

The third sector and the review of primary care out-of-hours services

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Introduction

The inclusive process adopted by the Review of Out of Hours Primary Care Services is a good example of the spirit of collaboration required to make sustainable improvement in health and social care services. The Review is an opportunity to celebrate the dedication and talent of people working in both the statutory and non-statutory sectors, but also to consider opportunities for doing things in a different way. Key features of our future caring systems should be that they place a high value on inter-connectedness, which applies at all levels, between individuals,

systems and sectors. There is untapped potential in developing a more reciprocal approach, where effort and benefits are equally shared between people living in our communities and those who provide care and support, no matter which sector they work for. The challenges in OOH primary care services caused by a lack of common processes and standards is well described in recommendations submitted by the Data Technology and Quality working groups.

The Christie Commission¹ made recommendations about managing demand and enabling people to do more for themselves and each other, which are relevant to improving OOH care. An important theme in the report was that effective services must be designed with and for people and communities – not delivered “top down” for administrative convenience - “working closely with individuals and communities to understand their needs, maximise talents and resources, support self-reliance and build resilience” and “prioritising preventative measures to reduce demand and lessen inequalities.” This is a good description of the type of services which the third sector have a long history of providing and which have an impact in OOH care.

There is an increasing awareness of the potential benefits of co-production and person-centred design in many areas of Scottish public services and the third sector. Through networks such as the [Co-Production Network](#),² movements such as [ULab](#)³, SCVO’s Digital Participation programme⁴, the ALLIANCE’s [Health and Social Care Academy](#),⁵ opportunities exist for different staff disciplines and sectors to develop joint approaches to improving health and wellbeing, promote prevention and self-management. Participation in its widest sense is now being discussed in Scotland (September 2015) through The National Conversation⁶ on health and social care services, which coincides with the Review. This has relevance for the Review, as it is an opportunity for people to put forward their views and ideas on how to sustain a 24 hour service which remains free at the point of delivery.

Harnessing these opportunities and strengthening existing relationships with the third sector, will enable solutions beyond traditional NHS approaches and have potential to improve OOH primary care services. These approaches will involve engaging people who use OOH services and strengthening multi-disciplinary, multi-professional and multi-sector collaboration.

¹ Christie Commission on the Future Delivery of Public Services, 2011
<http://www.scotland.gov.uk/Resource/Doc/352649/0118638.pdf>

² <http://www.coproductionscotland.org.uk/>

³ Ulab <http://workforcescotland.com/ulab/>

⁴ SCVO, <http://www.scvo.org.uk/news-campaigns-policy/campaigns/digital-participation/>

⁵ <http://academy.alliance-scotland.org.uk/>

⁶ www.healthier.scot

The third sector's role in health and social care

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

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

Examples of third sector activity:

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

The third sector workforce

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

The size and shape of the sector

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

Third sector organisations and the Review of OOH

Third sector representatives (Appendix 1) and the Chair of the Review of Out of Hours in Primary Care, Sir Lewis Ritchie, met in August, 2015 when the following areas were highlighted:

General comment:

- Funding cuts may lead to a focus on crisis management, rather than prevention. Service planners need to consider harnessing contributions from all sectors, to manage or reduce future demand.
- No-one is perfect and no-one has all the answers. We need to work smarter across all sectors and share learning to create a new and trusting landscape.
- There is a need for more honest and open dialogue about health services which is less political and less confrontational
- There is a need for changing the rhetoric about people who require health and social care services. For example, it can be misleading and unfair to refer to “inappropriate contacts” and describe older people as a “demographic time bomb” as so many older people are active and make a significant contribution to their community.
- Vested interests and established patterns of demand can inhibit change. There is a need to focus on the collective mission and consider changing patterns of demand and enable people to make changes for themselves.

Third sector specific:

- Data on third sector activity in the out-of-hours period is poor, which makes it difficult to capture the local and national contribution. An intelligence led approach is required.
- The third sector has a history of interest in people’s wellbeing (not just their health).
- There is a need for more consideration of people’s social circumstances and what *matters to them*.
- There is a risk that disproportionate funding cuts, where the third sector is subject to deeper or wider funding reductions than the public sector, will

impact on activities and services in our most fragile communities. We need to invest strategically in third sector organisations, community groups and social enterprises with experience in addressing inequalities.

- Third sector organisations need to be at the centre of a mixed-economy, non-hierarchical model of care. Resources should be shared equitably to enable this change.
- Improve communication - “good news” stories about community-based approaches to enabling and managing health are not heard enough. Sharing success instils confidence to do things differently.
- We need to invest less in “the next new idea” and take a more sustainable approach to funding *what works*. While the third sector has a track record in innovation, more support is required to sustain tried and tested approaches, which make a difference to individuals and communities.

Recommendation 1 (link DT24 QS raise public/professional awareness)

Improve understanding and support for the third sector’s role in OOH, prevention and self management

The Review of Out of Hours in Primary Care presents an opportunity to reflect on people’s understanding about how our support systems operate, about health outside the usual health buildings and how best to ensure that everyone has adequate knowledge to care for themselves and others, as far as they are able. This knowledge may be acquired in many ways, for instance through contacts with professionals, improved access to our personal health information and having more confidence about knowing where and when to seek advice. A key priority, identified in the Review, relates to the need to improve the public’s knowledge of behaviours to protect health, promote self care and self management of common illnesses and long term conditions.

It is clear from information about attendances at OOH, that many more of us could avoid contact if we had better knowledge of how major providers of care, such as our health and social care systems and the third sector works, how to manage a condition and how to be better prepared to avoid a crisis.

Fragmentation of systems has been highlighted in the Review as a problem in all sectors. For instance, people who are homeless and / or who have addiction problems are an example of a group who are likely to be supported by a mix of third sector, general practice, social care and voluntary organisations, and who therefore have their personal health and social care information scattered over a number of services and systems. This is an important issue given the number of people living in vulnerable circumstances in Scotland (for instance, there are 800 people registered with the Cowgate Access Centre, a health service for homeless people in Edinburgh).

There is no national system to pool data from statutory and non-statutory sectors, which hinders information exchange, joint learning and the opportunity to foster connections between different sectors. The People Using Services section of Data Technology's report refers to the frustration of people and staff who have contacts with a range of health and social care providers.

The third sector's contribution to OOH primary care services

An important aspect of national service provision, which is not sufficiently well understood, is the third sector's current and potential contribution to out-of-hours (OOH) and unscheduled care.

Organisations such as Voluntary Action Scotland, have produced ample evidence of the contribution of the third sector in their report⁷ into the impact of Scotland's 32 third sector interfaces (TSIs). TSI's have a valuable connecting role across third, public and private sector partners, with a focus on local activity and community priorities, and have four functions at local level:

- Supporting volunteering
- Supporting voluntary organisations
- Supporting social enterprise
- Providing the link to and engaging with community planning partners

The third sector already works in partnership with the NHS on a range of initiatives at local and national levels. However, there is scope to do more, through realising one of the priorities identified in the Christie Commission "maximising scarce resources by utilising all available resources from the public, private and third sectors, individuals, groups and communities."

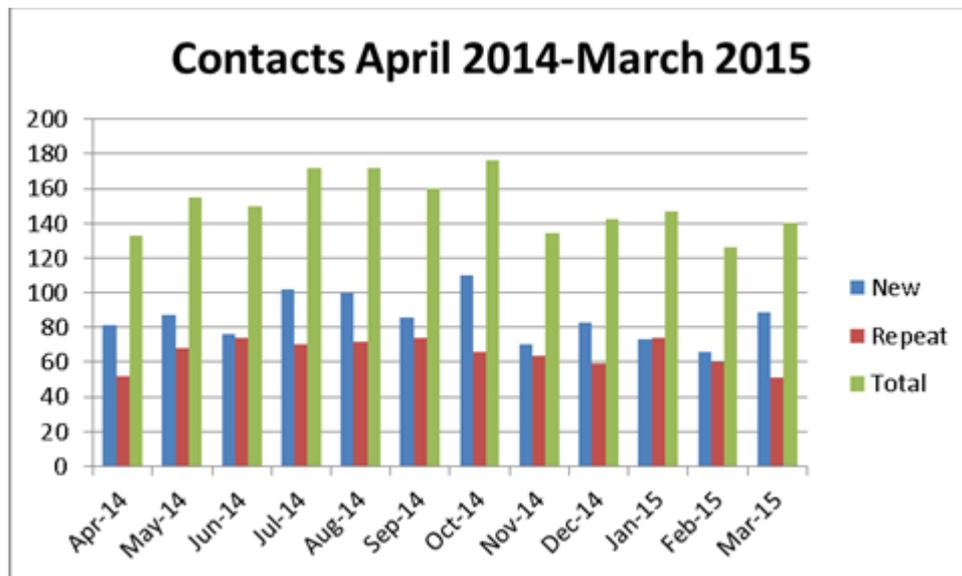
It is hard to measure the preventative effect of third sector services, but organisations such as Penumbra and the Red Cross are very likely to be reducing demand on both in and out of hours services. Both are examples of the third sector role in promoting prevention and self management.

Penumbra

The Edinburgh Crisis Centre is run by Penumbra and is a partnership with NHS Lothian, City of Edinburgh Council, Edinburgh Carers Council and Edinburgh Crisis Centre Users Group. This unique service provides a 24 hour helpline for people aged 18 or over who live in Edinburgh and are experiencing social or emotional distress. Support can also be provided to people who are carers or supporters of someone experiencing distress.

⁷ The Impact We Make The Potential We Have: A Report into the Impact of Scotland's 32 third sector interaces ; Voluntary Action Scotland
<http://www.gov.scot/Resource/0043/00430278.pdf>

Service users receive sensitive, one to one support and information and the centre provides a safe private space for people in distress to receive support along with the possibility of staying at the centre for up to seven nights. The total number of individuals staying overnight from April 2014 – March 2015 was 178. The total number of combined nights stayed at the centre was 352. (No overnight stays in October 2014 due to temporary service relocation).



This table includes both new and repeat contacts. The total number of contacts was 1,807, which includes 1,023 new contacts.

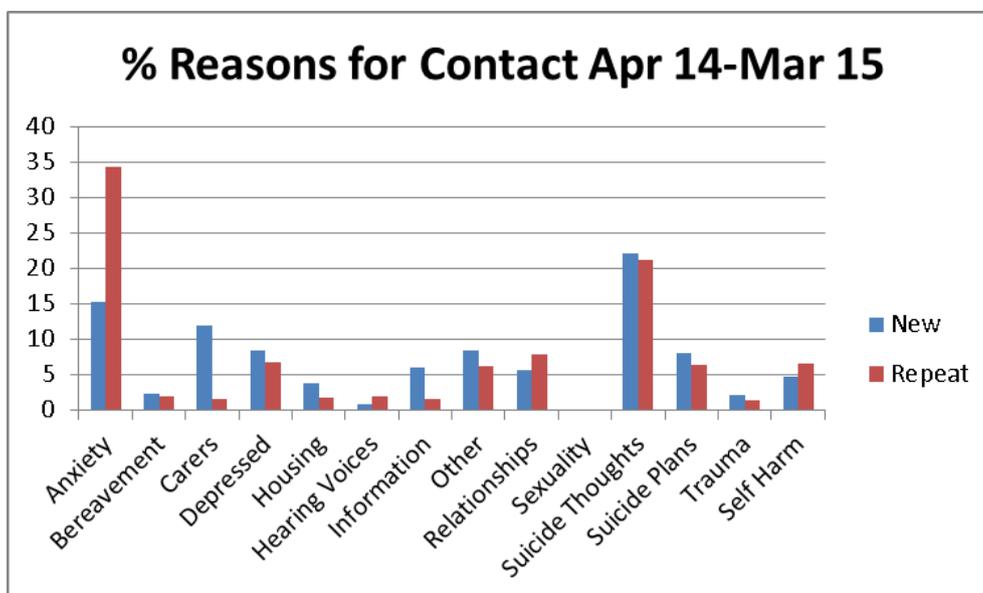


Table shows reasons for contact (at first contact) provided by users, over a 12 month period. 'Other' refers to when no reason for contact provided or the contact was incomplete.

The British Red Cross

The British Red Cross (BRC) provides a Home from Hospital Service across the UK. In Scotland, the service operates in Glasgow, North Lanarkshire and Ayrshire, supporting the work of the Emergency Departments in eight acute hospitals. Each service has its own access criteria and although support is targeted at older people, it is available to vulnerable people over eighteen years of age. The service has been operating in Glasgow since January 2013, at four acute hospitals and serving five local authorities, and supported 924 people between 01 January – 30th June 2015. The service operates from 1400 to 0200 seven days a week, with some additional hours provided to support people moving into or from intermediate care. The service varies to suit local priorities but may include the following:

- Transport from hospital to home in a BRC ambulance, with trained staff.
- Ensuring the person is safe and settled at home, which may involve checks on home safety and security, utilities, availability of food, contacting family, friends or agencies, helping with practical tasks (for example, dealing with pets, making a snack, clearing rubbish).
- A follow-up telephone call within 24 hours of discharge to check on the person's wellbeing and contact statutory services if there are any concerns.
- In selected cases, a worker will arrange a follow-up visit to assess and, if required, provide short-term support such as action to increase safety and reduce social isolation. This may involve helping with advocacy, signposting and personal administration, as agreed with the person.
- Other support includes arranging transport to hospital appointments and supplying mobility aids such as wheelchairs.

The following story is an example of the BRC service:

Mr Montgomery, aged 73 year, was admitted to hospital following an episode of acute kidney failure, and returned home with the support of the Glasgow Rapid Responses and resettlement service, who referred him to BRC. Mr Montgomery and his partner, MS Paton, agreed to accept BRC's support for a range of tasks:

- Clothes and personal belongings were taken to the hospital by BRC staff
- Liaison with ward staff during Mr Montgomery's period of hospitalisation
- Care Direct were contacted for advice about the couple's support needs
- Arranged a key box (as Scottish Ambulance staff were unable to get access)
- Telecare contacted to fit an alarm
- Arranged replacement and delivery of a hearing aid for Ms Paton
- Contacted GP, Carer's Centre, home care organisation and GAMH
- Arranged for Ms Paton to have complementary therapies to help with stress
- Ms Paton informed about support for domestic abuse and crisis situations
- A request for a respite short break

Recommendation 2 (link DT xx)

Improve national intelligence about contribution of third sector to Scotland's health and wellbeing, in and out of hours

The Review of OOH in Primary Care is a welcome opportunity to explore the potential for statutory and non-statutory sectors to share their data in a secure and useful way to improve personal and community health. Sharing common datasets has potential to positively impact on OOH services. The third sector plays a vital role in supporting the most vulnerable individuals in our society, and therefore the lack of connected systems will have an impact on quality and continuity of care.

The third sector generates a vast amount of health and social care data, which includes both the personal and administrative data required to operate services across Scotland. The third sector is the main provider of care and support for a significant number of people who may have little contact with their GP or other statutory services. There are many people whose life circumstances and health conditions might indicate a requirement for a high use of health and social care services, but using data to track use of these services would provide evidence that this was not the case.

Many third sector organisations collect and store personal health information, which is not normally shared with OOH primary care services or the GP record (which is considered to be the most complete record of an individual's health). Exceptions are charities such as hospices, which are part NHS funded, where staff have access to most (but not all) available information about people they care for. Many people turn to the third sector for support, as they offer the most appropriate service for their needs, the opportunity to consult an independent organisation and because they know information will not be shared in their NHS record, unless permission is given or in high risk situations. This can result in a significant information gap in the health record, which may present a major risk for individuals and staff in both sectors.

This has particular relevance for people attending OOH who are disabled, who require mental health and addiction services, or who are homeless. For example, many disabled people access social care support provided by the third sector, for short periods during the day or on specific days of the week (this is particularly true for people with a fluctuating mental health condition and for people who have a learning disability). Many of these people will have infrequent contact with health services and may not seek support until their condition has deteriorated. The role of advocacy is vital in these situations, as some people may not have an adequate understanding of the situation or be able to provide accurate information by themselves. In these circumstances, third sector organisations and social care providers may be contacted by OOH to seek important information and to ensure a

safe outcome. Scottish Action for Mental Health and Samaritans provide useful examples of how the third sector are supporting people both in and out of hours.

Scottish Action for Mental Health (SAMH)

SAMH Action Plans support people to self manage – in this example - medicines management. The following extract is from the medication section:

What I want to happen/achieve:

“I would like to stay well permanently and not slip back into not taking my medication when I feel I don't need this”

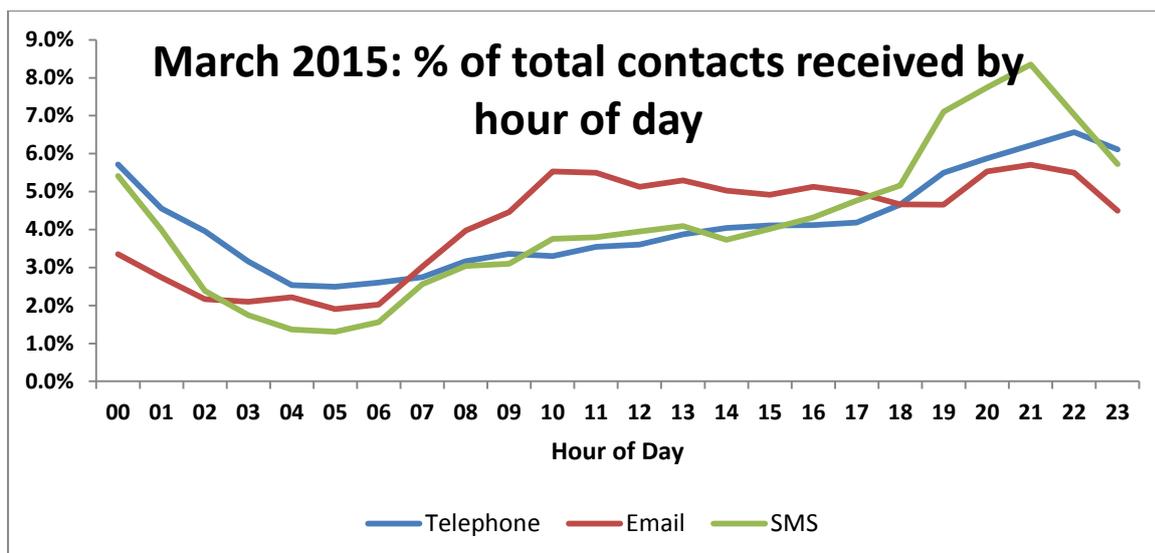
What SAMH will do to help me achieve this outcome:

- I will collect my medication from the pharmacy every Thursday independently and if I need support I will request this and staff will support me to the pharmacy.
- Staff and I will check and sign in my medication immediately after it is collected from the pharmacy.
- My medication will be stored in my flat in the locked box which is situated in the cupboard opposite the kitchen.
- One member of staff will prompt and encourage me to take my prescribed medication at 10am and 8.30pm.
- Staff will record in my file and MAR sheet that I have been supervised to take my medication. If I decline my medication this will be left in my blister pack.
- Missed and untaken medication will be returned to the pharmacy by me supported by staff.
- Staff will support me with PRN medication if and when I require it. Staff will monitor through my running notes and MAR sheet the amount of PRN I have taken to ensure I do not exceed the recommended dose.
- Staff will repeat medication prescription if needed from my GP practice.
- Should I experience adverse effects or side effects staff will support me to access relevant medical support/advice.

This example of the third sector's activity in promoting a sense personal control over health, has relevance for implementation of Scottish Government's ehealth strategy which aims to ensure completeness of personal health information and access to structured information about prevention and self management. It is also an important consideration for development of the patient portal.

Samaritans

Samaritans opened their first branch in Scotland, in Edinburgh in 1959, since then the organisation has grown to 20 branches across the country, stretching from Shetland to the Scottish Borders. Samaritans offer confidential services to support people who are feeling distressed, in a state of despair, suicidal or need emotional support. In the period 2010 - 2014 Samaritans in Scotland had 1.152m contacts through branches across the country via telephone, SMS, email and in person. Analysis of contact patterns shows that 66% of contacts were made in the out of hours period (outside 0900 – 1700) and 27% of those contacts are at weekends.



Telephone, email and SMS contacts received by Samaritans by hour of day for the month of March 2015, which is consistent with other months of the year.

Developing a culture of health

Linking data has potential to provide new insights at both an individual and population health level. For instance, to help inform individuals about actions they can take to improve their health and to support development of a culture of health in communities. The “big data” (aggregated sets of data) resulting from pooling information could be used to inform local people about the wellbeing of their community (which could be presented in clear simple terms such as posters in libraries, shops, schools etc) to encourage co-ownership of health and wellbeing services. Linking data will help indicate the impact of services, spot trends and gaps in provision, make funding decisions and plan health and social care services. The need to pool data and co-produce information is being made more urgent by the introduction of Integrated Joint Boards, who will require a robust data infrastructure to turn data into information, and information into ideas for local health improvement. For example, local quality improvement indicators could include track use of OOH services and the data generated by the third sector.

Barriers to sharing data include disparate IT systems and the competition, which can exist between organisations and sectors, especially in strained financial climates, which can also result in lack of shared standards for information governance. However, progress is being made.

The Health and Social Care Data Integration and Intelligence Project (HSCDIIP) has been developed to support the maximising of scarce resources referred to, through the process of health and social care integration in Scotland. HSCDIIP will provide

data and analytical support, evaluate services and help transform data into evidence for action.

The ALISS⁸ (A Local Information System for Scotland) programme at the ALLIANCE is being funded by Scottish Government to explore using the system to capture data about local assets and sources of support. The information generated through this process will provide the intelligence required for new health and social care planning and commissioning structures. This has particular importance for signposting, developing local and national strategies for prevention and self-management and promoting healthy communities.

Future priorities for NSS will include developing indicators to show improvement in personal outcomes and risk factors. There is potential to involve people identifying what is important to them and what they think their risks are; this type of approach could represent examples of user-informed preventative anticipatory care. Including the third sector in this project is an opportunity to enrich local and national intelligence and benefit all.

Actions to improve national intelligence about the contribution of third sector to Scotland's health and wellbeing:

- A national conversation with third sector organisations on their views on the benefits and challenges of sharing their data with the statutory sector
- Explore existing models of personal health data exchange (such as hospices)
- Explore the benefit of a strategic link between National Services Scotland Information and Statistic Division (NSS ISD) and the Health and Social Care Alliance Scotland (the ALLIANCE).

Recommendation 3

Explore models of governance in statutory and non-statutory organisations to ensure a person centred, safe and effective service

The issue of governance is a fundamental aspect of providing care and support, at any time of the day and in any setting. Arrangements must be in place to ensure safe and secure services, which take account of shared decision making, models of consent and patient's and professional's attitude to risk. This has relevance for the public's understanding and knowledge of behaviours, which will protect and promote their health and wellbeing. Shared decision making and attitudes to risk are important considerations in discussions about personal health records being shared across primary and secondary care, social care, patient portals and the third sector.

⁸ www.aliss.org.uk

The OOH review has heard about the impact of attitudes to risk, which can increase demands put on the service, for example, minor illness and injuries and social circumstances which could be managed without contact with health and social care services. It is critical that finite resources, such as OOH services, are easily accessible but are used in the most appropriate way and that, as was mentioned at a meeting, professionals in all sectors are “working at the top of their licence.” In the OOH setting, the GP is the senior decision maker and so issues around governance and attitude to risk must be given a high priority, especially with the prospect of fewer GPs and nurses being available.

Attitudes to risk will influence the development of the inter-professional and inter-sector relationships, which will be vital for future safe and sustainable models of care. This will require consideration of basic issues of governance such as forming trusting relationships, levels of autonomy, personal accountabilities, protocol led care, organisation of teams, availability of skills, knowledge and workforce. The third sector has much to contribute to improving community health and potential plans for hub and local cluster type arrangements. **Considerations should be given by both statutory and non-statutory providers of care to attitudes to risk. This is especially relevant in plans for integration of health and social care systems and improvement of OOH primary care services.**

Governance of third sector organisations

One of the key features of third sector governance is that it is voluntary. Members of management committees and trustee boards give their time freely to ensure the effective running of their organisation. People who volunteer their time are drawn from a range of backgrounds, including campaigners, community activists, people with lived experience and service users, as well as accountants, lawyers, etc. Third sector organisations are governed by management boards / committees and trustee boards. People with a governance role, described as trustees, are obliged to meet general and specific duties set out in the Charities and Trustee Investment (Scotland) Act 2005. Governance groups perform the following functions:

- Promoting and safeguarding the mission and values of the organisation
- Determining the strategy of the organisation
- Ensuring the organisation operates in an effective, responsible and accountable manner
- Ensuring its own effective functioning

How the third sector is regulated

In addition to the need for charities to meet the legislative requirements of the Scottish Charity Regulator, third sector organisations are regulated in a number of ways:

- Third sector organisations which are limited companies, must meet a range of requirements set out in company law and report to Companies House.

- Social care organisations are regulated by the Care Commission, which regulates, inspects and supports improvement of care, social work and child protection services for the benefit of people who use them.
- Hospices are regulated by Healthcare Improvement Scotland to ensure they comply with standards and regulations.

How third sector staff and volunteers are regulated

Staff and volunteers in the third sector are subject to similar professional and regulatory standards as their colleagues in public and private sectors. For example key groups of social service workers are registered by the Scottish Social Services Council, which also publishes Codes of Practice for all social service workers and their employers and regulates the education and training of the social service workforce. Staff and volunteers who apply to work with vulnerable groups, for example children and protected adults, are subject to a range of disclosure requirements via the Protection of Vulnerable Groups scheme.

The Links Worker Programme

The Scottish Government Links Worker Programme⁹, an example of integrated working at all levels, aims to address health inequalities in Scotland. Community Links Practitioners (CLPs) are employed by a third sector organisation (The Health and Social Care Alliance Scotland), they deliver services in general practices in deprived areas of Glasgow and connect people to support in all sectors. This system of inter-sector collaboration has been made possible by ensuring that robust governance arrangements are in place.

CLPs are based in seven practices, which were recruited from the General Practitioners at the Deep End¹⁰. Each CLP is a full member of the practice team, and there are three main aspects to their role:

- Provide one-to-one support to individuals from the practice list, helping to identify issues which can improve their health wellbeing
- Support people to access local resources and contribute to building the capacity of local networks and community assets
- Collaborate with practice staff to support development and implementation of the seven capacities identified in the ‘links approach’.¹¹

CLPs have the same rights and responsibilities for accessing and updating patient medical records, as other members of the team. In order to build trust and effective working arrangements between the parties involved, a series of policies and protocols have been developed (for example adult protection, boundaries, child protection, lone working and whistleblowing). Other key governance documents include honorary contracts and Service Level Agreements, which refer to data

⁹ <http://www.alliance-scotland.org.uk/what-we-do/our-work/national-links-worker-programme>

¹⁰ General Practitioners at the Deep End, University of Glasgow
<http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/>

¹¹ <http://www.alliance-scotland.org.uk/what-we-do/our-work/national-links-worker-programme>

protection and information sharing and provide a robust basis for successful integration of the new CLP role in the primary care environment.

Recommendation 4

Explore models of funding to third sector to ensure the third sector's contribution to in and out of hours services is secure.

Third sector organisations across Scotland allocate their funds towards resources for prevention and self-management, as well as investing in, and delivery of, high quality services. A third (£1.626 billion) of the sector's income is for activity in health and social care, while 30% is committed to housing, which has a well-established link with the health and wellbeing of people and communities.

Two-thirds of regulated third sector organisations have annual budgets under £25,000. In financial terms, this accounts for less than 1% of the sector, but these 12,000+ organisations make significant contributions to the health and wellbeing of local communities. These small organisations rely heavily on income from individuals – half of their funds come from donations, membership fees, sales of goods, fees for activities and fundraising events.

Some 5,500 organisations have an annual turnover of between £25,000 and £1m. Just over half of these medium-sized organisations receive funding from the public sector, usually in the form of core grants and project income and income from grant-making trusts.

The 800 or so third sector organisations with turnovers of £1m or more account for around 80% of the sector's financial activity. The contribution from the public sector makes up some 50% of the income of these large organisations. Large social care providers receive between 70% and 98% of their income from government, primarily from contracts with local authorities.

The third sector's contribution is often not well understood or acknowledged in local and national planning processes. Even in more favourable public spending climates, there has been a debate about the level of resource available to meet demand and the extent to which these resources are distributed equitably and in accordance with need. Whatever the locus or time of debate, it is clear that shifts in service provision – for example, from a medical to a more community-based model, must be accompanied by a shift in resources. This is consistent with the models of community orientated general practices, which have long been advocated by the World Health Organisation¹². However, there is concern within the third sector about their ability to sustain services in a climate of financial uncertainty.

¹² Placing People and communities at the centre of health services; WHO global strategy on integrated people-centred health services, 2016-2026; http://apps.who.int/iris/bitstream/10665/180984/1/WHO_HIS_SDS_2015.20_eng.pdf

Voluntary Action Scotland's report¹³ indicates that third sector organisations were concerned about reducing annual budgets and greater competition for funding. This impacted on their ability to contribute to achievement of shared outcomes, and caused some organisations to have serious concerns about sustainability.

Scottish Government's Many Conditions One Life Action Plan¹⁴ states that self management and integrated care and support for people living with multiple long term conditions must be a priority for health and social care partnerships. However, many third sector organisations produce evidence of the positive impact of their work to support self management, but remain unable to secure funding to sustain their service. This includes organisations such as Mindspace Recovery College¹⁵, Pink Ladies 1st¹⁶, Moira Anderson Foundation¹⁷, KICC Active Lothian¹⁸ and who have all experienced financial uncertainty.

This feeling of insecurity was echoed during an engagement, in November 2013, between Health and Social Care Alliance Scotland (the ALLIANCE) and the Cabinet Secretary for Health and Wellbeing, when members raised concern about the large number of people who end up in the healthcare system, such as OOH, who could have avoided it, if there had been an adequate level of social support. Organisations described frustration that, despite having evidence to support the benefits of their activity (particularly in relation to primary care), their service is not reflected in strategic commissioning plans and investment decisions.

Integration authorities should examine the scope for the third sector to play a greater role in out-of-hours services/unscheduled care and identify funding resources, which will enable them to do so.

Volunteers are also making a valuable contribution to managing demand:

Community Transport East Renfrewshire

Community Transport East Renfrewshire provides a service for people in East Renfrewshire to attend medical appointments at local GP surgeries, local clinics and any of the hospitals in the NHS Greater Glasgow and Clyde area. The vast majority of local GP practices know about the service and all referrals come through them. The service is available to patients who are registered at 14 GP surgeries within East

¹³ <http://www.gov.scot/Resource/0043/00430278.pdf>

¹⁴ <http://www.jitscotland.org.uk/resource/many-conditions-one-life-living-well-multiple-conditions/>

¹⁵ <http://mindspacepk.com/recovery-college/>

¹⁶ <http://www.pinkladies1st.org/>

¹⁷ <http://www.moiraanderson.org/>

¹⁸ <http://www.kiccactive.org.uk/>

Renfrewshire. They are not eligible for ambulance and patient transport services, do not have private transport and cannot use public transport.

The project has 46 volunteer drivers, who use their own time and vehicles, to take people to and from 50 appointments each week. Volunteers take patients to their NHS appointments, wait with them and take them home again. The amount of time contributed is 18,000 hours per annum. The project is supported by funding of around £20,000 per annum from the local Community Health and Care Partnership and £10,000 from Strathclyde Partnership for Transport. This funding covers the costs of co-ordination, fuel and vehicle wear and tear.

There is no other similar service and so, for many vulnerable people, the experience of attending medical appointments is less of an ordeal than it might be otherwise. Key learning points from this project are that the funders are committed to the project and a relationship exists which is based on trust. This model could be replicated across Scotland if there was adequate funding.

Recommendation 5 link with DTxx and QS x

Improve systems for communication and for connecting statutory (OOH) and non-statutory providers of care

The Review of OOH in primary care and recent difficulties with recruiting staff, present a welcome opportunity to explore the benefits and challenges of closer collaboration between providers of care and support.

Strategies to improve communication systems to connect statutory and non-statutory providers of care will raise many issues. For instance, the question of whether the public and professionals wish their information to be shared across different sectors, whether various institutions wish to share their information, the benefits of linking systems across sectors and the potential cultural, governance and cost barriers.

An important aspect of plans for integration of health and social care will be addressing the cultural and IT issues associated with linking information systems. This is a vital consideration, particularly given the third sector's role in supporting people in vulnerable circumstances, who may be most distanced from statutory services.

During the process of the Review, there was frequent reference to poor communication at many levels – individual, local and national. At an individual level, the Review heard people's frustration of having to repeat personal information over and over, risk to their health through lack of integrated systems and sometimes a

lack of awareness that their information was not already being shared. The person in the middle of multiple disconnected contacts is often confused and concerned that their information is not being safely shared. This lack of connectedness makes navigating the health and social care landscape very challenging, especially for people with low levels of health literacy.

Third sector organisations have valuable insight into the effects of this disconnectedness, as many represent people living with disabilities, hearing and sight loss. Too often, people report a poor quality of care as they experience challenges in accessing care and support. (See Accessibility in Data and Technology working group for evidence of this).

People having access to and control of their personal health record, as described in Gaun Yersel (2010) 19 and the Scottish Government's ehealth strategy²⁰, will be a vital mechanism for addressing many of these issues. Gaun Yersel cited access and ability to add to the personal health record, as a major contributor to improving self management and health literacy.

Many third sector organisations already share personal health information with health and social care services, with people's permission and within agreed governance arrangements. For instance, palliative care staff in hospices (which are charities), have access to some, but not all, patient information held in the NHS and social care system. Many organisations share health information in care home, homeless, alcohol and addiction and mental health services, where people may be more likely to have contact with third sector organisations.

Organisations within the third sector, mirror health and social care services, in that they also use a disparate mix of paper and electronic based systems to record data and run their services. At a national level, the SCVO's Milo system is database and interaction management system for the TSI network in Scotland. The database holds information on existing organisations, contacts, volunteer registrations and volunteer opportunities.

At an individual level, third sector organisations collect similar key clinical and demographic information as health and social care services. SAMH is an example of an organisation which shares information, when appropriate, with health, social work and psychiatric services. The type of information collected includes:

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Scottish Government and The Local Term Conditions Alliance Scotland (LTCAS), Gaun Yersel: The Self Management Strategy for Long Term Conditions in Scotland, 2008, Page 72, http://www.alliance-scotland.org.uk/download/library/lib_54b668b3d492a/

²⁰ Scottish Government, eHealth Strategy 2014-17, <http://www.gov.scot/Resource/0047/00472754.pdf>

- Active Problems (eg anxiety, phobia, eating disorder, homelessness, learning disability, memory/cognition impairment, medication side effects)
- Communication needs (eg first Language not English, hearing impairment, visual impairment, clear speech required, uses sign language, lip reads)
- Adults with Incapacity Status and Mental Health Act Status
- Significant Social Factors (eg problems with alcohol, benefits/finance, chronic physical illness, dependant others, substance misuse)
- Significant Risk Factors (Risk From Others, Risk To Others, Risk To Self, Neglect)
- Information about incidents and accidents
- Information around Suicide Prevention/Intervention
- Other Agencies Contacted (eg Community Psychiatric Nurse, Care Manager, GP, NHS 24, Crisis Team, Addiction Services, Occupational Therapist, Others)

Scottish Government, Integrated Joint Boards and the third sector should consider the benefits and challenges of sharing systems with the statutory and third sector.

PAMIS Digital passports is an example of how the third sector has developed technology which could improve quality of communication in OOH contacts for people with profound learning difficulties.

PAMIS

[PAMIS](#) is a third sector organisation which provides support for people with profound and multiple learning disabilities. Their Manage IT Project aims to enable families and carers to use technology to improve communication, manage long-term conditions and to plan care much more efficiently. PAMIS staff have first hand experience of the challenges faced by the people they support and are in a strong position to respond with solutions. Hannah Young, a researcher at PAMIS, had been working with a family to develop a PAMIS' Personal Passport, a paper document that a person with communication difficulties can use to provide information such as their likes, dislikes, specific safety and feeding needs, which presents a deeper insight into the person's personality and character. A carer asked if it was possible to have the information in digital form and the result is PAMIS Digital Passports²¹ This is an example of an innovative idea that is likely to come from the third sector, which has potential to improve communication with OOH services. However, a significant barrier is funding as further development will take time and money.

Social Prescribing

Social prescribing, or signposting, is part of a movement which heralds the beginnings of a slow shift from a traditional top down, reactive caring system, towards a less bureaucratic networked approach, better suited for persisting and

²¹ PAMIS Digital Passports; http://www.pamis.org.uk/_page.php?id=85

worsening health inequalities. Social prescribing places a value on local relationships and can help to de-medicalise health. Signposting people to sources of support, has an important role in OOH primary care services as many people attending could benefit from being linked to sources of formal and informal support in communities. Staff, such as those in the third sector, primary and secondary care, OOH, A & E, ambulance services, reception and pharmacies, are in a good position to signpost people to useful support.

Social prescribing has important potential to link people with the most appropriate support and lessen demand on statutory services. For instance, a significant number of people who contact OOH services have problems related to mental health, and yet the Scottish Action for Mental Health's (SAMH) report Know Where to Go²², reported that 800,000 adults did not know how to access help. When GPs were asked what kind of information on mental health would be useful, 87.3% suggested guides on local resources, including opportunities such as walking groups, stress management groups, voluntary sector support services (the report recommended using ALISS²³, which is an online system to find local resources).

This is echoed in a General Practitioners at the Deep End²⁴ report which focused on the experience of social prescribing among GP practices in deprived areas²⁵. This report described a high proportion of GP consultations being driven primarily by the experience of social adversity, especially poverty and financial problems, as well as experiences of violence, addictions, housing and other difficulties (which is mirrored in OOH contacts from vulnerable populations). GPs felt that they were often unable to respond effectively because of a lack of time, but also because of difficulties in accessing community-led services, which they knew could benefit their patients. Community Compass is an example of a service which has been created to address this problem.

Community Compass

Carr Comm's Community Compass project, established in October, 2013, has been working with the Craigmillar Medical Group and other organisations such as the Thistle Foundation, to support residents in the Craigmillar area of Edinburgh. The project is designed to connect people with local services and help them overcome the sort of issues which can't be addressed clinically such as debt, unemployment or isolation. In just under 2 years, Community Compass has had 280 referrals,

²² Scottish Action for Mental Health, Know Where To Go: Your Guide; http://www.samh.org.uk/media/241903/samh_know_where_to_go_-_your_guide.pdf

²³ A Local Information System for Scotland, www.aliss.org

²⁴ General Practitioners at the Deep End, University of Glasgow <http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/>

²⁵ General Practitioners at the Deep End, Report 8, Social Prescribing, September 2010, http://www.gla.ac.uk/media/media_179091_en.pdf

engaged with 70% of those referred and signposted to 49 different sources of support. Just under half of these referrals (130) were from GPs, practice nurses and the Minority Ethnic Health Inclusion Service. Patients are referred with a range of issues - 58% have low level mental health problems such as anxiety and depression, and a similar proportion are socially isolated and so are unable to access services to improve their health and wellbeing. Members of the primary care team commented that, since the project started, they were a reduced number of GP contacts for isolated, depressed and housebound people and that people were coping better and need less drugs. The project has also enabled people to attend medical appointments, which they may otherwise have missed.

Conclusion

The growing demand on services to support health and wellbeing in Scotland makes the need to share effort between all providers of support more urgent. Implementing the five recommendations suggested in this report will strengthen connections between voluntary, third and public sectors and contribute to improvement in the quality of our OOH primary care services. Recommendations have potential to improve the quality of care at both local and national level, at all times of the day.

Appendix 1

List of representatives, who attended a third sector strategic dialogue with Sir Lewis Ritchie, Chair of the Review of Out of Hours in Primary Care, on 11 August 2015.

Gayle Bell, STRiVE
Diane Campion, Scottish Government
Hilda Campbell, COPE Scotland and Voluntary Health Scotland
Christine Hoy, Health and Social Care Alliance Scotland
Sue Gray, Macmillan Cancer Support
Barrie Hunter, Penumbra
Carol Kearns, Inverclyde Council on Disability
Liz Lumsden, Royal Society for Prevention of Accidents
John Macdonald, Community Transport Association
Helen Macneil, Voluntary Action Scotland
Caroine Paterson, Marie Curie
Sir Lewis Ritchie, Chair
Geri Sinclair, CVS Inverclyde
Paul White, Scottish Council for Voluntary Organisations