Building on Success: Examples of Progress in Unscheduled Care

August 2010
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Introduction

The Better Health, Better Care Action Plan\(^1\) commits the Scottish Government Health Directorates to developing a more integrated approach to the delivery of unscheduled care across NHSScotland. This guide set out a number of recent developments in this area, many of which have been overseen by the Unscheduled Care Advisory Group.

As we seek to continue to evolve and improve unscheduled care services in the context of the NHS Quality Strategy, an Unscheduled Care conference\(^2\), was held in Dundee on 25 June 2010. The conference reflected on the achievements that have been made across NHSScotland in managing unscheduled care since the Better Health, Better Care Action Plan was published in 2007 and aimed to embed principles and practice for the future.

The purpose of this guide is to set out the various areas of good practice that were showcased or mentioned by NHS Boards at that event to help inform other NHS Boards of the good practices that exist and to also shape the future provision of a safe, effective and person-centred approach to unscheduled care. This guide also provides a note of the suggestions and recommendations that were made at the conference plenary and workshop sessions which NHS Boards may find helpful when developing local services as appropriate.

We are grateful to everyone who provided us with their good practice contributions for inclusion in this guide. Should other individuals, groups and/ or NHS Boards wish to similarly share their areas of good practice with us and a wider forum, please send them to Callum.Percy@scotland.gsi.gov.uk Any additional information received will be added to this good practice guide and revised versions will be regularly updated on the Shifting the Balance of Care website –

http://www.shiftingthebalance.scot.nhs.uk/

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August 2010

\(^1\) Better Health Better Care Action Plan, Scottish Government Health Directorates, 12 December 2007
\(^2\) Unscheduled Care Conference, Apex Hotel, Dundee, 25 June 2010 – notes and presentation can be viewed at http://www.shiftingthebalance.scot.nhs.uk/news-and-events
Background

Definition

Unscheduled care refers to healthcare that is provided in an unplanned, reactive, relatively instant-access way. It covers accident and emergency, the 999 and urgent ambulance service, in-hours primary care, self care, pharmacy, NHS 24, General Practitioners, out of hours service, Minor Injuries Units and emergency dental services.

Commitments in Better Health, Better Care

The Scottish Government's strategy for a healthier Scotland - Better Health, Better Care Action Plan – was launched on 12 December 2007 and set out our overall approach to unscheduled care. Built upon the commitments and achievements in Delivering for Health³, the Action Plan recognised that a good system of unscheduled care is one which responds promptly when called upon, but also one which responds in a way that is appropriate to patient needs.

The key elements of unscheduled care in the Better Health, Better Care Action Plan include the following commitments:

- Continuing to develop a more integrated approach to the delivery of unscheduled care in each local area
- Increasing the use of “see and treat paramedics” enabling patients to be supported without unnecessary travel to hospital;
- Supporting the development of decision support networks to maximise care delivery in the pre-hospital environment;
- Extending access to primary care;
- Using joint “rapid response” services;
- Building on improvement in services of NHS 24; and
- Better use of the Emergency Care Summary to ensure joined up care.

Two main groups have been established to take this work forward:

1. The Unscheduled Care Advisory Group

The Unscheduled Care Advisory Group was formed in 2007 to support the delivery of the unscheduled care aspects of the Better Health, Better Care Action Plan. The group continues to meet regularly to discuss progress of the above commitments and has supported and funded relevant projects over the last two years – see page 6.

Membership of the group includes representatives from a range of NHS Boards and other stakeholder organisations, relevant Scottish Government policy leads and other experts (see membership at page 29). The group is chaired by Derek Feeley, Director of Healthcare Policy and Strategy.

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³ Delivering for Health, Scottish Government Health Directorates, 2 November 2005
2. Emergency Access Delivery Programme and the Team (EADT)

The overall aim of EADT is to support NHS Boards in shifting the balance of unscheduled care so that patients receive emergency care at the most appropriate level of the care system, as quickly and conveniently as possible.

The most specific objective of the Programme is to support NHS Boards in developing locally agreed targets and trajectories for the reduction of attendances at A&E. This will only contribute to the achievement of a more balanced system of unscheduled care to the extent that patients are attending Accident & Emergency (A&E) who could be ‘better treated elsewhere’. There is growing evidence that a significant proportion of patients treated in A&E are there not because it is the best place for them to be treated but because they have ended up there to some extent ‘by default’.

The programme functions by facilitating the development and sharing of innovative and evidence-based approaches across the emergency care system. In particular the Programme is keen to encourage a whole system approach to unscheduled care to help fully implement the commitment in *Better Health, Better Care* that ‘people can gain access to appropriate care first time by better linking the ambulance service, NHS 24 and other health providers’.

The Emergency Access Delivery Programme is steered by the Scottish Government-led Emergency Access Delivery Team which is an action-oriented group, meeting monthly, with representation from the main sectors of the system of unscheduled care. The EADT provides direction and support to Boards to sustain the maximum 4-hour A&E wait and co-ordinate whole-systems winter planning.

**Building on Success**

Improving unscheduled care has been, and continues to be, a national priority. Working within the national strategic framework, NHSScotland has made good progress over the past several years in building a more integrated system of unscheduled care, with the objective of delivering the right care, in the right place, at the right time. The system of unscheduled care is increasingly “joined-up” across agencies and responding promptly, but also in a way that is appropriate and tailored to the needs of patients.

The National Unscheduled Care Conference held on 25 June 2010 highlighted and celebrated the successes across Scotland in improving unscheduled care.

We need to build on this momentum. We need to ensure that there is a clear connect and understanding between the Quality Strategy ambitions and planning for a sustainable, high quality system of unscheduled care. Against the ambitions in the Quality Strategy the key areas for going forward include:

*Safe*

- Ensuring Emergency Centres deal with the most complex emergency cases;
- Ensuring that patients are seen, assessed and treated by the most appropriate health care professionals.
Effective

- Using telemedicine to integrated the various levels of the unscheduled care system, reducing inappropriate referrals;
- Reducing the rates of attendance at A&E;
- Increasing the use of “see and treat paramedics” and other rapid response initiatives to support patients to be appropriately cared for outside of hospital;
- Extending the Emergency Medical Retrieval Service to remote and rural Scotland.

Person-centred

- Continuing to deliver on the 4 hour A&E target;
- The Scottish Ambulance Service continuing to respond to 75% of Category A calls within 8 minutes;
- Ensuring that patients can access the most appropriate care first time by better linkages and flow of information (such as the Emergency Care Summary) between the Scottish Ambulance Service, NHS 24 and other health services.

Next Steps

We believe much has been achieved but clearly more needs to be done beyond this. One of the most significant challenges is around managing the increasing attendance and demand for emergency health care. We therefore need to ensure that good practice across Scotland becomes the norm and to accelerate the implementation of evidence based healthcare.
Key projects

This section provides information on 3 key projects that have been supported and funded by the Unscheduled Care Group over the last two years.

**NHS Forth Valley – Triple Aim Project**

The Triple Aim project has been used as a development framework to support the whole-system transformation of Acute and Urgent Care Services in NHS Forth Valley, involving Acute Hospital, Out of Hours and Primary Care Services.

The Project is working to:

- Improve the experience of people accessing emergency and urgent care and improve access to emergency specialist assessment, investigations and treatment;
- Transform the emergency and urgent care model across Forth Valley to manage demand and improve care services for the population, by supporting people in the community to prevent avoidable presentation to A&E and/or admission to the acute hospital; developing access to alternatives to attendance to A&E and/or admission to acute hospital; and by supporting earlier discharge to the community; and
- Demonstrate value for money in the delivery of emergency and urgent care.

The Scottish Government Health Directorates provided £421,000 to NHS Forth Valley over 2008-09 and 2009-10 to support Triple Aim until March 2011.

Early results of the project have shown that a number of new ways of working have been implemented and initial data confirm these are proving to be very successful – for example, the average number of emergency admissions in Forth Valley has fallen from 40 per day in August 2008 to 28 per day in August 2009 – a drop of 30%.

**NHS Lanarkshire - NHS Emergency Response Centre (ERC)**

The concept of the ERC pilot is to provide an integrated process whereby the four key agencies involved in the management of emergency care patient flows – NHS 24, Primary Care and Primary Care Out of Hours, SAS and the local Acute Division – work more closely together in a co-located facility, to ensure that patients are:

- directed to the most appropriate clinical service in the most appropriate place, and
- seen by the most appropriate person on a timescale commensurate with their clinical needs.

NHS Lanarkshire received funding from the Scottish Government Health Directorates of £400,000 over 2008-09 and 2009-10 to develop this process.
Feedback from local GPs has been encouraging and further work is ongoing. The Centre has allowed for early identification of emerging pressures or extreme incidents by providing a central point of focus for all departments and partners, as well as by monitoring all aspects of emergency response throughout the Board.

As a result, rapid communication occurs between NHS 24, Primary Care and Primary Care Out of Hours, SAS and the local Acute Division, creating opportunities to reprioritise and redeploy resources to most effectively meet the needs of patients. NHS Lanarkshire has also improved its performance in meeting the 4 hour target.

**NHS Grampian ‘Know who to turn to’ social marketing pilot**

The Scottish Government Health Directorate provided funding of £250,000 to NHS Grampian to develop an approach to marketing Unscheduled Care Services with a view to reducing inappropriate referrals. The aim of the pilot marketing campaign was to raise awareness of the Unscheduled Care Services available in NHS Grampian and to inform the public about which services to use and when. Six options for the most appropriate medical assistance were outlined:

- Self care
- Pharmacist
- GP
- NHS Out of Ours Service
- Minor Injuries Unit
- A&E/999

The pilot ran from May to August 2009. Following the evaluation of the pilot, *NHS Grampian - Unscheduled Care Campaign - Summary*, the Scottish Government Health Directorates provided funding and a toolkit to NHS Boards to support marketing unscheduled care services by raising patient and public awareness.

More information on the ‘Know who to turn to’ pilot is provided in the next section.
Good practice examples across NHSScotland

This section provides a note of the good practice examples that were showcased or referred to at the Unscheduled Care conference, which may help other NHS Boards in developing their thinking around future planning and provision of a safe, effective and patient centred approach to unscheduled care.

NHS Ayrshire & Arran

Redirection of patients from A&E to appropriate Health Care Providers

Context

A range of work has been underway in NHS Ayrshire & Arran on the redirection of patients from A&E to appropriate healthcare providers. In November 2009 a multidisciplinary working group was established, and several facilitated workshops have taken place which have focussed on what would be appropriate for redirection of patients from A&E, culminating in the agreement of draft redirection algorithms.

Separate subgroup meetings have also taken place in parallel, focussing on patient redirections from A&E to the Community Pharmacy Minor Ailment Service, the Emergency Dental Service and the Occupational Health Service. Redirection algorithms were drafted and agreed, and it was ensured that the redirections group was kept up to date with the outcomes of such meetings.

Where the Board is now

Many of the draft redirection work has now reached pilot phase, and the PDSA approach was used in preparation for the pilots at the workshops. A&E colleagues are kept up to date with redirections progress through monthly Emergency Department staff bulletins. All algorithms are laminated and available at the point of triage. Data collection is currently by manual audit sheets completed by the Triage Nurse at the time of redirection. Work is currently being undertaken to facilitate data collection via IT Symphony.

Redirection of patients presenting at A&E to:

Occupational Health Department for NHS Ayrshire & Arran Staff – Pilot started on 6th April 2010 and ongoing, with 18 redirections of patients from A&E to the service so far. Issues arising during the course of the pilot have been corrected following swift meetings between the service leads, the redirections lead and the facilitator.

Emergency Dental Service – Pilot started on 12th April and ongoing, with 33 redirections of patients from A&E to the service so far. Issues arising have been corrected as above. Our Dental colleagues are currently awaiting guidance from Clinical Governance regarding an ‘exclusions’ box on the algorithm, following which there will be an update.
Community Pharmacy Minor Ailments Service – Pilot started on the 4th May and ongoing, with 6 redirections so far. 7 re-directions are being trialled as part of this pilot which received professional committee and sub-contractor approval (Athlete’s Foot, Cough, Request for Emergency Contraception, Run out of repeat medication when GP Practice is closed, Skin complaint, Sore throat, Warts and Verruca). No known issues so far.

NHS ADOC – Pilot launched on 7th June and includes trialling of 7 redirection algorithms (ENT, Eye condition/ problems, Headache, Muscular back pain (no trauma), Skin condition/ problem). Data collection: A&E Symphony and NHS ADOC electronic system. No known issues so far. Stake holder group planned for feedback and evaluation of data to date

3 Day Guideline – Consultant led 3 day and over redirections to GP based on NHS Tayside model. Several snapshots have taken place at Crosshouse and Ayr, with a further snapshot scheduled for 19th July. Snapshot results have shown there is potential for 3-4 redirections to GP over a ~4 hour period on a busy day e.g. Monday. Data collection: manual at the time of the snapshot

Next steps: Continue pilots with a view to potential expansion of inclusion criteria in the future, and work is currently underway for redirection to the Early Pregnancy Assessment Suite (EPAS).

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MINTS (Minor/ Major Injury/ Illness Nurse Treatment Service) pilot

A roll out of the MINTS Major pilot took place between 4th January 2010 and 31st March 2010, within the Acute Medical Receiving units of NHS Lanarkshire.

Practitioners supported the medical teams reviewing low acuity patients using set criteria which included presenting condition, age and MEWS score. All decisions around discharge and onward referral were taken by senior medical teams for the duration of the pilot.

Evaluation included clinical skills assessments and staff questionnaires. Each evaluation criteria has an individual report, in which high level messages are collated.

Overall, the experiences of the professional groups involved with the pilot were positive. There were some difficulties experienced with the implementation of the role on the Haimyres site, however, the pilot has demonstrated clear benefits to the service – particularly as this was the beginning of the development of a group of staff who, for a long time to come will contribute to the assessment, investigation and treatment of unscheduled attendances, previously the domain of junior doctors.

During the pilot there were several occasions where the practitioners were able to alert the senior medical teams to patients who were acutely unwell, ensuring a timely senior review and initiation of treatment. There were some challenges noted, especially some of the current restrictions on requisition of diagnostic tests such as x-rays. There were also clear opportunities to review the patient criteria to widen the scope of practice.

The evaluation of clinical skills demonstrated that the practitioners work to a very high standard, excelling in history-taking and organisation. They were clearly competent and in 84% of the cases scored, the practitioners performed above the overall competence level expected.

There were no clinical incidents recorded for the duration of the pilot.

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### Accident and Emergency awareness Sessions with local school children

#### Background

As part of the work to reduce A&E attendances, the need to develop a Social Marketing campaign is well recognised. Within Lanarkshire there was a desire to do something a bit different and innovative. We knew from previous health promotion campaigns, including smoking cessation that targeting children can have a positive effect on parents and carers, and it was felt that this method of targeting children could potentially influence the behaviour of adults.

Currently schools in Scotland are changing the way they deliver education with the introduction of Curriculum for Excellence which has 4 capacities to develop young people as:

- Successful learners
- Confident Individual
- Effective Contributors
- Responsible Citizens

Learning and Teaching Scotland states that, “Curriculum for excellence has an important role to play in promoting the health and wellbeing of children and young people and of all those in the educational communities to which they belong”.

It was felt that this initiative would provide an ideal opportunity to work in collaboration with our colleagues from North Lanarkshire Council Learning and Leisure Services to educate children in the upper school about the appropriate use of A&E. This would help the school to develop responsible citizens and, at the same time, try to influence the behaviour of their parents and carers.

#### Target Audience

St Aidan’s High School in Wishaw is a six year comprehensive and co-educational Catholic school that covers the towns of Wishaw, Newmains, Shotts, Lanark and Carluke. The roll for session 2009/2010 was 1177 pupils with approximately 100 staff, both teaching and non teaching.

The school is located within the catchment of Wishaw General Hospital. It has a well established Personal, Social and Health Education (PSHE) programme which has been recently reviewed. Every year in June, the school organises a health fayre as part of the induction programme for S6 pupils, the purpose of which is to increase their awareness of current health issues. Staff from NHS Lanarkshire took the opportunity to engage with these students to discuss the issue of attendance at A&E.
Methodology

A team from Wishaw General Hospital’s Emergency Department attended the schools’ health fayre. The team consisted of a consultant in Emergency Medicine, a Nurse Consultant for Emergency Care, a Minor Injuries nurse and two substance misuse use nurses. They set up a market stall with posters and health promotion leaflets, containing information on sunburn, teenage relationships, suicide prevention, as well alcohol. We know alcohol is a major contributing factor in A&E attendances, particularly at weekends, and felt it was an important message to get across to the pupils. The team also provided information on the range of healthcare services including the Minor Ailment service, NHS 24 and NHS Lanarkshire’s Keep Well programme, as well as the services provided by treatment rooms and GP practices.

The substance misuse nurses brought along a variety of measuring glasses and asked the pupils to guess how many units of alcohol were in bottles of wine, beer and cocktails. The pupils were invited to wear the “beer goggles” which simulate the effects of alcohol on the body and attempt to walk in a straight line, and to access the drink aware website and take part in the online quiz.

The team had compiled a healthcare quiz which pupils and staff took part in and prizes were given to the boys and girl with the top answers.

Feedback

Feedback from the school has been very positive and we have been invited back to talk to other year groups. It is hoped that by targeting the lower school we will have more influence on the behaviour of adults.

A&E staff felt this was a worthwhile exercise which is one worthy of continuing, however they would want to target other year groups.

Next steps

We will continue to work with other schools and have been invited to speak at Lanark Grammar and Earnock High school in Hamilton. Both of these schools are non-denominational schools therefore we will be able discuss a wider range of issues with older pupils such as contraception and safer sex. We would like to develop links with schools in the north of the county and will be actively pursuing this through the Learning and Leisure Services of North Lanarkshire Council. It may be possible to develop this as part of the role of the Public Health nurses, however the team felt that the fact they were seen by pupils and staff as being at the “front line” added more kudos to their message.

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NHS Grampian

Know Who to Turn to Workshop

In 2009 The Scottish Government provided funding to NHS Grampian to develop an approach to marketing Unscheduled Care Services with a view to reducing inappropriate referrals.

The aim of the 12 week pilot marketing campaign was to raise awareness of the Unscheduled Care Services available in NHS Grampian and to inform the public about which services to use and when.

The Scottish Government has now provided funding to all NHS Boards to support the marketing of unscheduled care as well as a toolkit to provide guidance and advice.

Workshop Outcomes

- Benefits and key principles of social marketing including the stages involved in planning a social marketing campaign (as defined by the National Social Marketing Centre)
- Learning and resources from the ‘Know Who To Turn To’ campaign at relevant stages in that campaign planning process – what worked and what didn’t.
- Be in a better position to use the toolkit that is being made available to all Boards along with £18k funding to each Board.

Process

The National Social Marketing Centre’s Social Marketing Planning Guide and Toolbox sets out six key stages for the development of any social marketing initiative and provides task areas and useful tools for each stage, linked to the experience of the Know Who To Turn To campaign at each stage of development.

Learning

Challenges

- What services to include/exclude in the campaign?
- Some staff lack of knowledge about other services
- Language and terminology is tricky yet crucial to get right
Successes

- Website received 18000 hits (164) per day
- Booklet was key
- One lead rep for each service to sign off is easier to manage views and opinions within service
- Research and evaluation helped us to clarify our baseline to understand the level of knowledge out there and be clear about the value of this approach
- Independence of evaluation task took it away from working group and possibly people were more honest because they were not talking to the NHS directly.
- Value of having a strong set of messages. Further developments to date include – targeting staff as a group, focussing on self management of Long term Conditions and raising the profile of the role of community pharmacists.

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Communication lies at the heart of the art of medicine. Clinical care is based on the effective transfer of data between the patient and the healthcare provider: “the consultation.” Traditionally, the consultation has occurred on a face to face basis and current health care education continues to assume this model of healthcare delivery is the gold standard. As a result, health care research and development have focused on developing new clinical diagnostics and treatments with little emphasis placed on improving processes for delivery of healthcare. This has resulted in inequity of access to well established, as well as novel, therapies with resulting suboptimal outcomes for patients, ranging from inconvenience to death (e.g. acute chest pain management).

Minor Injury and Illness represent a significant burden to Unscheduled Care Services. Whilst generally regarded as an inconvenience, minor illness and injury frequently consumes inappropriate amounts of resource across a range of services, including secondary care. Traditional pathways of care result in over-triage of cases and inefficient use of resources. In addition, patients are regularly required to needlessly travel significant distances to access services. The recent climate problems (severe winter and volcanic clouds etc.) have highlighted the need for better systems for triage, assessment and treatment in the pre-hospital setting.

There is mounting evidence of the effectiveness of Telecommunications in the delivery of healthcare and this has been contributed to by the Scottish Centre for Telehealth. Amongst the benefits are improved care, more equitable access to services and improved cost effectiveness of care delivery. The last of these is likely to be the most significant driver to effect transformation of delivery of healthcare services over the next 5 years. Face to face consultation is an expensive, resource intensive method of healthcare delivery and should not be used for triage but reserved for those patients who will derive measurable, cost effective benefit.

Despite the mounting evidence base of the effectiveness of TeleHealth, there remains marked inertia to its introduction as a significant, and ultimately primary, method of accessing healthcare. This has reached the stage that healthcare organisations, which choose not to maximise their utilisation of communications technology, may shortly face litigation if this results in suboptimal outcomes for patients.

To fully realise the potential of communications technology in healthcare requires widespread adoption both within and across health boards. Currently, the SCT is progressing national programmes for TeleHealth delivery of services in Paediatrics, Mental Health, Chronic Obstructive Airways Disease and Stroke. There is potential to develop national TeleHealth services in all aspects of Unscheduled Care.
However, this will require a change in the culture of the NHS in Scotland. In addition to the needs of the organisation, each individual healthcare provider should consider their ethical duty to deliver the best service available to their patients. They have a responsibility to ensure that any intervention undertaken on patients has an overall beneficial effect and any harm minimised. However, clinicians are also duty bound to ensure any omission in utilising available, proven healthcare interventions is not detrimental to patients under their care.

Therefore, as effective communication is a mandatory requirement for delivery of healthcare, healthcare providers must regard adapting their practice to reflect developments and trends in communications techniques and technologies to be as important as utilising new medicines or diagnostic techniques.

The time is ripe for TeleHealth to commence the transformation from being a minor delivery route to being the major medium for healthcare service delivery.

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Scottish Ambulance Service

‘See and Treat’

The Scottish Ambulance Service is able to deliver immediate on scene assessment, care and treatment to an increasing proportion of the 600,000 accident and emergency incidents attended each year. This ‘see and treat’ element of the Service is based on evidence-based practice clinically appropriate to the needs of the patient and, is delivered in the community, which enhances the patient experience. In addition, this is an efficient use of NHS resources and it alleviates the pressure on A&E hospital departments and in-patient hospital beds.

All SAS A&E staff are able to assess, treat and discharge 6 see and treat conditions if appropriate. These are:

- Mild asthma attack
- Epistaxis
- Hypoglycaemia
- Hysterical reaction
- Seizure
- Syncope

In 2009/10 57,560 people were treated on scene or at home. The chart below outlines the upward trend in patients treated at the scene between 2006/07 and 2009/10.
Community Paramedics

In addition, the Service has developed an enhanced skilled paramedic, or Community Paramedic role, which operates in most NHS Board areas. Community Paramedics have received additional training and work alongside NHS colleagues, often as part of Out of Hours service, or within A&E, or alongside Nurse Practitioners in the community.

Where Community Paramedics are operating, they have been able to reduce attendances at A&E for ‘see and treat’ conditions and minor injuries by up to 70%. In some NHS Boards, they are attending a wide range of calls as part of an integrated team and are able to autonomously assess, diagnose, treat and devise a care plan and discharge or refer patients with acute or chronic illness or injury.

Hear and Treat

Over recent years the Service has introduced paramedic clinical advisors into its call taking and dispatch centres (EMDCs), who listen into appropriate calls and intervene if necessary to ensure that patients are referred to the most suitable care pathway that is available. These paramedic clinical advisors are supported by senior clinical staff both within the Service and wider NHS.

Benefits to patients

Patients undoubtedly appreciate the improved experience gained when See & Treat procedures are appropriately applied to their needs.

The Service has undertaken independent evaluation of the ‘see and treat’ model to assess effectiveness and patient satisfaction, which demonstrates a high level of satisfaction with the model, with patients feeling they understood clearly why they did not have to go to hospital, feeling confident they received the right treatment and valuing being treated at home, both for minor injuries and for more chronic, long-term conditions.

Benefits to NHS Scotland

Prior to the advent of See and Treat, all of these 57,560 patients would have been taken to the closest A&E Department. The average cost of A&E attendance in 2008/9 was £111. Thereafter 6% of ‘walk in’ A&E attendances are admitted for in patient assessment/care. The average cost of an in patient stay is £2,566.

Therefore the Scottish Ambulance Service ‘See and Treat’ protocols effect a significant saving to NHS Scotland in terms of reduction in A&E attendances and reduction in patient admissions.

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4 ISD cost Book 2007/08 NHS Scotland costs A&E Attendances
5 NHS 24 Friend or foe to the A&E Department – Dr M Crooks 2008
6 ISD Cost Book 2007/08 NHS Scotland costs in patients
The Service is able to reduce unnecessary A&E attendances through this model, but there are broader benefits to be gained from ‘see and treat’. The model allows the Service to offer greater support to NHS Boards in developing appropriate care pathways for these patients, making more effective use of the skills of paramedics and strengthening joint working across the NHS to deliver emergency and unscheduled care.

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NHS Dumfries and Galloway

GP Practice Profiles

Background

Large variations have been observed across general practice in measures relating to the process and outcome of healthcare in Dumfries and Galloway. The Health Intelligence Unit has therefore developed the NHS Dumfries & Galloway GP Practice Profiles to provide primary care with timely and quality assured information to help address these variations. A total of 28 indicators have been included in the profiles, supporting the delivery of the Shifting the Balance of Care Improvement framework and associated HEAT targets.

Objectives

The aim of the GP practice profiles is to:

- Develop a set of key indicators across primary care for NHS Dumfries & Galloway
- Provide a consistent, concise, and comparable overview of variation between practices
- Develop understanding of the variation in the region to improve the quality of health care for the population
- Provide more timely and accessible intelligence to the organisation

Methods

The data in the profiles covers the time period April 2009 to March 2010. Rates have been standardised to take account of differences in the age-sex profile of the underlying practice populations. Indirect standardisation has been used, with Dumfries & Galloway CHP as the standard population. Indirect standardisation is the preferred method as it is highly robust in the context of small numerator values. Indicators have been presented with 95% confidence intervals, using methodologies recommended by the Association of Public Health Observatories. Where possible, Cumbria out of area activity has been included to provide meaningful comparisons for practices located close to the border.

Indicators

The initial indicators covered by the GP practice profiles are:

- GP 48 hour and advance access
- Out of Hours contacts
- A&E attendances
- Emergency admissions and bed days
• Over 65s emergency admissions and bed days
• Potentially Avoidable Admissions
• SPARRA cohort
• Outpatient referrals – all referrals and high-volume specialties
• Radiology referrals – ultrasound and x-ray

Outputs
Each practice received a package containing the GP Practice Profiles Tool, a practice specific summary report, the practice SPARRA cohort and a copy of SPARRA Made Easy. The tool contains the option to view either a ranked bar chart for a single indicator across all practices or a spine chart of three indicators for a single practice. The accompanying report highlighted relevant practice demographics (age, deprivation and rurality), the distribution of the practice population and key issues relating to the indicators.

Actions
Data has been presented to the Dumfries and Galloway NHS Board Primary and Community Care Management Group and GP sub-committee. It has been agreed that the data should be explored further on a locality by locality basis by clinical leads and general managers. This process is underway with agreement to visit individual practices, most notably the four large Dumfries-based practices. It is recognised that the factors influencing variation in primary care are highly complex. The Health Intelligence Unit is committed to further analyses to develop the organisation’s understanding of these factors, and support delivery of the Healthcare Quality Strategy for NHSScotland.

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North of Scotland Planning Group

Emergency and Urgent Response in Remote & Rural Areas – The Strategic Options Framework

Aim: The workshop aimed to provide an understanding of the work of the Remote and Rural Implementation Group (RRIG) in relation to Emergency & Urgent Response in remote and rural areas. Delivering for Remote and Rural Healthcare (2008) recognised that the different clinical configurations and the geographical challenges faced in Scotland meant that a one size fits all approach to emergency and urgent response was not appropriate and the Emergency and Urgent Care workstream of RRIG was tasked with developing a Framework approach that provided choices for NHS Boards but were based on a set of standards.

The Strategic Options Framework (SOF) provides a set of specific standards for emergency and urgent response in remote and rural areas and details the range of types of response that may be employed in a given situation. The SOF was developed in partnership and is built on a Memorandum of Understanding between the Scottish Ambulance Service and RRIG, on behalf of the territorial Boards.

The Memorandum of Understanding clarifies the statutory responsibilities and role of both Scottish Ambulance Service and territorial boards in relation to emergency and urgent services. SAS have strategic responsibility for pre-hospital emergency and urgent response services but require to work in partnership with territorial Boards to design and commission the response appropriate to a particular community. This responsibility includes operational responsibility for appropriate emergency vehicles.

Three Standards for Emergency and Urgent Response, based on existing QIS standards for out of hours care, aim to improve patient outcomes are set within the SOF, as follows:

Standard 1: Accessibility and Availability, including one time based standard.
Standard 2: Safe and Effective Care
Standard 2 Audit, Monitoring and Reporting.

The SOF also describes a matrix of response and includes the skills and competencies of the responder, vehicle and equipment requirements and a Framework of Response where the skills and competencies are matched to levels of care.

The NHSScotland Quality Strategy commits to implementation of the SOF as evidence of effective care that provides appropriate support and services and SGHD has recently issued CEL 21 (2010) which requires Boards to implement the SOF and provides a timetable for completing a gap analysis and developing prioritised options.
Participants were presented with 5 questions to focus the debate. These questions were:

1. What are the challenges within your area to implementation of the SOF?

2. What would the priority be in your area?

3. What criteria do we use to identify locations requiring an ER&T response, and how do we decide upon the type of response to implement.

4. What approach and structures are required within your area to support implementation?

5. How should we address the obvious communication challenge between a nationally agreed Framework and local delivery?

Debate focused on what is a community, the need for appropriate vehicles and clear access points. Participants identified the theme, highlighted in the plenary sessions, of confusion amongst the public and suggested that one number to access services should continue, even though the response for a particular community was different from that for another community.

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NHS 24 and Scottish Ambulance Service

The Unscheduled Care Common Triage Tool

Over the past five years, demand for unplanned care services in Scotland has increased significantly. More frequently patients call 999 or attend A&E departments with symptoms and conditions which could be better treated at a primary care level. Similarly, NHS 24 and Out of Hours clinics receive a small but significant number of calls relating potentially life-threatening conditions which would be better directed to 999.

Currently, unscheduled care providers use different tools to assess patient needs. Whilst NHS 24 has a well established network of referral pathways available for advice, treatment, and referral on to local services, the options for SAS call handlers are limited to ambulance dispatch or transfer to NHS 24. This situation can lead to increases in call transfers, and to delays in patients receiving the most appropriate outcome.

Both NHS 24 and SAS have a key role to play in ensuring that patients are appropriately routed to the care they need when accessing emergency or unscheduled care services, and improving patient access to appropriate healthcare.

A new, single clinical decision support tool or single common triage tool would mean that regardless of which route is used to access emergency and out of hours healthcare, there will be consistency in the triage of patients’ needs, with users of the system having the ability to route patients to a variety of healthcare pathways, dependent on the individual need.

A shared system for assessing need would ensure the right response for patients, first time. It would cut down on the number of calls transferred between NHS 24 and SAS and potentially speed up the response patients receive as a result.

Both NHS 24 and SAS, and other unscheduled care providers, would have access to a full range of health services and clinicians, allowing them to refer patients more quickly to the care they need. This would avoid unnecessary attendance and hospital admission for the patient.
Unscheduled Care Common Triage Tool

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Forensic medical services in Tayside have undergone a dramatic change since January 2009 – previously, a private company used to deliver the service.

The current service is provided by a partnership between NHS Tayside and Tayside Police and is funded by a 3 year Scottish Government Pilot. The service involves the provision of healthcare for the detainees in the 3 Tayside Police Custody Units as well as a specialist clinical forensic medical service for the Procurators Fiscal and the police in the Tayside area.

The detainees’ healthcare is delivered within a nurse-led system currently employing 10 forensic nurses who are based in the Dundee Custody Suite 24 hours per day. They work in collaboration with the Centre of Forensic and Legal Medicine, University of Dundee, where the Forensic Physicians who cover the normal working hours from Monday to Saturday are based. Local GPs provide the forensic medical service during the remaining shifts.

One of our main aims is to provide high quality healthcare for the detainees. Protocols for the safe and effective treatment of alcohol and opiate withdrawal have been developed in collaboration with Tayside Substance Misuse Services (NHS). The implementation of NHS computer links into the medical suites of all three custody suites has greatly facilitated our treatment decisions in view of the detainees’ medical history and their current complaints.

Our second aim has been to increase the professional standard of clinical forensic examinations in cases of physical or sexual assault to the level that has for a long time been provided in the investigation of suspicious deaths. In part this has been achieved by employing physicians who are dually trained in clinical forensic medicine and forensic pathology.

As a result of this change in the service provision the number of admissions to Accident and Emergency has decreased by 18% and the number of call-outs for the Forensic Physicians has been reduced by approximately 75%. The remaining call-outs requiring the attendance of the Forensic Physician are now for truly forensic reasons such as the assessment of injuries or examinations for fitness to plead.

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Suggestions/recommendations received from Unscheduled Care Conference, 25 June 2010

This section provides a note of:

a) the general feedback received from delegates who attended the Unscheduled Care conference and

b) the specific feedback from those delegates who attended the conference workshops.

As follows:

Conference comments/feedback

1. General Practice needs to provide an on-the-day service, with either a visit, telephone discussion with a General Practitioner (GP) or a nurse and the option of a face to face consultation with a GP or a nurse that day. This service would need to be balanced with the need for continuity of care.

2. GPs should have direct access to beds. Once a patient has been seen by an experienced GP and they have decided that the best option available is admission, the patient does not need to be seen again in A&E.

3. All Care Home patients should have an Anticipatory Care Plan, as well as those patients identified as the most at risk of admission. This may be using SPARRA, local systems or knowledge. This should be extended to patients with early cognitive decline and involve Next of Kin, Power of Attorney, Preferred Place of Care and Do Not Attempt Resuscitation decisions documented.

4. NHS 24 Localisation, at a minimum regionalised to Health Board level. Scoping should be undertaken to see if this can be taken down to City, Locality or MIU level. The local knowledge that this level of care brings to Unscheduled Care is vital to improve the appropriateness of response. Making the decision support software, soon to evolve into common triage tool, available very locally should be the goal.

5. Thrombolysis for MIs should be audited by Boards.

6. Telemedicine using SKYPE is a cost effective alternative for the remote boards. It is an innovative method of discussing patients and reducing or improving the appropriateness of transfers. Peripheral x-rays, taken at peripheral units and plastered in the peripheral units will improve patient care and reduce travel and clinic times and be safer than basing everything around a central unit. The technology is there, training MIU and peripheral A&E units should be carried out as part of the Remote and Rural Implementation Group. Telemedicine is not just for remote/rural areas - all Board areas could benefit from its use.
7. On a broader scale, admission choices need to be widened from A&E or a consultant bed in a secondary care unit. Having the options:

- to admit to a community unit
- or respite bed in a care home
- or being able to put in emergency home care

as well as home care will reduce the admission rate. Routing these calls through one number which also handles the transport as well would be ideal for those on the front line.

9. Integration of services, not just co-location, is key and development of multi professional teams.

10. Emergency Department and Primary Care working better in the future.

11. Use all of the available resources (e.g. voluntary sector, work across the Boards)

12. Encourage and develop the enthusiasm

**Workshop Summaries**

**Mental Health Out of Hours Service – NHS Grampian**

- Has developed over time to cater for Moray's circumstances (high unemployment, high alcohol consumption, rural population).

- Provides support for the acute psychiatric ward, consultative advice now as well as emergency psychiatric liaison. Initial challenges around relations with doctors in acute psychiatric wards - fears that service would deskill their staff/ overlap with its service - but has encouraged greater collaboration.

- Has been a 24% reduction in adult admissions to acute psychiatric wards since beginning. Source of referrals: 33% A&E; 20% Liaison; 17% GPs; 11% Self; 7% MDT; 6% Others (police); 4-6% ward.

- Current challenge - have developed their own probationary prescribing policy for the nurses which is less restrictive than Grampian's policy so that the service's nurses can prescribe more medications out of hours - currently anticipating permission to act on this.

- Effectively takes pressure off A&E

**Managing Drunk and incapable people**

- Total change of culture required. “Increasing cost of alcohol on its own not going to solve problem” Danger of people neglecting other things e.g. food in order to buy drink. Potential for this to impact on health services harder.
• Places of Safety. More work into the development of set places to take people who simply require to "sleep it off/ sober up" out of the already oversubscribed weekend/night time unscheduled care services.

• "People likely to respond positively to penalties such as fixed penalties, warning letters, three strikes and out etc.

• Change in attitudes, night time economy, attitudes to duty of care from authorities and availability of alcohol have all increased pressure on A&E/ ambulance service from drunk and incapable people:

• People don't feel embarrassed by their behaviour any more and there is a pride in getting drunk – importance of personal responsibility. The availability of alcohol today encourages this - 'pre-loading' before people go out - importance of licensed premises taking responsibility.

• Duty of care - police are more risk-averse today and so less keen/ willing to take drunk and incapable people to the cells (fear of accidents), therefore look to A&E to look after people who are often not injured.

• The HEAT target on emergency admissions makes it hard for A&E to treat drunk and incapable people who often need longer than 4 hours to sober up.

• Greater planning from all authorities involved in city centres would reduce pressure on A&E/ SAS to bear full responsibility for these people.

• Pilot in Glasgow at Christmas - first aid triage in city centre meant fewer people went to A&E unnecessarily.

• Nurse practitioners working with police on a pilot in Tayside - providing basic healthcare in cell environment and being on hand to provide advice so people aren't taken to A&E automatically.

NHS Lanarkshire Emergency Response Centre

• "Excellent example of how to make the transition between primary and secondary care as seamless as possible for all patients”

• Provides a central point of focus, centre of command for all departments/partners. All aspects of emergency response monitored from centre and this allows for early indication of emerging pressure/ extreme incident. Example given of centres response to “Slippy Monday” – 14 December 2009)

• “Useful co-ordination service” – potential remains for building in of more secondary care services and opportunity for alternative disposals.

• Early identification of pressures in A&E throughout the Board;
• Rapid communication across NHS Lanarkshire;
• Control over the system - reprioritisation and redeployment of resources to allocate them as effectively as possible;
• Improved performance meeting 4 hour target.

NHS Grampian ‘know who to turn to’ social marketing campaign

• Public perception/ confusion/ uncertainty around the skill levels of different practitioners and what is available at different unscheduled care facilities and at different times.
• Need to target staff groups as ambassadors of unscheduled care services information (what is available where and when).
• Further and continuing focus on the role of the community pharmacist required – significant bang from the buck still to be realised.
• Social marketing needs to be ongoing and run in line with strict policy of redirection of inappropriate attendances.
• Public need to understand that the alternatives to A&E are more convenient for them.
• Increase signage as people enter A&E, redesign of the front door.

Unscheduled Care – an integrated approach to improve patient flow

• A need to shift from a reactive hospital based system of unscheduled care towards one which is founded on a preventive, anticipatory approach to managing long term conditions on a whole-person basis.
• Importance of individual approach to patient care that is tailored to each patient specific needs. One patient’s needs can be completely different to that of another with the same condition. Can be very time consuming but worthwhile in long term. A&A (SPARRA – Scottish Patients At Risk of Readmission and Admission) project has reduced unnecessary admissions to hospital, especially for A&E “frequent flyers”.
• System in NHS A&A needs time to be allowed to develop, perhaps forming closer links with palliative care. Feeling that many long term condition patients are not recognised as having palliative care needs.
• Collaboration working through communication and not working in silos has had proven success.
Challenges to NHS Boards when it comes to public engagement about service delivery, especially where service change may be under consideration.

Nature of model which has supported the service in the past against the model proposed for the future will determine the likely success of the engagement.

Any proposed service that may be perceived to be of a lesser level than that which has existed unlikely to be well received. Also dependent on the mix of the population and their history of living in remote and rural area and attitude to the attendant risks.

Raises issue of lack of clarity of understanding amongst the public about the competencies and skills that many non-medical practitioners possess. So paramedics, community paramedics and nurses, including those with extended skills continue to be seen as “inferior” and unacceptable to medics as much through ignorance of the level of resilience and service which they can support.

Systems need to be smarter about knowing in real time where all available unscheduled care services are – especially in remote and rural areas.

Objective should be about getting appropriate staff resource to patient in community, including where it will enhance the capability of the staff resource attending the patient telehealth support to facilitate profession to profession contact.

Lack of local authority support services – especially out-of-hours – increases risk of patient being admitted to hospital for want of community based respite support.

Infrastructure challenges. Some areas where the emergency vehicles are old or unsuitable for the purposes required of them. “Black spots” in mobile radio network.

Risks of volunteer overload. Also has to be volunteer responsibility – i.e. those who do volunteer have to be dedicated and accepting of disruption that can arise in order for them to be available for those time periods when they are on-call.

See and treat and Common Triage Tool

Shared sense of frustration with need for dialogue with patients about accessing Emergency Care Summary. View expressed that most patients will presume that unscheduled care workers helping them in accessing care will have access to their medical records. Sense that patient decision in accessing unscheduled care should be regarded as providing presumed consent.

Absence of links/dispositions into local authority services – e.g. social work services – will prevent common triage tool from achieving optimal service outcomes.
• Work going on around Long Term Conditions – good service considered to be provided in NHS Lothian.

• Lanarkshire work – e-care system – started with child protection and vulnerable adults helping to converge local authority and child medicines work.

• Grampian electronic shared single assessment record that unscheduled care providers can access. Includes key worker information and who should be contacted and what the care plan should be for the patient – e.g. residential care respite, GP community hospital bed etc.

• Patients call 999 instead of NHS 24 number as it costs to call.

• Want to set up a system that patients will call one number – 111 - being tested in England. This will be free to call and the call handler (non clinical) can stream off the safety questions and assess which portal to go down.

• Also it was discussed and noted that the data being processed is rich but not been shared with boards to best use. Data needs to be shared out more across the NHS Boards.
Useful links and contacts

If you would like to update this guide with additional, new or amended information please e-mail them to Callum Percy, Policy Manager in the Strategy and Planning Team of the Scottish Government Health Directorate at:

Callum.Percy@scotland.gsi.gov.uk

The Better Health Better Care Action Plan can be found at:


The link to the Shifting the Balance website which contains the notes and presentations from the Unscheduled Care conference is:

http://www.shiftingthebalance.scot.nhs.uk/news-and-events/

Further information on the Unscheduled Care Toolkit can be obtained from Brian Coane at the Leith Agency at:

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