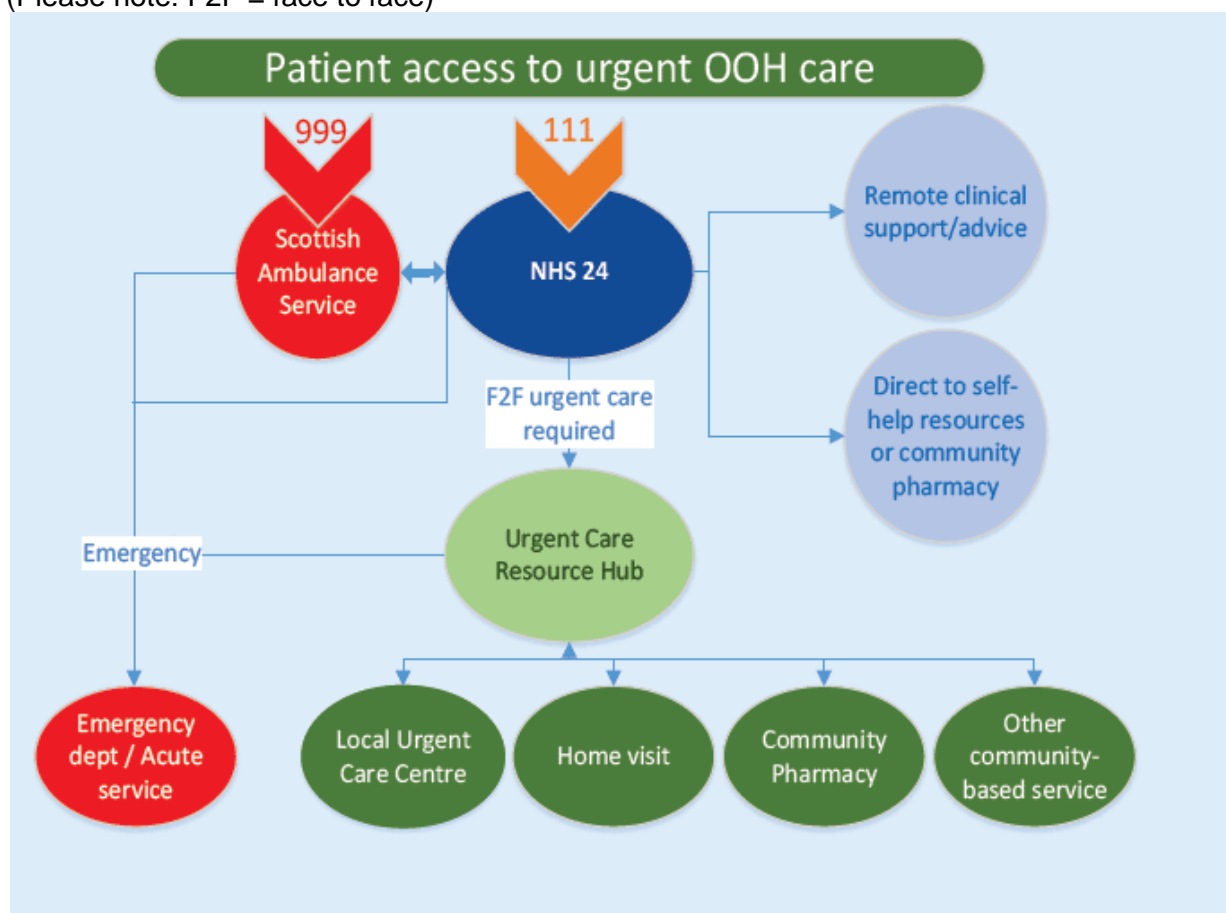
Recommendation 1 - A New Model of Care for Out of Hours and Urgent Care Services

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.