Annex A

REASONS FOR NOT PROVIDING INFORMATION

An exemption applies

Section 38(1)(b) – applicant has asked for personal data of a third party

An exemption under section 38(1)(b) of FOISA (personal information) applies to some of the information requested because it is personal data of a third party, i.e. names and contact details of individuals, and disclosing it would contravene the data protection principles in Article 5(1) of the General Data Protection Regulation and in section 34(1) of the Data Protection Act 2018. This exemption is not subject to the 'public interest test', so we are not required to consider if the public interest in disclosing the information outweighs the public interest in applying the exemption.

An exemption applies, subject to the public interest test

Section 29(1)(a) – formulation or development of government policy

An exemption under section 29(1)(a) of FOISA (formulation or development of government policy) applies to some of the information requested because it relates to the formulation of the Scottish Government's policy on the redesign of urgent care.

This exemption is subject to the 'public interest test'. Therefore, taking account of all the circumstances of this case, we have considered if the public interest in disclosing the information outweighs the public interest in applying the exemption. We have found that, on balance, the public interest lies in favour of upholding the exemption. We recognise that there is a public interest in disclosing information as part of open, transparent and accountable government, and to inform public debate. However, there is a greater public interest in high quality policy and decision-making, and in the properly considered implementation and development of policies and decisions. This means that Ministers and officials need to be able to consider all available options and to debate those rigorously, to fully understand their possible implications. Their candour in doing so will be affected by their assessment of whether the discussions on the redesign of urgent care will be disclosed in the near future, when it may undermine or constrain the Government's view on that policy while it is still under discussion and development.

Section 30(b)(ii) – free and frank exchange of views for the purposes of deliberation

An exemption under section 30(b)(ii) of FOISA (free and frank exchange of views) applies to some of the information requested. This exemption applies because disclosure would, or would be likely to, inhibit substantially the free and frank exchange of views for the purposes of deliberation. This exemption recognises the need for Ministers and officials to have a private space within which to discuss and explore options before the Scottish Government reaches a settled public view. Disclosing the content of free and frank discussions on the redesign of urgent care will substantially inhibit such discussions in the future, particularly because these discussions relate to a sensitive or controversial issue.

This exemption is subject to the 'public interest test'. Therefore, taking account of all the circumstances of this case, we have considered if the public interest in disclosing the information outweighs the public interest in applying the exemption. We have found that, on balance, the public interest lies in favour of upholding the exemption. We recognise that there is a public interest in disclosing information as part of open, transparent and accountable government, and to inform public debate. However, there is a greater public interest in allowing Ministers and officials a private space within which to explore and refine the Government's policy on the redesign of urgent care until the Government as a whole can adopt a policy that is sound and likely to be effective. This private thinking space is essential to enable all options to be properly considered, so that good decisions can be taken. Premature disclosure is likely to undermine the full and frank discussion of issues between Ministers and officials, which in turn will undermine the quality of the policy-making process, which would not be in the public interest.

Document 1 - RUC Submission - 8 October - Progress Update

08 October 2021

Redesign of Urgent Care – Progress Update

Purpose

The First Minister is invited to note the progress of the Redesign of Urgent Care (RUC) Programme and the current Flow Navigation Centre (FNC) model across Scotland. In response to Covid, this has been developed at pace and transformational change of this scale will take time.

Background

1. The Redesign of Urgent Care programme is a national approach to change how we deliver and access urgent care, which may take up to 3 years to fully realise the benefits. A key ambition of the Programme is to direct self-presenting patients to the right care in the right place and prevent unnecessary hospital attendance. The cohort of attendances the programme will impact on is the 860,000 per annum self-presenters where research suggests around 20% could be managed more appropriately by signposting to more appropriate professionals or self-care; right care in the right place.

2. The RUC pathway aims to provide urgent care as near to home as possible by expanding and promoting NHS 24 111 as the preferred initial contact and creating local Health Board FNCs. The FNCs provide rapid access to a senior clinical decision maker and clinical assessment by phone or using digital technology, provide self-care advice and where necessary onward referral to scheduled urgent care services, including Primary Care (PC), rapid access outpatient clinics, Minor Injury Units (MIUs) and in some cases Accident and Emergency (A&E), with an agreed time slot to be seen to smooth peaks in demand and provide better patient choice.

3. The programme launched with the implementation of a conceptual framework and a minimum specification described as a “soft launch” on 1 December 2021 following a successful pathfinder test of conceptual model in NHS Ayrshire and Arran over November 2020. Key components of the initial specification are:

- a single national number through NHS 24 /111;
- Flow Navigation Centres;
- Virtual consultation through Near Me;
- Scheduling of unscheduled attendances to smooth peaks in demand

Benefits and Impact

4. Some of the key findings and perceived benefits of the new pathway so far include:

- **Reducing A&E attendance**
    - Data shows that volumes to A&E would be higher without the introduction of the RUC NHS24 and FNC pathway
    - 700 people a day who contact NHS 24 and select the option which says they think they need to go to A&E avoid an A&E attendance
    - In the latest month there was a 2% (2,250) reduction in self-presenting patients compared to pre-Covid levels

- **Flow Navigation Centres (FNC) in every Board**
  - Provides 24/7 access to a Senior Decision Maker
  - All FNCs have the ability to schedule to A&E services to avoids peaks in demand and allows patients to attend at a time that is suitable to them – a more safe, person-centred approach
  - Of this 6 boards schedule into both A&E and minor injuries, with the remainder only into minor injuries
  - Creates a better experience for patients with the option to reschedule at a more suitable and quieter time
  - Improved professional to professional ways of working
- **Collaborative working**
  - There is broad based support from the workforce for the intent and principles of RUC pathway
  - Staff report unprecedented levels of partnership working which has created trust and mutual problem solving through clinical safe space meetings
- **Patient Experience**
  - Information gathered through patient experience work (*note: taken from a small sample*) indicates people who are using the service are, on the most part, having a positive experience which is effective and efficient
  - Satisfaction levels for NHS 24 are high despite often long delays
- **National Messaging**
  - National communications is working well with good campaign recognition
  - People are beginning to see NHS 24 has a 24/7 service
  - 41% of people claim to have acted on the campaign messages – the most likely action to call 111 instead of attend A&E

Current FNC Model

5. The requirement for the FNC model can be described in 4 core elements:

- FNC available 24/7 to receive from NHS 24;
- Access to a senior clinical decision maker (SCDM, agreed at ST4 and above) 24/7;
- Ability to schedule into ED and Minor injuries
- Use of Near Me technology

6. Boards have established their FNC model as services have evolved to meet local circumstances, such as levels of demand and availability of staffing resource, including:

- core operating hours and dedicated clinical resource, smaller Health Boards do not have a critical mass to have a fully dedicated resource other than call handlers and senior clinical decision makers who often have other clinical commitments, especially out of hours
- clinical decision maker role is largely undertaken by A&E Consultants, GPs and Nurse Practitioners but staffing models and skill mix differs, which is informed by clinical need
- NHS Highland provides FNC services to the three island Health Boards

7. Across all board areas, providing sustainable staffing for the FNC is the main challenge. This has been particularly difficult as COVID numbers and self-isolation contacts increased. Where the model has medical clinician input, this is in the main being delivered through additional temporary staff and additional shifts. This is particularly challenging in smaller boards as activity through the FNC is not high in the out of hours period.

8. Feedback from local clinical teams is that they highly value professional to professional calls and clinical decision support offered through the FNCs, to discuss clinical risk and identify safe alternative pathways. The use of digital consultation is understood to improve clinician and patient confidence, effective clinical decision making and provides more patients with appropriate alternative care pathways.

Scheduling

9. Scheduling is taking place across all boards. Of this 6 boards schedule into both A&E and minor injuries, with the remainder only into minor injuries (with the exception of NHS Dumfries and Galloway which schedule only into ED). This is reported by some Boards as having a positive impact particularly into minor injuries as appointments can be matched to activity/staffing. Where scheduling is being used into ED, patients are given a time slot. Due to the current pressures across the whole system, A&E teams are still describing significant numbers of people self-presenting and people who are referred that could have been offered alternative pathways. However, as the programme matures and the public becomes more aware of the new service we expect the level of scheduling to increase.

RUC Activity

10. The aim of the RUC is to reduce attendances to A&E by up to 20% through redirection of self-presentations to more appropriate care pathways away from A&E.

11. The data remains variable and we continue to work with partners to strengthen the data. Prior to the introduction of RUC pathway self-attenders accounted for 60% of all attendances. In latest monthly data (September 2021) self-attenders had dropped very slightly to 58% of all unscheduled attendances. Meaning there were 2% (2,250) fewer self-presenting patients over the September compared to pre-Covid levels. Against that we have saw around 4,400 planned attendances into A&E via NHS 24 111 and FNC.

12. Additional call volumes to NHS 24 are around 10,000 per week. In September there were 36,340 completed contacts originating from NHS 24's A&E telephony option/queue. Of these, 15% were directed to A&E directly or through SAS, 24% were referred on to FNC (around 8,800 patients), 33% were referred to primary care, and 28% were directed to self-care. Approximately half those patients referred to FNCs were given a planned appointment at A&E

13. Whilst we acknowledge 'front door' ED activity is at pre-Covid levels, the indication is that volumes would be higher without the introduction of the RUC NHS24 and FNC pathway.

14. As we actively work to improve data we would hope to evidence the improvement more clearly, but we can say the data is suggesting progress is being achieved and that the

redesign urgent care pathway is positively impacting or at least neutrally impacting on urgent care against a changing environment of public behaviours and access.

NHS 24

15. As a key component of the RUC programme NHS 24 has transformed its operational delivery, at pace to provide a 24hrs per day 7 days per week service to underpin the RUC programme.

16. The NHS 24 Service has worked hard internally to review the ways in which they can improve performance, focusing on capacity during peak points of demand, increased resourcing and reducing call handling times to free up call handler capacity. At present NHS 24 has currently recruited around 80% of their target for recruitment for RUC. NHS 24 are also working on the opening of a new call centre in Dundee, which will be operational by the end of October 2021.

17. NHS 24 is currently receiving around 10,000 extra calls per week. There are around 1,600 calls presented to the new ED option a day (this option asks the patient to press a number if they think they need to go to A&E).

18. Around 24-30% of contacts via the ED option are being routed to the FNC and 12% directly to ED. The remaining callers to this ED line are being routed to alternative options – that equates to 700 callers a day, who indicate they think they should be in A&E that the service are actually routing away from A&E (this figure includes the estimated 50% of FNC contacts redirected away from ED also).

19. The patient journey time is comparable with overall 111 figures - this was 38 minutes for w/e 3rd Oct 2021. NHS 24 advise that this tends to be longer at the weekends, but 38 minutes is the average across the week. The higher proportion of self-care the higher the average, as these calls take longer, so the calls ending up at ED or FNC actually generally take less time.

20. NHS 24 advise that Patient Experience has remained positive despite the longer waits.

21. The demand for the ED line is very much in line with current modelling and NHS 24 are taking 10,000 – 12,000 extra calls a week through this, which is broadly around the 65-70% of self-presenters. This and the other 111 demand has been in line with predicted levels. The exception to this is COVID, which ranges between 4000-8000 a week and is difficult for the service to predict. It is this aspect of demand that is causing the greatest impact in terms of NHS 24 being able to match capacity, often at short notice.

Patient Experience and Public Engagement

22. To gather a greater understanding of the patient journey through the redesigned pathway we commissioned NHS 24 and NHS Greater Glasgow and Clyde to undertake a joined piece of work aimed at understanding if the new pathway is working well from a patient perspective. The approach combined a clinical review of the appropriateness of the pathway and follow up telephone questionnaire to understand their experience.

[redacted]

National Messaging

23. To inform the public of the changes to urgent care we commissioned the Right Care, Right Place public messaging campaign. The first campaign ran from the end November 2020 until end March 2021 and was built up incrementally with TV and radio running over the summer months. An evaluation was carried out in September and overall, the campaign performed exceptionally well, recognition exceeding average campaign levels and the campaign is clearly understood. Key findings from the evaluation are:

- People who recognise the campaign are more likely to call 111
- Fewer people now see NHS 24 as an OOH service and awareness has risen that NHS 24 is available 24/7 – this is higher for people who recognise the campaign
- People with children and people who have underlying health conditions more likely to recall the campaign
- Older people and males less likely than younger people and woman to have seen the campaign but still recall levels are still good
- 41% of people claim to have acted on the campaign messages – the most likely action to call 111 instead of attend A&E
- Satisfaction levels for NHS 24 and A&E are high

24. Planning for a further burst of activity through November is underway and Right, Care, Right Place messaging will be incorporated into this year's winter campaign which is being developed by NHS 24.

Evaluating the RUC

25. An evaluation programme has been established to deliver a comprehensive evaluation of progress with pathway implementation and to monitor the impact on public confidence, patient expectation, satisfaction and experience, quality, safety and cost benefit. An Advisory Group has been set up, chaired by Sir Lewis Ritchie and Prof Derek Bell, and made up of key stakeholders including representatives from the professional bodies, Health Boards and a Lay person. A First Staging Report was published in July 2021 and a Second Staging Report is in development, due to be available later this month.

26. The Second Staging Report will bring together data, information and intelligence from a number of commissions, activities and sources including:

- Review of the risks and mitigations detailed in the pathfinder report
- Review of the progress with recommendations from the First National Staging Report
- Management data and information at key touchpoints across the RUC pathway
- Listening exercise (12 focus groups) undertaken to understand the lived experience of the NHS Scotland staff involved in the RUC pathway
- The Redesign of Urgent Care Gathering Views Report, Healthcare Improvement Scotland (September 2021), to understand what matters to people who are more likely to experience barriers or disadvantage when accessing the RUC pathway via NHS 24 111
- Public Heath Scotland report on equity of access of RUC
- Evaluation of the RUC public messaging campaign
- Review of the patient pathway including a report on patient experience

- Reports to the Strategic Advisory Group
- Feedback from the RUC Evaluation Advisory Group

27. To inform the report 12 focus groups were held to engage with a wide range of staff across NHS Scotland to hear their lived experience of the RUC pathway. Overall, there is broad based support for the intent and principles of RUC pathway and each Health Board has made progress with implementation. Staff have also reported that partnership work across multidisciplinary and multi-agency teams has improved removing barriers and building relationships and trust.

28. Findings from the report will help inform what further work may be needed to enhance the RUC and move forward ensuring a service that is fit for the future and results in better outcomes of care and experience for our patients and staff.

29. A further external evaluation is being commissioned and will augment the two Staging Reports by focussing on a specific set of research questions with a final report due by end March 2022. The research is required to understand the impact on staff experience; patient and public experience; cost benefits and to better understand the whole system response and what additional data is required. In preparation, Chief Executives have been asked to ensure work is underway locally to assess patient and staff experience and ensure appropriate processes are in place which will allow the external team to develop a cost benefit analysis.

Next Steps – Phase 2 of RUC

30. In the meantime, to support the pathway to mature over winter and beyond, phase 2 of the programme continues to develop which focuses on the interconnectivity between clinicians and will deliver the following workstreams -

- GP – in and out of hours referral process and interlinkages between Flow Navigation centres, NHS 24 and GP
- Community Pharmacy – with increased provision of minor ailment services there is a need to seamless transfer and recognise clinical assessment to avoid duplication.
- MSK service – this is a high volume flow and improved access to specialist opinion as early in process as possible with improve outcomes for patients
- Scottish Ambulance Service – to avoid duplication in referral and communication and reduce delays in handover, keeping patients as close to home as possible, wherever possible.
- Mental Health Pathways – this is a high volume and complex pathway that requires rapid access to the right clinical team without multiple handover and delay.

31. This work will maximise the opportunities in the system to direct patients to the most appropriate pathway of care for their needs, first time.

Conclusion

32. Overall the RUC programme is delivering a reduction in self-presentations to ED departments. It should be acknowledged that the model is in its infancy, having only been

in place for 10 months and fully launched with the public since July 2021 against the backdrop of a pandemic and unprecedented healthcare demand.

33. The Second Staging Report will be available later this month and will shape the direction of the external evaluation and way forward for the next year.

Document 2 - Redesign of Urgent Care - Submission - 30 November

From: Helen Maitland
November 2021
Unscheduled Care

PS / Cabinet Secretary for Health and Social Care

Redesign of Urgent Care – Second Staging Report

Purpose

34. To provide the Cabinet Secretary with an update on the Redesign of Urgent Care Second Staging Report which has been led by Professor Derek Bell and Sir Lewis Ritchie and is a summative report that aims to inform and improve the direction of travel of the Redesign of Urgent Care pathway. It should be noted that the Programme was developed at pace in response to Covid however this transformational change of this scale will require further redesign and improvement. A full set of actions have been identified in response to the report which will be progressed at pace and are outlined at para 29 -30.

Background

35. The Redesign of Urgent Care programme (RUC) is a national approach to redesign how we deliver and access urgent care, and set out a programme timescale of 3 years to fully realise the benefits. A key ambition of the Programme is to direct self-presenting patients to the right care in the right place and prevent unnecessary hospital attendance.

36. The Second Staging report is the third report assessing the Redesign of Urgent Care programme. The first report assessed early progress of the NHS Ayrshire & Arran RUC Pathfinder in November 2020. The subsequent report, the RUC First Staging Report, covered the period December 2020 - March 2021 and this RUC Second Staging Report, covers the period April 2021 to September 2021.

37. The first staging report offered a number of recommendations to progress the Redesign of Urgent Care. It recognised the pace of this work was as a result of recruitment to NHS 24 (particularly clinical supervision roles) being more challenging and as a result the subsequent delay to national communication and marketing to fully inform the public of the new pathways and influence public behaviours.

38. The purpose of this Second National Staging Report is to review the progress of the RUC pathway implementation, opportunities, challenges, lessons learned and to make recommendations to inform how the pathway and transformation programme approach is further developed. The report has been informed by patient pathway data and incorporating the experience and views of the Scottish public and care professionals.

Findings

39. [redacted]

Summary and Next Steps

40. The recommendations (Annex A) will be considered by Chief Executives at their meeting on the 14 December and we will seek endorsement for the Scottish Association for Medical Directors and Scottish Executive Nurse Directors. Ahead of further development a key priority will be to consider how best to integrate FNC roles into the broader health system and reduce delays in the care pathway.

41. Following this report becoming available, on the 22 November officials met with the Chairs of the Strategic Advisory Group, Prof Derek Bell and Sir Lewis Ritchie to discuss the strategic direction of the RUC Programme. The paragraphs below outline the critical next steps identified:

- There is consensus on the need to refocus the approach to ensure whole-system transformation, moving from a singular approach to integrated one with Primary Care as a strong foundation providing responsive 24/7 access to urgent and unscheduled care.
- Ahead of further development, the RUC Programme will seek to obtain full compliance from NHS Boards and an in-depth analysis will be undertaken of the responsiveness and resilience of the individual components of the patient pathway. This exercise will be used to model a set of options which will be tested to determine best value for money and impact on patient care.
- The next phase is currently underway and will consider the recommendations fully and seek to be more ambitious. The plans for phase two correlate with consistent engagement from a number of stakeholders as part of the focus groups who will be essential partners in the next stages of development, in particular Community Pharmacy, GP's and SAS.
- Improvement goals, deliverables and milestonesare being developed for all pathways with ongoing evaluation and monitoring.
- To fully understand the effectiveness, efficiency and user experience of the current RUC pathway, work is being progressed to ensure all NHS Boards undertake a pathway review, taking forward the approach and learning from the NHS GG&C test. This will enable the necessary improvements in the patient pathway, ahead of Phase 2 launch and further investment.

42. Overall, this Second Staging Report suggests a need to refine and optimise aspects of the RUC Programme, rather than increasing activity/volume across the whole pathway.

43. As the Redesign of Urgent Care evolves, it will be imperative that shared learning of implementation issues and solutions continue to be assimilated and effectively deployed throughout NHS Scotland.

44. We will continue to evaluate, monitor and consolidate progress to deliver the ambition of a reduction in self–presenters to A&E guiding the public to the Right Care in the Right Place

Conclusion

45. The Cabinet Secretary is invited to note and comment on the Second Staging report.

Document 3 - Cabinet Secretary Submission - Marketing and Communications - 14 June 2021

From: Helen Maitland

Unscheduled Care
14 June 2021

Cabinet Secretary for Health and Social Care

REDESIGN OF URGENT CARE – COMMUNICATIONS UPDATE

Purpose

1. To seek the Cabinet Secretary's approval on timelines and budget for the previously delayed TV and Radio elements of the Redesign of Urgent Care (RUC) communications plan.

Priority

1. Urgent

Background

2. A key ambition of the RUC Programme is to direct patient to the right care in the right place and thus prevent unnecessary hospital attendance. The cohort of attendances the programme will impact on is the 860,000 self-presenters where research suggests circa 20% could be managed more appropriately by direction to more appropriate professionals or self-care. Initially we saw marginal and incremental gains in the shift in attendances of this cohort to A&E however as restrictions are easing and perceived confusion in the public of what services are open, attendances and contacts across all parts of the system are increasing.

3. The Redesign of Urgent Care national approach was launched on 1 December 2020 following a successful pathfinder test of conceptual model in NHS Ayrshire and Arran over November 2020. To support the national roll out a national marketing and communication plan was agreed that included Digital media, radio and Television to support the public to make the right choices and access the right care in the right place.

4. The TV and radio elements of the RUC campaign were initially due to take place in January/February, however this was delayed due to the service pressures already on NHS 24. We know TV in particular will have a significant impact on call demand and it was important to ensure that the service would not become overwhelmed by any spike in demand from advertising.

5. While digital and press activity continued to the end of March, the next stage of the campaign was then re-planned to start post Easter with bursts of activity over a two month period. However, following discussion with a small group of board Chief Executives and NHS 24 sponsor team, it was agreed that the national RUC programme launch was to be further delayed for the remaining planned media due to the potential of adverse media

coverage in the run up to the election as well as to ensure service demand on NHS 24 had settled and recruitment targets were more aligned with demand.

6. As part of the work undertaken by the RUC National Messaging workstream, a number of communication and engagement pieces of work have already been undertaken to date. During the NHS Ayrshire and Arran pathfinder, the national messaging was tested through local channels and there was agreement that the soft messaging was useful in allowing processes to fully embed. To support a seamless introduction of the new service, it was agreed to replicate this approach with a soft launch of the national programme through December and into January – with social media, press and PR.

7. In January, there was a national door drop leaflet issued across Scotland which included a broad range of information on all available NHS services available over winter and acted a very useful guide to the public. There was a small section on the new pathway to NHS24/111, contained within a broad range of useful information on all services and on balance aimed to reinforce all alternative and appropriate services for care to guide the public to the right care at the right place. While paid for activity on this campaign is currently on hold, Health Boards continue to push key messages through their channels.

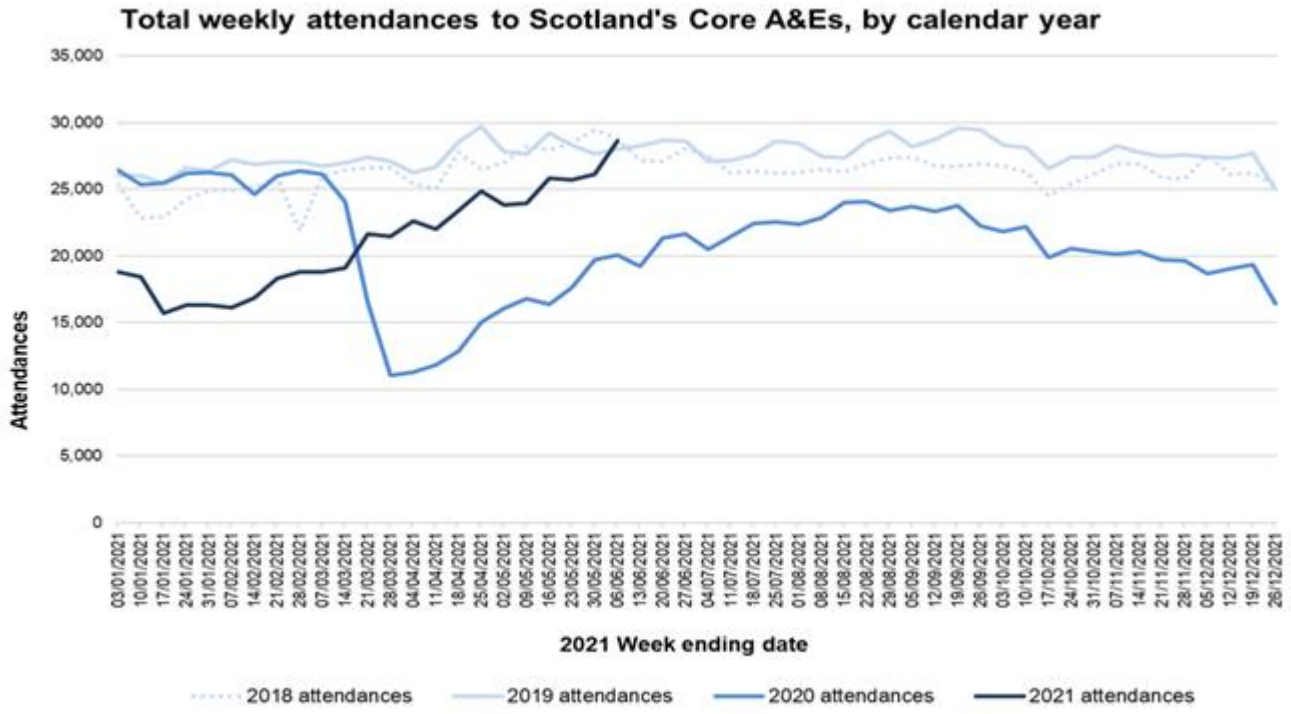
8. We are now seeing significant pressures across all areas of the system due to pent up demand from the pandemic, with national messaging required to help the public access the appropriate pathways. We have evaluated the overall risk to further delay of the campaign and the current rise in attendances at A&E and the potential adverse impact on NHS 24 response. On this basis, the Strategic Advisory Group has agreed the need to proceed with the campaign as soon as possible to avoid losing the gains already made. It is proposed that the revised RUC media plan will ideally run from 21 June – 8 August, although this can be delayed by 1 week (28 June) if needed, and the considerations given are set out in this paper along with a table setting out dates and expected reach in **Annex A**.

9. In addition to the signposting to the right care in the right place, another ambition of the programme is to keep patients and staff safe by minimising the risk of nosocomial infection in overcrowded A&Es. As pandemic related restrictions begin to lessen, as expected we are starting to see change in public behaviour evidenced in a significant rise in A&E attendance. This model offers an opportunity to schedule unscheduled care and manage the variation in demand in a more structured way through planned appointment slots. Feedback from users has been very encouraging with parents and carers in particular welcoming this approach.

A&E Attendances

10. Scotland core attendances have increased during the last few months with most recent management information showing that for week-ending 30/5/2021 there were a total of 26,376 unplanned attendances at ED with average 4-hour performance at 85.5%. With planned attendances averaging around 800 per week, the total attendances being seen in ED in that week were approximately 98% of pre-Covid attendance levels when ED attendances averaged 27,700 per week (over 2019). Some of the most challenged sites including those within NHS Lanarkshire, NHS Lothian and NHS Borders, are already seeing attendances exceed pre-Covid levels.

11. Compared to February unplanned attendances have increased by 50%, up from an average of 2,506 to 3,768 attendances per day. Flow 1 (minors) is the group that shows the highest increase in attendances, up 75% for w/e 30-May compared to February. Self-presentations continue to rise as a proportion of total attendances and for w/e 30-May accounted for 55% of all attendances. It is considered that many of these patients could be helped to access more appropriate services for their needs through the RUC pathway. More recent data indicates that we have exceeded pre-Covid average.



12. It is also important to note that currently the biggest challenge for our acute sites is capacity and occupancy. This is compounded by a rise in patients presenting who have delayed accessing care and for some are much sicker. This results in a higher admission rate and a longer length of stay. As a result we are hearing reports of crowding in EDs which is also impacting on ambulance turnaround times. Any increase in attendances would compound these pressures and have a measurable impact on performance and patient delays.

NHS 24

13. The resource and service demands within NHS 24 have impacted on the ability to move to the next phase of the RUC programme, delaying high-profile national and public communications to seek to influence optimal public urgent care help seeking behaviour.

14. At the beginning of the year NHS 24 was experiencing significant challenges with its call answering performance with callers often experiencing waits of over an hour to access the Service, particularly at peak periods of demand over weekends and public holidays.

15. As a result, Scottish Government officials have been working closely with NHS 24 to support them with performance improvement. A short life working group was set up focussing on 4 key themes to support this improvement - demand and capacity modelling, recruitment challenges, staff absence rates, and a peer review with the Welsh 111 Service.

16. The Service has also been working hard internally to look at ways in which they can improve performance, focusing on capacity during peak points of demand, increased resourcing and reducing call handling times to free up call handler capacity.

17. At its peak in February 2021, the median time for calls to be answered was over 18 minutes, with the 90th percentile time at 1 hour 38 mins. Since then, as a result of the work this group has undertaken, and actions put in place call answering times have improved significantly, with the median time to answer last week being 9 mins 18 seconds and 90th percentile 31 mins 52 secs. Going forward, NHS 24 are now have a short term target for median time to answer of less than 10 mins, and 90th percentile calls to be answered in 30 mins or less by end June 2021. NHS24 also have a trajectory to reduce this further over the next 3 months whilst simultaneously coping with increased demand.

18. These improvements are based on modelling, which has factored in the additional demand that will be placed on the Service by the roll out of this media campaign and also takes into account the recruitment of additional staff to meet that demand. It should also be noted that the longer waits for call answering are predominantly for the mental health hub and a rigorous plan to increase mental health practitioners to cope with this increasing demand is underway in parallel.

19. This work undertaken with the Service and the significant improvement we have seen in call answering standards has provided the re-assurance that the Service are in a good position to cope with the additional demands which will be placed on their services following the further roll out of the media campaign. Performance will continue to be closely monitored and reported weekly by the NHS 24 sponsorship team.

20. The impact of stronger public messaging will undoubtedly increase the NHS 24 111 – FNC pathway and A&E attendances will decrease. This should also be considered alongside ensuring the public are aware that their GP practice is open for their care needs.

Evaluation

21. An interim evaluation study of the campaign thus far was run in May 2021 to help gauge how much spend and weight to put behind the full national campaign. The evaluation, involving a quantitative study of a nationally representative audience, in addition to some focused evaluation for NHS Ayrshire and Arran, demonstrated the campaign so far has in fact been highly effective with four of the five SMART objectives having been achieved already. Successes include:

- Four of the five SMART objectives were exceeded:
    - Relevance, target 40% achieved 80%
    - Clear understanding, target 40% achieved 87%
    - Take action, target 40% achieved 51%
    - Explain why it's important, target 25% achieved 89%

- Satisfaction scores for all NHS services, including waiting time to answer the phone on 111 were high.
- Spontaneous recall was fairly high. Good levels of cut through despite very crowded landscape and not fully rolled out campaign.
- Good prompted recognition given the campaign is not fully rolled out.
- The campaign fostered high levels of engagement.
- It is communicating clearly and high numbers of people claim to have acted on it

22. In terms of visibility and reach, there was fairly good prompted recognition given the campaign is not fully rolled out. Radio performed very well, especially as it aired only in Ayrshire and Arran, as did Facebook and younger people were more likely to recognise the campaign. Recognition in A&A was higher that Scotland, which endorses the use of radio. Parents and carer/sufferers were more likely to recognise the campaign.

23. The take home message was that the campaign is clearly signposting people where to go as well as encouraging people not to put off getting medical care.

Conclusions

- The more channels people see the greater likelihood of them acting on the campaign.
- Half of those who have seen the campaign claim to have acted on it. 40% phoned 111 in place of using other service. This calculates to 7% of the total sample
- Understanding of NHS 24 111 as an out of hours service persists.
- The campaign has not actually run with its full proposed media plan (i.e. no TV) and yet it has performed well
- The use of TV would be likely to drive recognition which will result in an increase of calls to 111.
- If the intention is to inform the public without overwhelming the NHS 24 111 telephone service, the roll out of radio, with an extension of social and press barring TV would be an effective strategy.

Campaign Approach

24. Based on the evaluation above and on data for NHS 24 and A&E, Options of different weight campaigns, that included or excluded TV, were presented to the Strategic Advisory Group for Redesign Urgent Care who deliberated and agreed a blended approach combining all aspects of social media should be developed.

25. This conclusion was presented to the newly formed Integrated Unscheduled Care Steering Group (IUCSG), chaired by John Burns, on 2 June 2021 to consider and ensure this campaign would not impact on the wider determinants of Unscheduled Care. The group offered no disagreement but agreed that a risk strategy should be considered and that adequate monitoring was in place with ability to turn down the campaign if systems became too pressured.

26. The recognised risk that TV could produce a spike in calls to 111 remains, although NHS 24 workforce will be more aligned to service demand to mitigate the risk. A robust

monitoring of this impact will be in place and a refresh of the communications toolkit which will be reissued to boards for their own communications channels.

27. There was agreement that on balance, we will undertake a blended approach incorporating elements to ensure maximum reach in an incremental way. This will include building in balance and check measures for each phase of media monitoring impacts on the system before moving to the next step. TV would be the final step in cognisance of the significant impact this will have.

28. Readiness Assessments have been carried out with NHS Boards and NHS 24 to ensure they have systems and processes in place, as well as capacity to manage demand from the full role out of the Redesign Urgent Care pathway. We will write directly to Chief Executives alerting them of the launch date. We will continue to monitor the impact on NHS 24 and NHS Boards and have the ability to decrease the volume of the campaign if any pressures are emerging.

Proposal

29. It is proposed to run the phased campaign from 21 June to 8 August and consists of TV, radio, social/digital, press and outdoor (pharmacy panels). The TV and radio are staggered as before, plus the digital and press are layered in at a lighter weight when TV is off air. This is to be able to robustly monitor call volumes to 111 and in response adjust our media activity if required.

30. This means almost 82% of All Adults in Scotland will see the campaign at least once and over 61% three or more times. On average people are likely to see the campaign 17 times.

Budget

31. This will be funded utilising existing unscheduled care funding. Budget required to deliver the activity will be circa £300k to cover:

- Media: £263.5k (as per attached plan, plus £13.5k towards the Pharmacy Posters)
- Fees and Production: £21.5k allowance for our agencies to reactivate. Costs TBC on approval of media plan.
- Evaluation: £15k

32. A separate submission will be issued to the Deputy First Minister this week for the full marketing budget which will include this marketing expenditure of £300k.

Recommendation

33. The recommendation is to run the revised RUC media plan from 21 June – 8 August and would consist of TV, radio, social/digital, press and outdoor (pharmacy panels). The TV and radio would be staggered as before, plus the digital and press would be layered in at a lighter weight when TV is off air. This is to be able to keep an eye on call volumes to 111 and in response adjust our media activity if required.

Conclusion

34. The Cabinet Secretary is invited to approve the communications plan from 21 June – 8 August, including timescales (tbc), the budget required to deliver the current plan for communications including timescales and the rise in A&E attendances.

HELEN MAITLAND
National Director Unscheduled Care
14 June 2021

Media	Format	June				July				August				
		7	14	21	28	5	12	19	26	2	9	16	23	30
TV														
STV/C4/ITVB	30"													
Broadcaster VOD	30"													
Sky Adsmart	30"													
RADIO														
Commercial Radio	30"													
BAME Radio	30"													
Community Radio	30"													
PAID SOCIAL / DISPLAY														
	Static / GIFs / Video													
PRINT														
	Local Press pages													
OUT OF HOME														
	Pharmacy Panels													

Coverage & Frequency	All Adults Scotland
1+	81.90%
3+	61.30%
Reach 000s	3.8m
Ave OTS	17.0

Document 4 - Cab Sec Update - RUC Paediatrics Pathway to FNCs - 25 May 2021

From: [redacted]
Unscheduled Care
25 May 2021

[redacted]

Document 5 - Briefing for Cabinet Sec- RUC Discovery V0.4 (FINAL)

From: [redacted],
Directorate For Health Performance and Delivery,
Elective and Unscheduled Care,
19 January 2021

Cabinet Secretary for Health and Sport

NHS REDESIGN OF URGENT CARE DISCOVERY

Purpose

35. To provide the Cabinet Secretary with a report on the work undertaken by the Scottish Government Digital Transformation team in relation to the Redesign of Urgent Care, to understand the potential impact on health inequalities.

Priority

36. Routine

Background

37. A critical factor in successfully redesigning urgent care services is ensuring that it does not further disadvantage or widen health inequalities. To support this, an eight-week discovery project was undertaken by the Scottish Government Digital Transformation team to better understand the needs, motivations and potential issues that self-presenting citizens accessing urgent and emergency care may encounter, with a specific focus on the impact that the change in service will have on vulnerable citizens. The report identified a number of key user needs that were not currently being met by this new pathway, and presented a number of recommendations to mitigate any unintentional inequity in accessing these services.

38. The project team targeted three user groups they deemed most likely to suffer from the change of service; those whose first language was not English, those experiencing homelessness, and those with anxiety and depression. It is important to note that this work was carried out with a small group of users and based on existing research. Further work is required to test out the findings and identify any gaps.

Report Findings

39. Overall the report finds that those who encounter little or no difficulty interacting with the redesigned urgent care pathway can expect to experience many benefits from the changes.

40. Report findings show that there are a number of benefits to the new service including:

- Avoiding the cost of transport
- Accessing medical consultation from the comfort of home

- Scheduling visits to the hospital around care responsibilities
- Access to local specific information hubs
- Avoiding or minimising the discomfort of attending A&E
- Avoiding unnecessary travel
- Source of reassurance
- Minimising risk of infection
- Minimising crowding in waiting areas

41. However, journey mapping carried out by the service designers suggests that utilising digital alternatives to A&E attendance has the potential to create additional barriers for vulnerable groups. As a result, for those with complex needs, self-presenting at accident and emergency may be less stressful.

42. In order to best demonstrate the current gaps between the service as it stands and the needs of the users most vulnerable to health inequalities, the discovery report outlines nine user needs identified through DTS research and the impact of not addressing these needs during the Redesign of Urgent care roll out. Coupled with these needs are the related opportunity statements - these help to expand on the benefit of addressing these needs and provide a platform for any future work. The recommendations focus on improving access to digital; improving telephone services for those with language barriers; ensuring call handlers have appropriate training to ensure appropriate and equitable care; targeting national messaging at vulnerable groups; ensuring collaborative working with partner agencies. The recommendations are contained within **Annex A.**

Next Steps

43. It is pertinent to note that the project was undertaken using a small number of participants and it is important that before we move to fully implement the recommendation that these are tested out on a wider scale. To take this forward the unscheduled care team are working with colleagues from Healthcare Improvement Scotland (HIS) to develop a robust public engagement process. This will include two initial exercises:

<u>Gathering Views</u>

- HIS – Community Engagement's network of engagement offices are able to collate comments and experiences from across Scotland to give local, regional and national perspectives using focus groups, interviews, questionnaires and events. Additionally this approach works with local third sector organisations and community groups to reach people, especially those who are often excluded from consultations.

- The focus for Gathering Views is to run early 2021 to address equalities-related engagement gaps in the discovery phase work with particular regard to the protected characteristics and most marginalised communities. This work will also be informed by experience gained during the NHS A&A pathfinder exercise, with findings to be published on the HIS website and publicised through their social media platforms.

- The timeframe for Gathering Views is set to begin in January, with a provisional timeframe of March / early April 2021 for completion.

Citizens' Panel

- HIS will run a Panel in May 2021 which will comprise a series of questions relating to the Redesign of Urgent Care and in particular the service configuration, barriers to access considerations, and ways to improve. This will be directly informed by the engagement activities undertaken from October 2020 with the discovery phase, through the practical experience of operating the new delivery model over the winter period, and the learning gained from the Gathering Views work.

- The timeframe for the Citizens' Panel is set to begin in April, and would take the work through to end July / August 2021.

44. HIS has also been asked to consider how patient experience might be evaluated. To do this they will assess how NHS A&A locally has evaluated the pathfinder project. HIS agreed to act as a 'critical friend' to the NHS A&A team and to disseminate their comprehensive approach to assessing patient and staff experience of this new service to other NHS Boards.

45. We are also working with *Care Opinion* to determine how we can assess and shape the service model. This may lead to HIS developing an evaluation framework which can be used by NHS Boards and, potentially at national level, to determine the impact of this new model of care.

46. Additionally it is important to note that across the programme all workstreams are ensuring patient experience is at the heart of the Redesign of Urgent Care. As such a number of these issues are already being addressed. For example, our communication plan includes a clear focus on reaching disadvantages groups; we are working with NHS 24 to ensure equitable access for those with language barriers; we have been clear with Boards that no patient should be turned away; mental health colleagues are working to increase the navigator programme.

Communications and Engagement

47. Scottish Government marketing team is currently working with the following organisations to identify specific challenges in effectively reaching seldom-heard or vulnerable groups with the Redesign of Urgent Care messaging; NHS and PHS colleagues, BEMIS (Umbrella organisation for Ethnic Minority Voluntary Sector), CEMVO (National intermediary partner and strategic partner of the Scottish Government Equality Unit) , MEHIS (Minority Ethnic Health Inclusion Service) MECOPP (Minority Ethnic Carers of People Project) and the Scottish Public Health Network (Gypsy/Traveller Community). Insights gathered from these conversations will help shape marketing materials, and collaborations will help to ensure messaging reaches communities via trusted voices, such as community leaders.

48. Marketing materials such as 'The Right Care Right Place' Door Drop will be available online in multiple languages and formats, including all PHS primary and secondary languages, BSL, Easy Read, Large Print and Audio versions. Launch

communications will also be sent to Equality and ME community stakeholders via online channels. In addition to this, an A4 Fact sheet is currently in development which aims to summarise guidance, this will also be available in multiple language formats for further dissemination.

Conclusion

49. The Cabinet Secretary is invited to note and comment on the discovery report which has been carried out by the SG Digital Transformation team to understand the potential impact on health inequalities and the work underway in partnership with HIS to test the recommendations. The Cabinet Secretary will also wish to be aware that this work will form part of the overall Redesign of Urgent Care evaluation. An evaluation group is in development and will be fully established in the coming weeks, this may be subject to change due to COVID-19.

50. With the consent of The Cabinet Secretary, we plan to publish a version of this report alongside the EQIA early this year.

[redacted]
DIRECTORATE FOR HEALTH PERFORMANCE AND DELIVERY
UNSCHEDULED CARE

Annex A

Key User Needs & Recommendations

Key User Need	Design Hypothesis
1. I need call handlers and clinicians to be aware in advance of any additional support needs that I may have so that I don't need to repeat this information.	I. **We believe that by providing** call handlers, clinicians, and reception staff with any information related to the practical and emotional needs of the user, **we will reduce** the user's anxiety and fatigue by repeatedly reassuring them at every step that they have been listened to and their needs are being addressed. **We will know this to be true when** we receive positive feedback from users and see a reduced dropout rate. II. **We believe that** by exploring how people who might have additional support needs could log their needs with NHS 24 in advance of an urgent care event, **we will enable** people to have greater choice and control over their everyday care needs and reduce the need to obtain that information at the time of an urgent care event, resulting in less emotional distress and more efficient and effective consultations. **We will know this to be true when** we receive positive feedback from users and support groups. III. **We believe that** by improving NHS 24 automated messaging menu to meet the needs of those for whom English is not a first language, while improving awareness of these improvements among affected communities **we will** minimise difficulty and frustration people have when accessing interpretation support when in need of urgent care. **We will know this to be true when** we receive positive feedback from users and support groups, see reduced dropout rates, and see improved access rates during rollout.
2. I need for my abilities, needs and motivations to not be presumed, so that I am provided with appropriate and equitable care.	I. **We believe that** by developing procedures and training to support call handlers and clinicians to actively promote additional measures into their workflow, **we will improve** the user experience and foster more collaborative relationships between service users and service providers. **We will know** this to be true when we see the uptake of additional support measures increase and when we receive positive patient and staff feedback.

3. I need access to a phone so that I can use it to get help, no matter where I am.	II. **We believe that** by improving access to basic mobile telephones with specific instructions on how to access NHS 24 for issues most commonly experienced by people who experiencing homelessness, **we will improve** awareness of NHS 24 and remove barriers to accessing telephony based health. **We will know** this to be true when we see data of increased phone ownership among people who are homeless.
4. I need access to a supporter so help me in a crisis so that I can find and access the help I need.	I. **We believe that** by providing phone charging points within A&E waiting rooms, **we will ensure** that people with access to phones can keep in touch with supporters who are unable to join them in the waiting room area but who they may rely on for emotional or practical support, reducing anxiety and give people access to means of arranging transport upon discharge. **We will know** this to be true when we receive positive patient feedback to experiments. II. **We believe that by** providing a simple, clear, and dignified exemption process to allow supporters to attend A&E appointments similar to that for mask exemptions, **we will** reduce user anxiety, enable better clinical outcomes, and reduce health inequalities through access. **We will know this when** we receive positive feedback from users and support groups, and see improved access rates during rollout. III. **We believe that by** providing exemption badges to people who are allowed a supporter while waiting in A&E due to additional support needs, **we will** deter other patients from questioning why somebody is allowed a supporter and they are not, preventing confrontation, embarrassment and confusion. **We will know this when** we hear positive feedback from those using badges. IV. **We believe that by** exploring how NHS practitioners and third sector organisations might collaboratively provide clinical, practical and emotional support in community spaces trusted by vulnerable people, **we will** enable greater access to preventative treatments and avoid later trips to A&E, as well as providing intermediary support to access clinicians via NHS Near me. V. **We will know this to be true when** we see a reduction in the number of self-presentations from specific groups and when we see a greater

	number of supported remote consultations triaged from community based practitioners. VI. **We believe** that by increasing awareness among clinicians and patients of functionality to enable multi-person conversations via Near Me, **we will improve** access to additional emotional and practical support for those who need it most. **We will know this when** we see data that shows an increase in the use of this functionality and when we receive positive feedback from patients and clinicians.
5. I need privacy so that I can speak freely and honestly about my needs.	I. **We believe that** by providing access to text based communication methods for initial urgent inquiries via 111, **we will improve access** to urgent care for people who are vulnerable to the surveillance or judgement of people they live with, improving safety and the ability to provide essential, confidential information. **We will know** this to be true when we monitor the types of inquiries coming through text messaging or web based messaging services and who is using this functionality. II. **We believe that by** working with community based charities to provide access to space for private conversation, **we will** reduce user anxiety, enable better clinical outcomes, and reduce health inequalities through access. **We will know this when** we receive positive feedback from users and support groups, and see improved access rates during rollout.
6. I need access to a device and data/Wi-Fi so that I can have a remote consultation	I. **We believe** removing data charges associated with accessing NHS Scotland web-based services **we will** ensure that the NHS is free at point of access for all and that those who cannot afford data costs or do not have access to WIFI when in need of urgent care can use remote consultations. **We will know this to be true** when we see greater numbers of remote consultations originating in locations of multiple deprivation. II. **We believe** that by providing temporary accommodation facilities and having training and resources to support access to NHS remote consultations, **we will** reduce provide targeted support to people with significant emotional and practical barriers to accessing care. **We will know this to be true** when we see an increase in remote

	consultations from locations which support people who are homeless. III. **We believe** that through partnership working with local libraries to provide private space for remote consultations**, we will** increase access to video enabled care for those without access to video devices. **We will know this to be true** we see data from libraries regarding the uptake of this opportunity.
7. I need access to primary care services so that I can manage, improve and maintain wellbeing.	I. **We believe** that by removing the requirement for service users to be registered with a GP when accessing Pharmacy First services, we **will** enable people most vulnerable to health inequalities to prevent a health difficulty requiring urgent care. **We will know this to be true when** we see an increase in the use of pharmacy services among specific groups and a reduction in urgent care attendance. II. **We believe that** by providing accessible digital registration services for people who need to register with a new GP practice **we will** enable people vulnerable to health inequalities to receive support in their communities to register. **We will know this to be true when** we see the number of people who are not registered with a GP declining.
8. I need to be provided with up to date, accurate, and relevant information so that I can make an informed choice about where to access care.	I. **We believe that by** augmenting the national campaign with specific messaging for communities vulnerable to health inequalities with people from those communities, delivered by people trusted by the communities, **we will** reach people who may not engage with national communication campaigns and increase the numbers of people from these communities seeking urgent care support and mitigate the spread of inaccurate information about the service. **We will know this when** we see user levels resemble the predicted level of specific community's needs.
9. I need to be able to access care if I can't or don't want to give a phone number to a call handler so that I still receive the care I need.	I. **We believe** that by providing a priority triage for those unable to receive a call back, **we will** reduce user anxiety, and improve patient safety for those most vulnerable to health inequalities. **We will know this to be true when** we see reduced dropouts for those with limited telephony access.

Document 6 - SUBMISSION - Right Care Right Place Campaign Plan

[redacted]

Document 7 - Cab Sec Update - RUC -proposed incremental approach – 141020

From: John Connaghan
Chief Executive of NHSScotland
14 October 2020

PS /Cabinet Secretary for Health and Sport

REDESIGN OF URGENT CARE – IMPLEMENTATION PLAN

Purpose

51. To provide the Cabinet Secretary with an overview of the work undertaken to assess Board readiness in relation to the Redesign of Urgent Care programme and to seek approval on the proposed option for implementation including timescales and approach to delivery. The Cabinet Secretary is also invited to approve the proposal to allocate funding to Boards this week for the Redesign of Urgent Care work.

Priority

52. Urgent

Background

53. The Redesign of Urgent Care programme promotes a significant change in how we stream patients through our entire system. The programme carries a number of significant benefits in modernising our unscheduled care pathways to ensure patients have access first time to the right clinical care but also carries risks to implementation- such as staffing being ready, trained and available to provide new and enhanced services, and realigning public behaviour such that attendance at our Emergency Departments is not seen as an automatic first choice and we can support the public to access the right care, in the right place, at the right time.

54. To mitigate against these risks we have asked Boards to submit fortnightly **readiness assessments** to allow the unscheduled care team and workstream leads to determine where there are issues. To evaluate the readiness assessments we brought together a sub-group of the Strategic Advisory Group for the Redesign of Urgent Care as a stocktake group. Discussions focussed on the direction of travel, the impact on the whole system and considering how we can mitigate against risk by looking at alternative options to the national roll out of the full programme as originally planned for 31st October. Four options have been considered –

- Full Implementation with national rollout from 31st October
- Delayed rollout of full implementation (e.g. December)
- Incremental rollout from December
- Incremental rollout from December but one or two Boards go early (Nov) as pathfinders

55. To assess the desirability, viability and feasibility of each options it was agreed a number of factors would be taken into consideration including the readiness assessments, discussion with implementation leads to understand benefits and risks, and impact assessment of each option.

Board Readiness

6. In September 2020, the RUC programme wrote to NHS Boards and requested they complete and return a readiness assessment in order for the programme to have a national view on the ability to 'go-live' with new service models in Autumn 2020. In summary some Boards are not able to confirm that they will be ready for the full implementation rollout by start of November. The current position is that we have engaged with all partners and a slower start up giving Board an extra month to prepare but allowing two Boards to act as pathfinders from 1st Oct is the preferred way forward. In essence we will concentrate on flow one to A&E which is the flow which might benefit most from treatment and advice outside the confines of A&E

7. For Island Boards NHS Highland have agreed to host the assessment hub for all these Boards as they have done so in Covid. The process model is being agreed and we will look at this as different model as part of evaluation process.

Winter Pressures

8. In general, demand on all aspects of the system has returned to historical levels for September and October, the exception being A&E attendances and delayed discharges which are at 75% and 66% of historical levels respectively. As well as early autumn/winter pressures we are seeing increases in both COVID-19 presentations (consistent with a second wave) and respiratory presentations. The 4 hour emergency access target has fallen in recent weeks too, and is now 89% consistent with pressure within the system. There are growing concerns about the system's ability to deliver these services, including managing a COVID 19 pathway within current constraints, in particular, workforce. The planned redesign is ultimately intended to address some of these challenges, but brings its own workforce issues and risks which are difficult to quantify. Recruitment is proving challenging for this redesign alongside recruitment drives for Test and Protect and Vaccination programmes.

9. There is widespread agreement that a do nothing scenario is not an option due to the significant risks to the safety of patients, staff and the whole system ability to deliver. There remains consensus from all Chief Executives on implementation of the full approach at some point.

GP Out-Of-Hours

10. GP OOH plays a vital role in the urgent care of patients out of hours which constitutes 2/3rd of the working week. NHS 24 111 currently refers approximately 50-60% of their contacts to all GP OOH services which makes up the vast majority (80%) of their workload. At present for a proportion of boards staffing GP OOH is an on-going concern and the potential for increased demand through NHS 111 without sustainable

staffing of GP OOH Doctors and Nurses poses a risk in relation to the service as well as redirection of patients back to A&E in times of pressure. We are working with primary care colleagues through the readiness assessment process to assess, mitigate and respond to workforce concerns.

Assessment

11. In all options a local flow navigation centre would be established in each health board area to receive clinical referrals for consultation from NHS24. This would include provision of a multi-disciplinary clinical and administrative team, optimising virtual technology wherever possible to undertake an initial digital consultation and avoid unnecessary face to face appointments. The scheduling of urgent care (non-life threatening presentations) would be planned with the right clinician, optimising alternatives to A&E where feasible and at times that support the Board to manage surge activity periods and avoid crowding to maintain a safe environment. We are developing a minimal specification for all Flow Navigations Centres to establish with and recognise further developments will come on line as the system matures

12. A number of Tests of Change are currently underway across the country on all aspects of this redesign pathway and are informing the wider roll out. However, on the back of the Board readiness assessments and our own analysis of these, we are concerned that while the systems might be in place and recruitment is happening, workforce challenges mean that in some boards, including NHS24, there might not be sufficient staff available across the whole system by 31st October. There also remains a high level of uncertainty over the consequences of system redesign on patient demand across the system, in particular Out of Hours.

Option A. Full implementation with national rollout 31st October 2020

Currently NHSScotland has approximately 1.44m attendances at A&E per annum with 860K individuals self-presenting directly to A&E. With full implementation and all aspects of the model operational approximately 200-300,000 patients could be managed through appropriate triage and alternative pathways and streamed away from A&E to a more appropriate clinical setting including GP in/out of hours, self-care, Community Pharmacy, Optometry, Dentistry to avoid a face to face attendances at ED. (Nb this is commensurate with international and UK studies on who needs to attend ED)

The option would continue to work towards delivery of a single national point of access through NHS24 111 with clear public messaging to the public who are considering self-presenting to A&E to call 111 first to support them and to access the most appropriate service for their needs. This is currently in user testing phase.

Full evaluation of the model and impact on patient access will continue to inform further developments required

The key risks to this option are that all parts of the system may not be ready for 31st October and there is potential unintended impacts on parts of the system happen in a full scale way in particular GP OOH which could overwhelm the

system. Workforce challenges - recruitment risk at NHS24, Flow Navigation Centres, and GP OOHs are also a concern.

Option B. Continue to plan for full implementation as above but delay until late November to enable more time to prepare

This would allow a longer lead in time for recruitment and training of staff and allows more time for modelling potential whole-system impact and testing messaging with user groups to optimise approach. Although the risk remains that attendances will return to pre-Covid levels the rate of attendance has now flat lined and there may be opportunity to postpone slightly. However latest modelling suggests that we will see an increase in Covid levels as we go into November therefore there is a requirement to minimise A&E attendance quickly.

Option C. Incremental approach from December

An incremental approach would offer an alternative to the full agreed conceptual framework above and only certain aspects or pathways would be adopted at local level with the access point through NHS24 111. For example these would be: Minor Injuries, Covid, GP OOH and potentially Mental Health.

This option would allow for changes to be rolled out incrementally (this is a development project that will take a number of months to reach full potential in terms of system change in response to public behaviour). For clarity, Covid and GP OOH are already accessed via the single national route of NHS 24's 111 service.

There is a risk that this would be a more complicated message to present to the public and would also be more challenging for NHS24 to manage their systems, particularly if pathways vary by Board area. Public messaging needs to be clear and provide the public with a clear call to action. Additionally the current marketing campaign, which is in the final stages of development, will need extensive work to redesign and develop new messaging, including an incremental plan. There is a risk of the public misunderstanding of the definitions of these conditions and continuing to present to A&E with less reduction in overall attendances than planned or desired.

Alternatively, variation of this pathway approach would be for a local developmental incremental approach for all boards to stand up a de minimus service from 1st December with access from NHS 24 allied to flow hubs. Locally pathways would be varied to meet their local demand and workforce availability as described above. We will work with those Boards experiencing recruitment challenges to agree the minimum clinical input required.

The unscheduled care team will work with local teams to develop, refine and roll out their pathways incrementally at local level while working towards full specification.

The option would continue to work towards delivery of a single national point of access through NHS24 111 with clear public messaging to the public who are considering self-presenting to A&E to call 111 first to support them and to access the most appropriate service for their needs.

Option D. **Board Pathfinder (from November as a precursor to option C)**

Due to the variation across boards in the reported sustainability of local GP OOH's and COVID assessment centres, a local pathfinder approach is proposed which enables boards who have responded to state their system can safely deliver key components of RUC by autumn, are encouraged and supported to implement and act as pathfinder sites for the remaining boards across Scotland.

NHS A&A have indicated their support to be the first pathfinder board and are preparing a proposal for evaluation. They would begin implementing the full specification of the redesign programme from 2nd November. NHS Forth Valley have indicated willingness to be the second site and we are in discussions around feasibility of this with NHS 24**. All other Boards would follow on 1 December**. This is in line with the test of change approach and implementation date that the other UK nations are taking, helping reinforce the message.

To support this there will be locally targeted media campaigns advising the public of the service available via NHS 24 111 in their local area. NHS 24 111 will undertake initial triage, redirection and signposting and make referrals made to local A&E team with scheduling aligned to capacity. This will allow the model to be safely tested within those boards who have achieved a degree of resilience in their unscheduled care services and GP OOH's services. This would be monitored daily with clear built in continuous review and adaptation of the model by NHS 24 and the local boards.

The implementation of the pathfinder sites will follow a Quality Improvement approach supported by QI fellows to allow tests of change to be monitored and captured to inform the wider roll out.

NHS 24 have indicated they would be supportive of this approach however due to the technical challenges this would bring in relation to disposition to local hubs and change in messaging they could only support two Boards for this Test of Change.

Recommendation

13. The stocktake group have reviewed all assessment summaries and discussed the options available and anticipated impact on patients, boards and whole system capabilities. All these options were discussed at length with the stocktake group including Chief Executives.

14. It was agreed that full implementation of the specification would not work as not every Board have the resource in place for 31 October.

15. It was agreed Option C would be feasible as a softer start would carry less risk. The message to the public will need to be carefully constructed.

16. It was agreed that full testing would be useful before full implementation and NHS A&A made a strong case for using their Board as a testing site.

17. On balance, we recommend that the Cabinet Secretary approves our recommendation to endorse a combination of option D, with the clear understanding that national implementation with phased incremental stand up of local pathways as described in option C would take place from beginning of December working towards full implementation of agreed model. In essence this combines a delayed national roll out of a developmental incremental approach and option D above.

18. NHS A&A will become the first pathfinder site implementing the full specification of the redesign programme from 2nd November. NHS A&A will provide a local flow navigation centres with the ability to receive clinical referrals from NHS 24 for all previous self-presenting attendances. To support this change in behaviours they will test the components of the national public messaging campaign at local level. The programme will be monitored closely and fully evaluated by a panel chaired by Sir Lewis Ritchie, as a test of change to inform the systems and processes to eventually deliver full roll out. The unscheduled care team will provide intensive quality improvement support to ensure smooth implementation and develop lessons learned for where there is challenges and case studies for stories of success engaging with the clinical QI Fellows to ensure a quality improvement approach captures all learning. The programme team will provide daily support in tandem with the review group. We will be agreeing the scope and terms of reference for this group.

19. The national team will support the board to incrementally develop their pathways through the 6EA - Building on Firm Foundations improvement programme.

20. NHS Forth Valley have indicated their readiness to become the second pathfinder site and discussions are underway with NHS 24 around feasibility.

21. The option of a pathfinder and incremental approach allows a longer lead in time for recruitment and training of staff and for modelling potential whole-system impact and testing messaging with user groups to optimise approach. This pilot approach has been advocated by Scottish Academy and BMA to test and understand the whole system impact.

22. We have already had positive feedback on public testing on the messages and a test of change on the whole system locally enables us to further test that and see if its effective before we roll out nationally.

23. This additional time will allow planning for OOH resourcing to be refined.

24. National rollout will be implemented on 1st December 2020, across all boards.

Public Messaging

25. To ensure maximum compliance and effective public communication, we need to be clear with the public about what the changes are and when they will come into force. Therefore we would propose that as part of the winter plans preparations, we announce that the new pathway will be introduced in Scotland in December. This would ensure we are being clear with the public and the media about the new approach, and will act as a softer launch throughout November while the pathway is introduced in Ayrshire and Arran. We would work with the local health boards to deploy local messaging, particularly focusing on using local stakeholders to cascade information to the public. We will provide Cabinet Secretary with a communications plan after the Strategic Advisory Group considers the specification for roll out from 1st Dec. This communications plan will be ready for Cabinet Secretary approval w/c 19th Oct.

Funding

26. As this is an entirely new approach it would not be possible to accurately predict the total funding required. An estimate of costs for this shows a full year initial investment of £15 million rising to a full year cost of circa £30 million from 2021/22 onwards. For this reason, we have suggested taking an incremental approach to the service implementation and therefore as part of this will put in place a stringent monitoring mechanism. An initial £10 million nonrecurring funding will be released to territorial Health Boards and an evaluation will be carried out early next year to assess the benefits and impact to inform any additional funding requirements and the next phase of the redesign from March 2021. While not yet quantified we may anticipate significant off-setting savings in future years as pressure is reduced in A&E departments and patients avoid multiple journeys.

27. NHS 24 will hold a significant portion of the costs for this, with recruitment taking place of over 350 call handlers, and costs of equipment, IT and estates to allow an effective service to be maintained.

28. The cost of implementing this change in pathway is £21m on a recurring basis, with an estimated £10m cost in 2020/21. This is based on eventually 100% of the 850,000 self-presenters being routed via the 111 service. This costing can be revised up or down depending on the agreed activity level (hence initial funding of £10m non-recurring), but we have suggested we take a prudent approach to recruitment to mitigate against this risk.

29. If the Cabinet Secretary is content with proposal recommended we would propose writing to Boards this week setting out expectations for the redesign work alongside their allocations. We suggest allocating £10 million to territorial Boards on an NRAC basis and £10 million to NHS 24. We will continue to work with Health Boards to understand cost estimates, challenging where certain Boards have higher than expected costs or have not included any offsetting savings. A letter will be prepared for the Cabinet Secretary's consideration.

Conclusion

30. The Cabinet Secretary is invited to approve and comment on –

[redacted]

Document 8 - Cabinet Paper - Redesign of Urgent Care - 30 September

[redacted]

Document 9 - Cab Sec Update - RUC - national roll out week 5 - 8 Jan

Helen Maitland
Unscheduled Care
08 January 2020

PS / Cabinet Secretary for Health and Sport

REDESIGN OF URGENT CARE – NATIONAL IMPLEMENTATION UPDATE – WEEK 5

Purpose

1. The purpose of this paper is to provide the Cabinet Secretary with an update on week 5 of national rollout of the Redesign of Urgent Care work. This report also seeks the Cabinet Secretary's approval on delaying our TV, Radio advert and proceeding with the national door drop.

Priority

2. Routine

Programme Update

3. The Redesign of Urgent Care programme continues with the Flow Navigation Centres (FNC) activity increasing daily. The intended principles of the FNC are being achieved and the current split of 111 activity is reported as 50/50 FNC/ED with no issues being flagged by any board on the delivery of the FNC pathway. There is positive feedback from Board Chief executive who report this has been a positive part of the winter/covid response and showing an impact on flow through the departments. Weekly implementation meetings continue to share lessons learned as well as weekly meetings for Boards to highlight any issues/actions taken at Board level. Local clinicians are reporting that the new system is working well and has been successful in minimising pressure during this challenging time.

Monthly Overview

4. The following bullets give a Scotland and Scottish Boards summary from 1 September to 4 January, covering NHS 24 111 and Flow Navigation Centre Go-Live systems roll out as part of Redesign of Urgent Care Programme (RUC).
    - The two festive periods have shown a seasonal and public holiday increase in activity for NHS 111 and GP OOH
    - NHS 24 Mon-Fri all contacts have increased since Go-Live, with the majority of this relating to In Hours Mon-Fri activity
    - GP OOH and COVID hubs activity appears stable overall

- 7 out of 14 boards showed a reduction in attendances since the Go-Live date. The remaining boards have shown no decrease in baseline for ED attendances since the Go-Live date (Borders, Fife, Grampian, Lanarkshire, Lothian, Shetland and Ayrshire & Arran).
- ED performance for Scotland shows two step change decreases with the second after Go-Live date. This step decrease after Go-Live is mirrored by 3 boards (Lanarkshire, Grampian and Dumfries & Galloway). The remaining boards have shown no decrease in baseline for ED performance since the Go-Live date.
- Scotland shows two-step decrease changes in self-presenters in the pre Go-Live period, and a further step change decrease since Go-Live date. This step change decrease after Go-Live date is mirrored in 7 of the 14 boards (Grampian, Glasgow & Clyde, Fife, Lanarkshire, Forth Valley, Highlands and Tayside).
- FNC activity: Circa 2/3 of NHS 111 referrals to FNC are within working hours Mon-Fri. Disposition data suggests over 1/3 of FNC recorded attendances are referred to ED/MIU, under 1/3 are advised to self-care, and 1/6 are asked to contact primary care. Further work to validate and understand FNC data is ongoing.

Communications and Engagement

5. The communications and marketing campaign is designed to be comprehensive, and over December has seen positive and encouraging results with the public making use of the in hours pathway through 111.

6. Over the eight days of the two festive weekends, NHS 24 took more than 73,000 calls and on the busiest days, there were longer waits than usual for calls to be answered at peak times. In common with all other healthcare providers and partner health boards, NHS 24's workforce is also being impacted directly by the pandemic, with staff shielding, isolating and on leave due to Covid. It has also been noted that some GP services have been pro-actively redirecting in hours demand to NHS 24 in communications to their patients. In addition, on Monday, January 4th the escalation of cases of Covid across the UK, with the prevalence of a new variant, has put further pressure on all NHS services and Scotland entered a new period of lockdown.

7. Public feedback and response to the new pathway via social media interactions has generally been very positive (see attached appendix with details of engagement). Social media posts via SG have afforded around 1.3 opportunities to see assets with a reach for December of 860,000 adults in Scotland. The combined impact of all Boards social media channels and reach will be significantly more. Media coverage has also been very positive with pick up in regional and local press across Scotland (NHS 24 recorded 36 media articles all positive).

8. Comments about the new pathway and the availability of 111 during the day has been positive, although SG marketing noted adverse reaction to the perceived availability of GP services in Scotland. As a response to this, the GP line in the marketing material which currently indicates 'Your GP is open as normal' is being reviewed, to reflect that services are more restricted during the lockdown period.

9. Following discussions with SG and health board CEO's in early January, members of the workstream and the programme team met and it was agreed that the higher profile launch of the RUC pathway that includes weighted marketing via TV, radio and press, should be delayed. This is to avoid further pressure being placed on NHS24 at a time of additional demand through COVID and workforce risks.

10. We sought the views of policy leads and chief executives on the value and risk of the national door drop. The recommendation is that the national door drop leaflet includes a broad range of information on all available NHS services available over winter and is a very useful guide to the public and should go ahead as planned for 18 January. There is a small section on new pathway to NHS24/111, contained within a broad range of useful information on all services and on balance will reinforce all alternative and appropriate services for care to guide the public to the right care at the right place

11. Existing levels of digital and social media, as well as board communications will also continue and a further review will be carried out of the potential to upscale the marketing towards the end of January.

Paediatrics

12. We have commissioned a Short Life Working Group to review and identify an optimal pathway of unscheduled care for under 12s. This is Chaired by Steven Turner, Consultant Paediatrician from NHS Grampian, Scottish officer for the Royal College of Paediatrics and Child Health. The group held its first meeting on 15 December to agree scope and assessment criteria and will meet weekly over a 4 week period, reporting end of January/early February with recommendations for consideration. The group met on the 6 January and there is general agreement that children should be gradually introduced into the pathway and discussions continue around when would be safe time to do so.

Next steps

- We are continuing to establish the next phase implementation plan to build on the de minimis specification to include interfaces with: GP in hours, dentists, optometrists, community pharmacists as well as interface with Scottish Ambulance Service. We will also explore options as alternatives to attendances such as optimising pathways of care for Mental Health, and looking at community rapid response .
- We are establishing an evaluation group in mid-January which will explore all aspects of the programme including health economics, clinical value, patient and staff experience and access to health and impact on the inequalities gap.
- This evaluation report will be available late February to inform the next planning phase of the programme. Building on his pathfinder rapid review, Sir Lewis Ritchie will continue to contribute to this report along with the Centre for Sustainable Delivery and university partnerships.
- We are carrying out a patient engagement process in partnership with Healthcare Improvement Scotland (HIS) starting early new year which will comprise of a Gathering Views exercise followed by a Citizens Panel and will help shape the service going forward.

Conclusion

The Cabinet Secretary is invited to note the updates on the fifth week of the national implementation of RUC which include:

- Ongoing work to support Boards with any implementation issues as they arise
- Public feedback and response to the new pathway
- SLWG in place to agree the pathway for children and young people
- The plans in place to establish an evaluation group early in the new year.

The Cabinet Secretary is invited to approve the release of the national doorstop drop week commencing 18 January.

Document 10 - Cab Sec Update - RUC - National roll out week 6 - 18 Jan

[redacted]
Unscheduled Care
22 January 2021

PS / Cabinet Secretary for Health and Sport

REDESIGN OF URGENT CARE – NATIONAL IMPLEMENTATION UPDATE – WEEK 6

Purpose

1. The purpose of this paper is to provide the Cabinet Secretary with an update on week 6 of national rollout of the Redesign of Urgent Care work. As requested by the Cabinet Secretary, information on a direct referral pathways from GPs to NHS 24 has been included in the update.

Priority

2. Routine

Programme Update

3. The Redesign of Urgent Care programme continues with the Flow Navigation Centres (FNC) activity increasing daily. The intended principles of the FNC are being achieved with the split of 111 activity currently 54/46 FNC/ED with no issues being flagged by any board on the delivery of the FNC pathway.

4. In recognition of the current system pressures the weekly meetings with Boards have been stepped down to monthly following discussion and agreement with each board. There continues to be regular communication with boards allowing the opportunity to raise or escalate any issues directly to the RUC team. Weekly implementation meetings for all boards to attend continue with two boards per week presenting their lessons learned and experience of the FNC's with all other boards.

5. As part of the RUC work we set in place clinical safe space meetings between NHS 24 and Boards to discuss any emerging clinical pathway issues and seek to address these to improve the patient experience and support a safe patient journey. Through this process it has been fed back that the MIU to FNC for call back within an hour was an outcome boards wished to remove and replace with a direct attend at ED. This was discussed at the multiple clinical safe space meetings with Boards and NHS 24 and clinical opinion was sought through the Expert Clinical Observation Group where it was agreed clinical presentations that are deemed to require 1 hour attention by NHS 24 triage should go directly to ED. The impact on overall ED attendance was minimal and it was a safer, improved patient journey.

Board RUC Programme Feedback and Data

6. Overall feedback has been very positive from all Heath boards who note this pathways has been a critical part of the winter planning approach. Four Boards, in particular, have provided some excellent examples of where ED attendance was avoided and there was a significantly better patient journey. All boards are reporting that feedback from patients has been overwhelmingly positive. Common themes from patient feedback include a pleasant environment, accessibility, minimal waiting times, access to senior advise without unnecessary travel and importantly lack of crowding. Key examples include:

[redacted]

NHS 24 Update – 11th – 17th January 2021

7. Of the records created during the week, 15,767 (63.4%) were urgent care, 6,488 (26.2%) were COVID flagged, 1,260 (5.1%) were mental health, and 1,239 (5%) were dental calls. The breakdown of the 15,767 urgent care calls, which includes the out of hours 111 activity, is set out in the table below:

Outcome	Urgent Care	
999	1,014	6.43%
A&E / MIU	1,675	10.62%
Contact GP Practice	1,599	10.14%
Contact Midwife	54	0.34%
Contact Optician	25	0.16%
Flow Navigation Centre	1,562	9.91%
GP Telephone Advice	2,715	17.22%
Home Visit	1,186	7.52%
Not assigned	1	0.01%
Other Professional	30	0.19%
Pharmacy	337	2.14%
Self Care	2,351	14.91%
Urgent Care Centre	3,171	20.11%
Total	15,767	100%

Key points:

- Of all the ED outcomes, 48.3% (1,562) were referred to the FNCs in Boards with 51.7% (1,675) a direct 1 hour referral. Generally FNC referrals are now consistently marginally above direct ED, however, Sunday impacted on the overall totals for the week.
- 484 of the 1,675 ED 1 hour referrals (28.9%) were children under 12; above week on week levels.

- Children under 12 urgent care records totalled 1,660 for the week, representing 10.5% of the total records created, again very consistent week on week.
- Across the week, 10.1% of all urgent care callers were advised to contact their own GP, an increase from the Christmas week. Referrals to the out of hours service reduced to 44.9%, still maintained below the normal rate of c60% for 111 calls.
- Self-care outcomes increased marginally to 14.9%, and, if added to the advice to contact another healthcare professional then 27.9% of all calls resulted in no onward referral.
- 999 ambulance outcomes increased (6.4%) but remained in line with normal rates, down from previous weeks.
- Of the 1,260 mental health calls through the 111 mental health hub, only 10 were referred to ED (0.8%), with 78 ambulance outcomes (4.8%) below general 999 referral pattern. There were a total of 49 DBI referrals (3.9%) and 636 (50.5%) of callers to the hub were given self-care with no onward referral.

Flow Navigation Centres

8. Key Points:

- FNC disposition data from board derived activity logs shows just over 1/3 of FNC recorded contacts are referred to ED/MIU, 1/3 are advised to self-care, and 1/6 are asked to contact primary care.
- Based on available data Scotland since go-live to date FNC have an average call back time of 30 mins (range 0-373) excluding primary care OOH.
- Planned referrals to ED/MIU Planned attendances from the FNC to ED/MIU is evolving and currently is between 3-4% of the total current ED/MIU attendances or between 8-9% of current minor attendance numbers.
- **Further work to better understand FNC data is on-going.**

Direct Referral Pathway for GPs Update

9. The Cabinet Secretary has previously asked what progress has been made on direct referrals from NHS 24 to GP practices. NHS 24 having the ability to book appointments directly in practice systems would be an area to explore however this may not be an optimal solution, further work is required to ensure a process for the GP to apply local knowledge and patient insight. This may include utilising digital to support access and interface between GPs and NHS 24. At the moment patients ringing 111 are told to contact their local practice if that is outcome decided during that call. GPs are strongly opposed to NHS 24 having direct access to their appointments for the following reasons:

- fewer available appointments for those who are phoning their GP surgery first
- patients “bypassing” the appointment system by phoning 111 instead of their GP practice and therefore impacting on their ability to manage urgent same day requests and the number of transfers down from 111
- Little professional to professional communication exists to ensure the most appropriate appointment for the patient.

10. There has been some anecdotal reports of people phoning their GP surgery in the first instance, with non-Covid issue , to be told to contact 111, and patients who do follow 111 advice to contact their GP surgery then have difficulties making an appointment. Similarly, some Practices have reported that patients are being referred back into practice when other options such as community pharmacy and optometry can handle.

11. NHSEngland have already introduced prof to prof relationships and referral processes between 111 services and General Practice which includes a virtual waiting room to allow GPs to make their own assessment. This model has been shared with primary care colleagues and some concerns have been expressed in terms of the transferability of this model to Scotland due to the differing systems and urgent care networks in England.

12. Our view is that SGPC are unlikely to agree if simply asked to offer appointments and due to their independent contractor status they have the right to refuse. To better understand the issues and jointly develop solutions, including bringing SGPC on board, we are establishing a clinically led group, including colleagues from NHS24, SGPC/RCGP, acute clinicians and those actively engaged in the current RUC work. Progress will be reported to Cab Sec through the existing RUC reporting arrangements.

Communications and Marketing

13. To avoid further pressure being placed on NHS24 at a time of additional demand through COVID and workforce risks, the decision was taken to delay the high profile launch of the RUC pathway. That included weighted marketing via TV, radio and press, should be delayed. Whilst Boards appreciate the impact of the festive demand on NHS 24 111 and the reason for the deferment of the national media campaign, there is disappointment across the boards that an opportunity has been lost to direct of larger volumes of activity away from ED into the new FNC pathway.

14. This week marks the release of the national door drop leaflet which includes a broad range of information on all available NHS services available over winter including a small section on the new pathway to NHS24/111, contained within a broad range of useful information on all services. Existing levels of digital and social media, as well as board communications have also continued. Over the next few weeks we will review the impact of this and discuss the potential to upscale the marketing in early February.

Next Steps

15. Work continues to embed and develop the FNC's across the system. All boards have expressed a willingness to develop and expand the FNC work as they can see the wide system value and positive patient impact. A workplan is being developed to establish the key components of the next phase implementation, building on the de minimis specification and will include interfaces with: GP in hours; mental health hubs; community pharmacists and Scottish Ambulance Service.

16. The evaluation group we had planned to establish in mid-January has currently been paused as we deal with current operational service pressures and terms of reference will be submitted to Strategic Advisory Group end of January and a workgroup will hopefully resume in February subject to Covid.

17. The following will also be progressed over the next few weeks:

- Work continues in partnership with Healthcare Improvement Scotland (HIS) to establish a patient engagement process which will comprise of a Gathering Views exercise followed by a Citizens Panel and will help shape the service going forward.
- A clinically led group is being convened this week to map the complex and emergent issues of direct referral pathways for GPs.
- Engaging with key stakeholders to understand what learning can be taken from other established or emerging prof to prof relationships and referral models.
- Small group meeting again this week to looking at 4-hour A&E performance target modelling and impact of new pathway on statistical ability to meet 95% EAS.
- The paediatric short-life working group are due to finalise their report this week which will likely include a recommendation around how we begin to gradually introduce paediatric patients into the new pathway. Further advice wil follo won this in due course.

Conclusion

18. The Cabinet Secretary is invited to note the update on the sixth week of the national implementation of RUC including the response to points raised around the GP referral pathway and plans to establish a clinically led group.

19. If the Cabinet Secretary is content, we would suggest moving these reports to a monthly basis going forward with the next report submitted by early February to allow us to provide more useful trend data. We would continue to alert the Cabinet Secretary to any concerns through the winter sitrep.

Document 11 - Cab Sec Update - RUC - national roll out week 3 - 23 December

Helen Maitland
Unscheduled Care
24 December 2020

PS / Cabinet Secretary for Health and Sport

REDESIGN OF URGENT CARE – NATIONAL IMPLEMENTATION WEEK 3 UPDATE

Purpose

13. The purpose of this paper is to provide the Cabinet Secretary with an update on week 3 of national rollout of the Redesign of Urgent Care work. This report will also provide an overview of the monthly findings at the NHS Ayrshire and Arran pathfinder.

Priority

14. Routine

Background – Programme Update

15. The Redesign of Urgent Care rolled out nationally on 1 December following successful implementation within NHS Ayrshire and Arran pathfinder site. Weekly implementation meetings continue to share lessons learned as well as, weekly meetings for Boards to highlight any issues/actions taken at Board level. The weekly Board calls will be paused during the festive period and the implementation leads have been informed to contact SG if any issues arise. Currently there remains no critical issues with the programme and no further ongoing issues have been raised by NHS Boards since the previous update.

16. We are beginning to see an improvement in data collection and are moving towards an automated system. Due to data issues with national data systems at the beginning of the RUC rollout, it was not possible to extract data electronically in relation to the FNC work. Boards were asked to collect data manually until 21 December whilst the national electronic data extract issue was resolved. An electronic system is now in place which will provide weekly data updates. As a result this week's report gives an overview of trends over the last few weeks.

17. However, for Boards where FNC activity is being recorded only via the A&E system, rather than Adastra, there will be a continuing requirement to submit this data daily (Monday to Friday). PHS will continue to work closely with those Boards to ensure continuity of recording for FNC activity.

Monthly Overview

18. The following bullets give a Scotland and Scottish Boards summary from 1 September to 20 December 2020, covering NHS 24 111 and Flow Navigation Centre Go-Live systems roll out as part of Redesign of Urgent Care Programme (RUC).

- NHS 24 Mon-Fri all contacts have increased since Go-Live with the majority of this relating to In Hours Mon-Fri activity.
- GP OOH activity remains stable across Scotland and most boards, with small changes evident in Glasgow, Lothian and Tayside pre Go-Live.
- COVID hubs and assessment centres activity is largely stable across Scotland and boards.
- SAS incidents attended and conveyed in Scotland and boards is largely stable with minor changes evident in activity in beg of Nov and mid-Oct respectively, pre Go-Live.
- ED attendances have been declining prior to the Pathfinder and Go-Live periods, consistent with the second wave of COVID-19 across Scotland and most boards.
- Tayside, Dumfries and Galloway and A&A also show decreases corresponding to the Go-Live or Pathfinder.
- ED performance for Scotland shows a two-step change decrease with the second during Go-Live. Patterns of performance across boards show variability, with 5. This is as a result of increased Covid pressures.
- Boards being stable throughout, 4 showing decreases pre Go-Live and 5 showing decreases during Go-Live.
- Scotland shows a two-step reduction in self-presenters in the pre Go-Live period, and a further step change decrease since Go-Live. Most Boards show change decreases prior to Go-Live, with 5 boards showing a further decrease since Go-Live (including A&A since Pathfinder).

19. A further data breakdown is available in **Annex A**.

NHS Ayrshire and Arran – Monthly Overview (Annex B)

20. The report in **Annex B** provides a summary of monthly findings from the NHS Ayrshire and Arran pathfinder which launched on the 3 November. To date the pattern of access by age, gender and index of deprivation for NHS 24, SAS and ED attendances is similar compared with historical organisational patterns. These patterns will need to be continued to be monitored. Key points to note include:

- A&A total Mon-Fri NHS 24 contacts have shown a step change increase in activity since the beginning of the pathfinder which largely reflects the expected increase in NHS 111 In Hours contacts.
- GP OOH Mon-Friday for A&A have remained stable since September and during Pathfinder and Go Live
- There is no change in GP Out of Hours activity at weekends for A&A and GP OOH Mon-Friday for A&A remains stable

- Data for ED 'self presenters' shows three step change decreases in baseline on 24 September, 3 November and 24 November. The last two step change decreases correspond to the Pathfinder period.
- A&A from beginning of 1 December shows 309 patients were referred to the FNC, of which 244 (79%) were referred to MIU/ED at UHA & UHC, of which almost half were to the MIU flow. The remaining 65 (21%) were telephone consultations only.

Paediatrics

21. We have commissioned a Short Life Working Group to review and identify an optimal pathway of unscheduled care for under 12s. This is Chaired by Steven Turner, Consultant Paediatrician from NHS Grampian, Scottish officer for the Royal College of Paediatrics and Child Health. The group held its first meeting on 15 December to agree scope and assessment criteria and will meet weekly over a 4 week period, reporting end of January/early February with recommendations for consideration. The group met on the 23 December and the meeting focused on the risks and benefits to including children for them being included in the FNC system.

Next steps

- We are continuing to establish a next phase implementation plan to build on the de minimis specification to include interfaces with: GP in hours, dentists, optometrists, community pharmacists as well as interface with Scottish Ambulance Service. We will also explore options as alternatives to attendances such as optimising pathways of care for Mental Health, and looking at community rapid response .
- We are establishing an evaluation group in early January which will explore all aspects of the programme including health economics, clinical value, patient and staff experience and access to health and impact on the inequalities gap.
- This evaluation report will be available late February to inform the next planning phase of the programme. Building on his pathfinder rapid review, Sir Lewis Ritchie will continue to contribute to this report along with the Centre for Sustainable Delivery and university partnerships.
- We are carrying out a patient engagement process in partnership with Healthcare Improvement Scotland (HIS) starting early new year which will comprise of a Gathering Views exercise followed by a Citizens Panel and will help shape the service going forward.

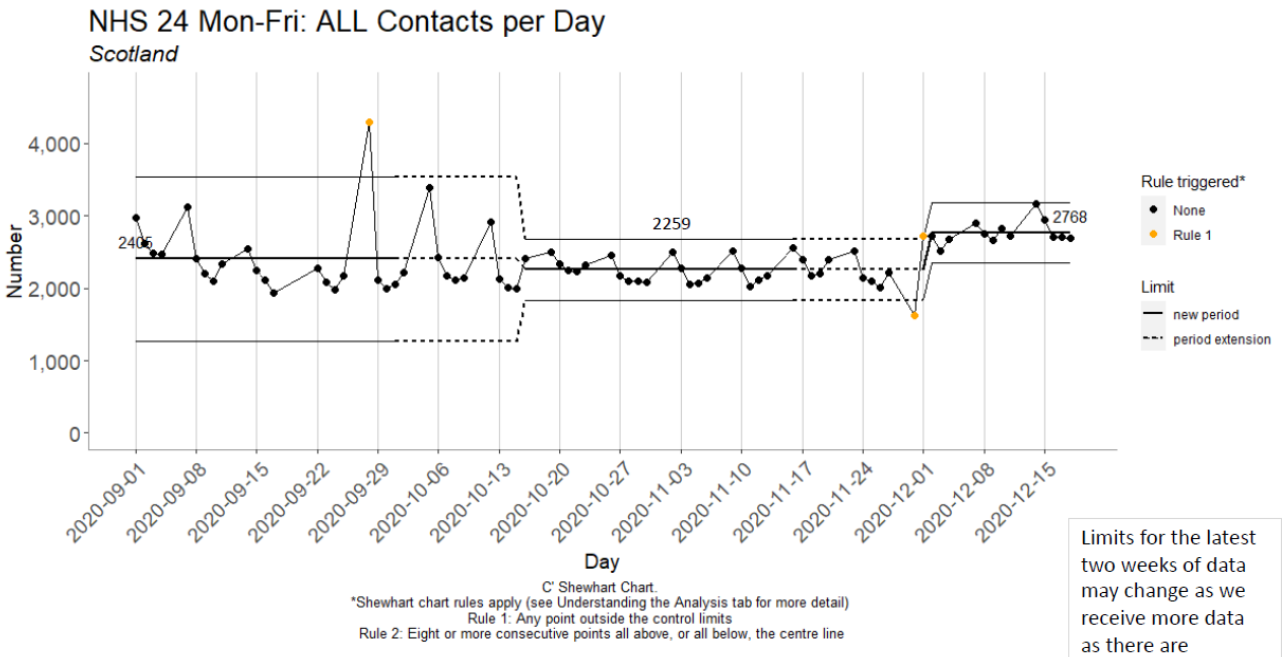
Conclusion

The Cabinet Secretary is invited to note the updates on the third week of the national implementation of RUC which include:

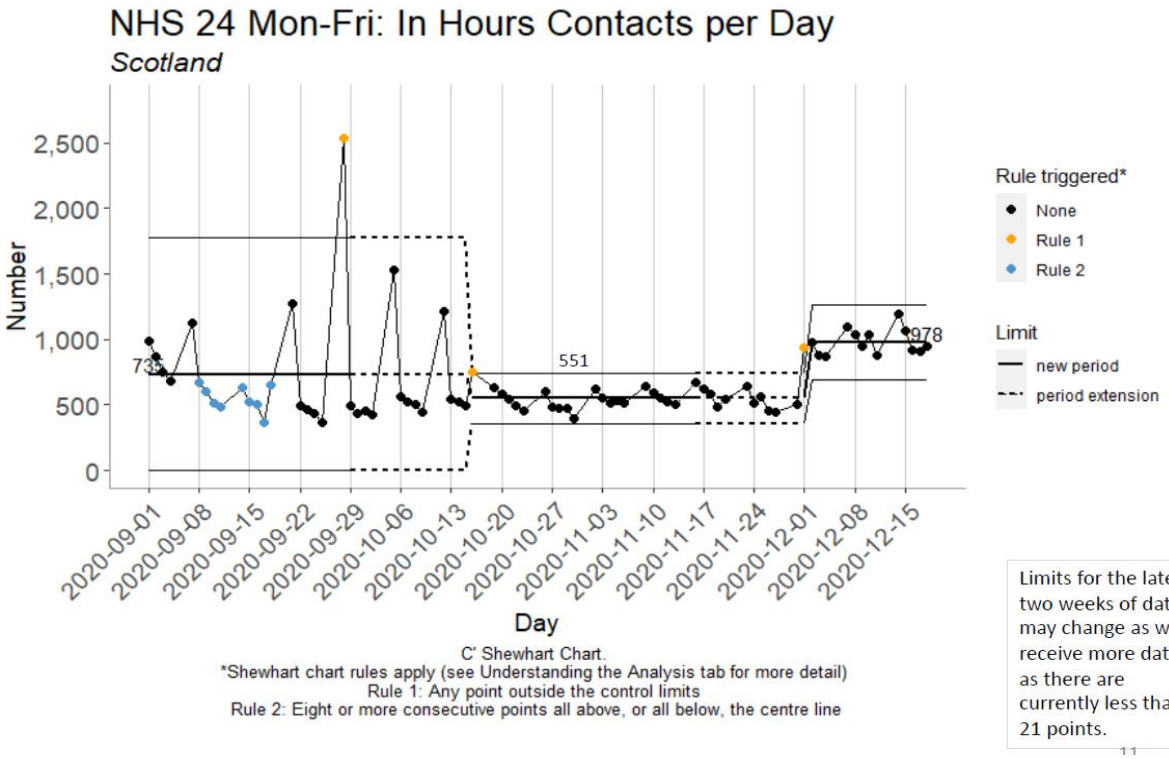
- Ongoing work to support Boards with any implementation issues as they arise
- Data overview since launch on the pathfinder
- SLWG in place to agree the pathway for children and young people

- Development of an implementation plan for the next phase of the RUC programme
- The plans in place to establish an evaluation group early in the new year.

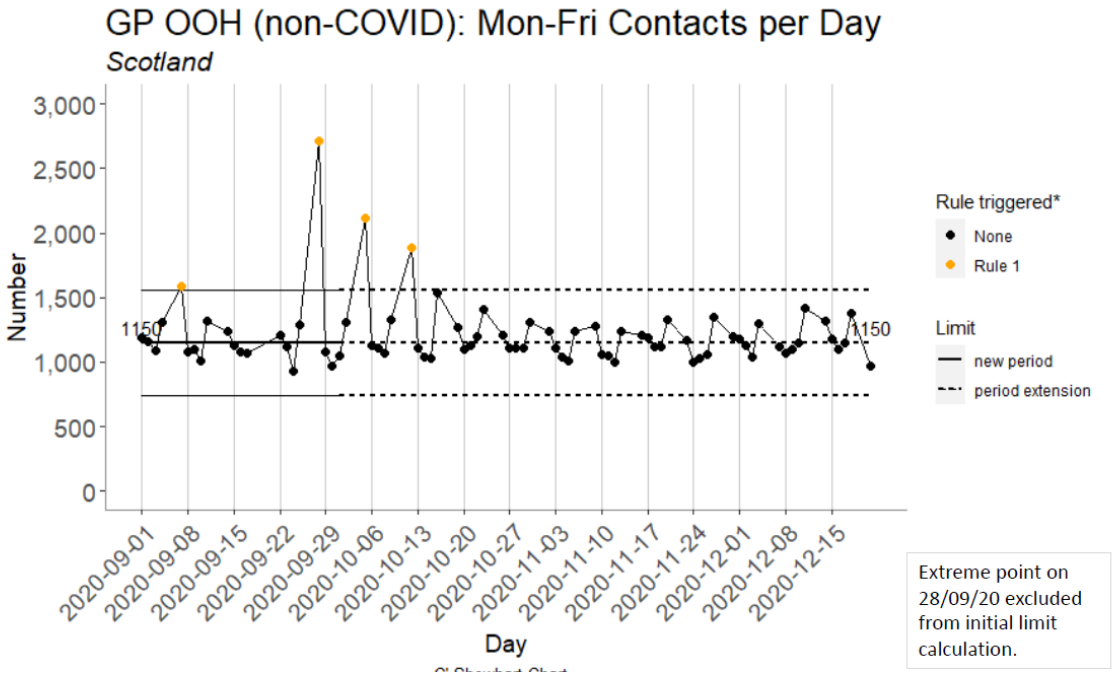
ANNEX A

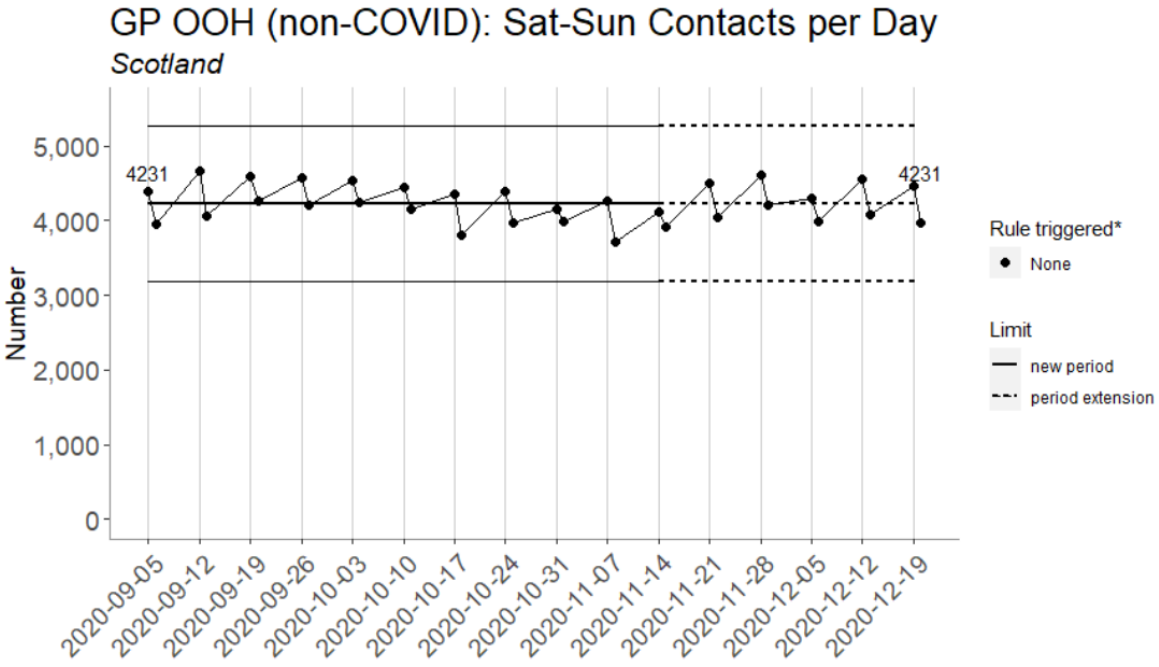


Limits for the latest two weeks of data may change as we receive more data as there are currently less than 21 points.



Limits for the latest two weeks of data may change as we receive more data as there are currently less than 21 points.


GP OOH (non-COVID): Mon-Fri Contacts per Day
Scotland
Number
3,000
2,500
2,000
1,500
1,000
500
0
1150
1150
2020-09-01
2020-09-08
2020-09-15
2020-09-22
2020-09-29
2020-10-06
2020-10-13
2020-10-20
2020-10-27
2020-11-03
2020-11-10
2020-11-17
2020-11-24
2020-12-01
2020-12-08
2020-12-15
Day
Rule triggered*
None
Rule 1
Limit
new period
period extension
Extreme point on 28/09/20 excluded from initial limit calculation.


GP OOH (non-COVID): Sat-Sun Contacts per Day
Scotland
Number
5,000
4,000
3,000
2,000
1,000
0
4231
4231
2020-09-05
2020-09-12
2020-09-19
2020-09-26
2020-10-03
2020-10-10
2020-10-17
2020-10-24
2020-10-31
2020-11-07
2020-11-14
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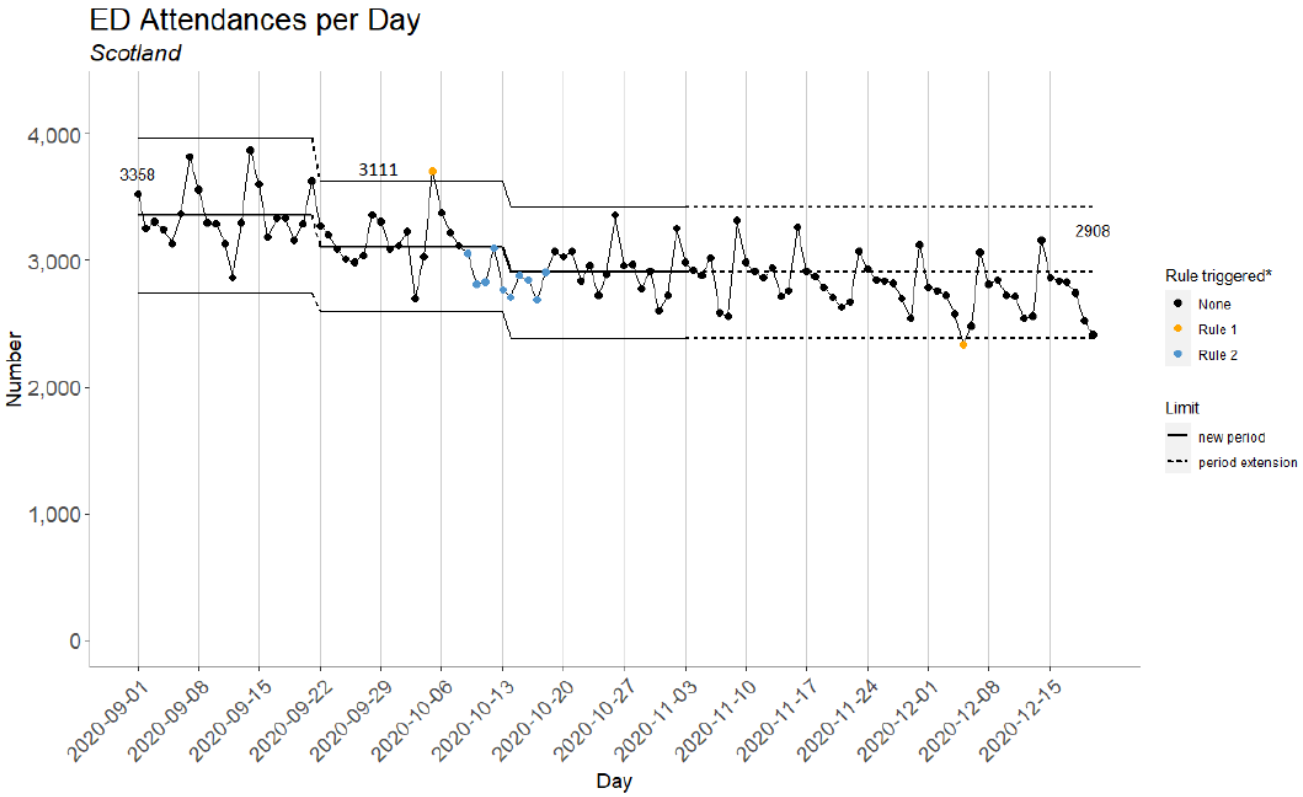
2020-11-28
2020-12-05
2020-12-12
2020-12-19
Rule triggered*
None
Limit
new period
period extension


ED Attendances per Day
Scotland
4,000
3,000
2,000
1,000
0
Number
3358
3111
2908
Rule triggered*
None
Rule 1
Rule 2
Limit
new period
period extension
2020-09-01
2020-09-08
2020-09-15
2020-09-22
2020-09-29
2020-10-06
2020-10-13
2020-10-20
2020-10-27
2020-11-03
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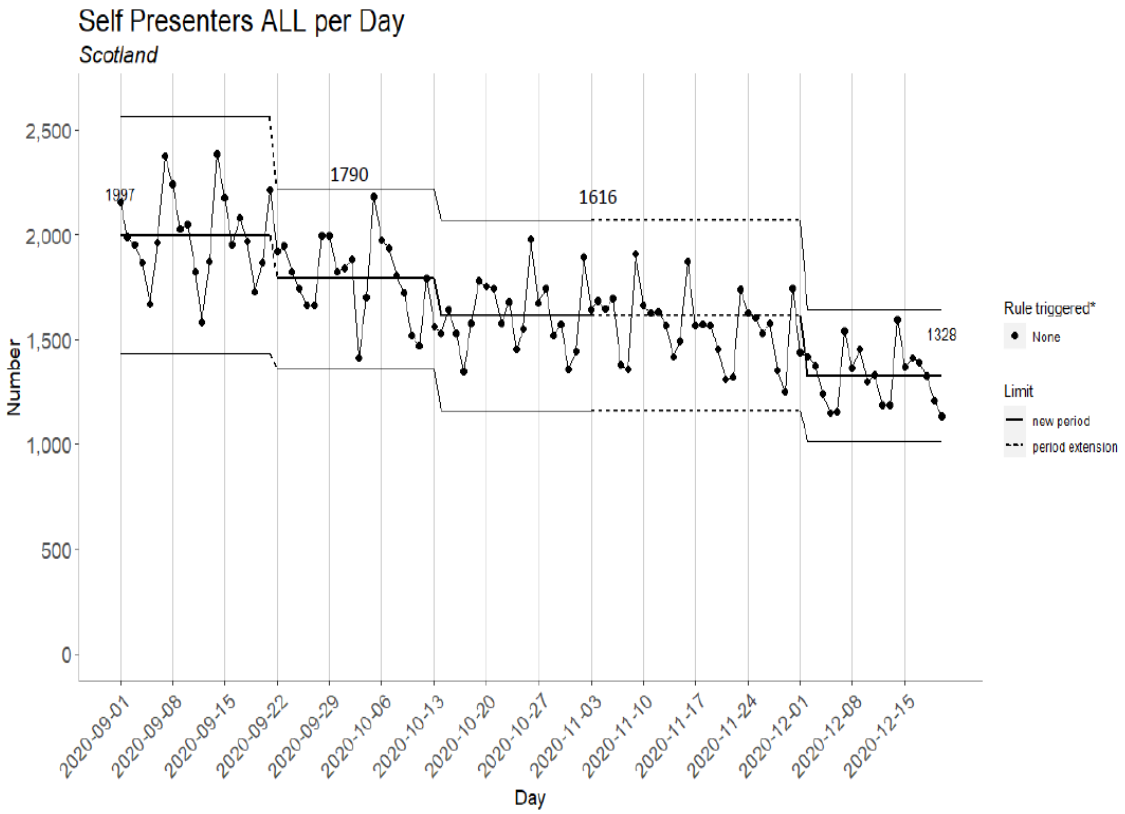
2020-12-15
Day


Self Presenters ALL per Day
Scotland
2,500
2,000
1,500
1,000
500
0
Number
1997
1790
1616
1328
Rule triggered*
None
Limit
new period
period extension
2020-09-01
2020-09-08
2020-09-15
2020-09-22
2020-09-29
2020-10-06
2020-10-13
2020-10-20
2020-10-27
2020-11-03
2020-11-10
2020-11-17
2020-11-24
2020-12-01
2020-12-08
2020-12-15
Day

ANNEX A

MONTHLY REPORT
16 DECEMBER 2020

BACKGROUND

The Ayrshire and Arran (A&A) Pathfinder went live on 3 November 2020, with NHS 24 triaging patients 24/7 and ensuring they were diverted to the appropriate service or self care advice. A&A established a flow navigation centre (FNC) which NHS 24 could refer patients to for additional acute triage. The FNC triaged the patient further and considered again the relevant disposition e.g. planned appointment at the Emergency Department. This pilot was being undertaken during a second wave of COVID-19 activity and with Tier related social distancing measures in place which will have impacted on data interpretation. The aim was for this format to form the basis of the reports for all Boards.

DATA

Due to system re-set after first COVID-19 wave, previous years historic data is no longer an accurate control for the data sets, therefore September and October are used as current baseline; for most of the metrics activity is lower than historic controls. Of note, GP in hours data is not routinely available which limits fuller analysis. For ED 4-hour standard the data definitions remain the same as in the pre-Pathfinder period. Comparative data utilised is from: **4 November to 13 December**.

Further data is required for certain metrics (e.g. weekend data). There is an urgent need to agree data definition and recording mechanisms for the Flow Navigation Centres to be able to better understand their role and provide automated reports as part of an ongoing data monitoring and evaluation. Scottish data is given for comparison, together with some data for NHS Fife.

OVERVIEW OF AYRSHIRE & ARRAN

To date the pattern of access by age, gender and index of deprivation for NHS 24, SAS and ED attendances is similar compared with historical organisational patterns. These patterns will need to be continued to be monitored.

Data covers the ‘baseline period’ and onwards from the initiation of the Pathfinder on 3 November. It should be noted that the second wave of COVID 19 will have an impact on the patterns seen in Boards and in Scotland over this period. Data is provided for A&A, Fife, Scotland and Glasgow:

NHS 24

- A&A total Mon-Fri NHS 24 contacts have shown a step change increase in activity since the beginning of the pathfinder which largely reflects the expected increase in NHS 111 In Hours contacts.

- Fife saw a step change increase in total Mon-Fri NHS 24 contacts from the beginning of December with the national GO LIVE data. Similarly, Scottish data suggests/shows an increase in Mon-Fri activity from 1 December and Glasgow data also suggests an increase but more data points are needed. This increase reflects an increase in in-hours contacts from the go-live date.
- NHS 24 Weekend activity has remained unchanged since Sept for A&A, Fife, Glasgow and Scotland.

GPOOH (excluding COVID and Flow Navigation Centre (FNC))

- GP OOH Mon-Friday for A&A and Fife have remained stable since September and during Pathfinder and Go Live. Scotland and Glasgow have seen a small reduction in GP OOH activity which precedes the Pathfinder and Go Live.
- There is no change in GP Out of Hours activity at weekends for A&A, Fife, Glasgow and Scotland over the Pathfinder period or since start of December.

COVID Hubs and Assessment Centres

- Activity has been stable for A&A, Glasgow and Scotland. Fife had a small step change decrease from 6 October.

SAS

- SAS attendance activity has remained stable for A&A and Fife since Sept. Scotland showed a small step change decrease at the beginning of Nov unrelated to A&A activity. Glasgow data shows a step change in baseline on 27 November.
- SAS conveyancing in A&A data shows step change decrease in baseline on 3 November corresponding with the Pathfinder period. SAS conveyancing activity in Fife and Glasgow has remained stable since September. Scotland conveyancing activity showed a small step change decrease in mid Oct preceding pathfinder and National go-live.

ED

- A&A ED attendances data shows three step change decreases in baseline commencing 22 September, 14 October and 9 November. The last within the Pathfinder period.
- Scotland ED attendances shows a two-step change decrease in baseline pre-Pathfinder on 22 September and 14 October; activity has remained stable since. Fife and Glasgow both had a one-step decrease from beginning of Oct and have remained stable since.
- ED Performance in A&A showed a step change decrease in baseline commencing on 19 October from 91% to 82%. This has remained stable since, including the Pathfinder period. Scotland also experienced a similar step change decrease on 21 October from 91% to 87% and has remained stable at this level. Fife had a step change decrease in baseline from 96% to 92% on 26 October and has remained stable. Glasgow data shows a step change decrease in baseline from 94% to 89% commencing 5 October.
- Data for ED ‘self-presenters’ shows three step change decreases in baseline on 24 September, 3 November and 24 November. The last two step change decreases correspond to the Pathfinder period. Fife data shows two step change decreases in baseline on 7 October and 28 November. Scotland data shows three step change decreases in baseline on 22 September, 14 November and 2

December. Glasgow data A&A data shows two step change decreases in baseline on 13 October and 2 December.

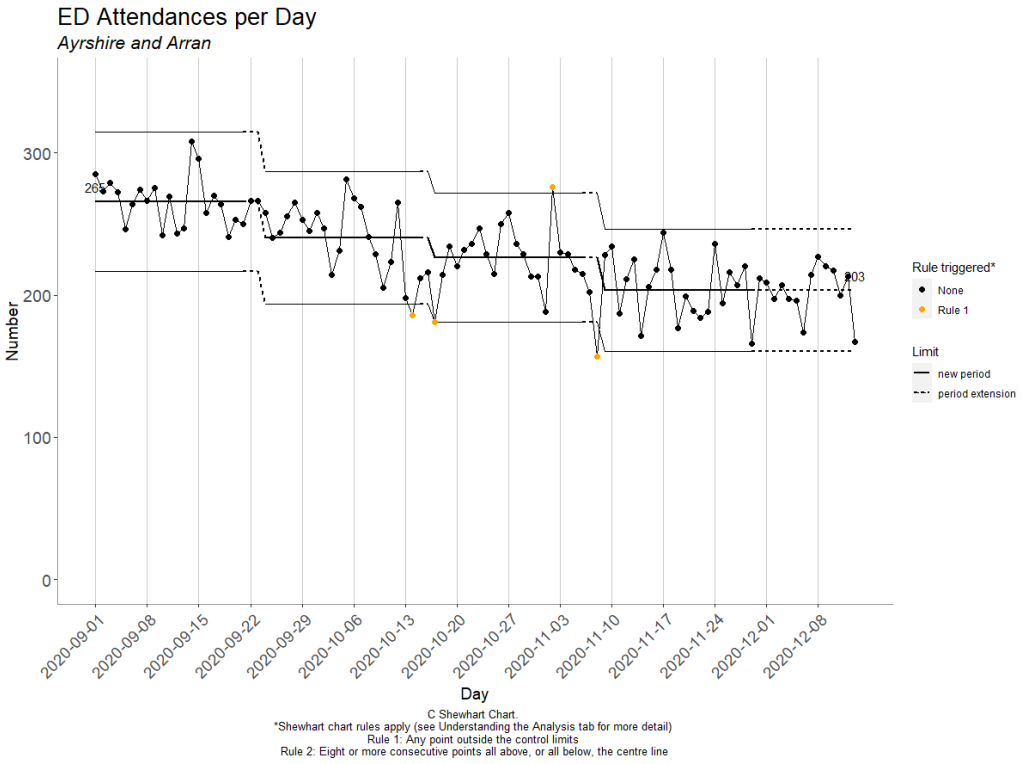
FNC early Interpretation of Disposition data excluding COVID hubs (further work to validate and understand disposition data is required):

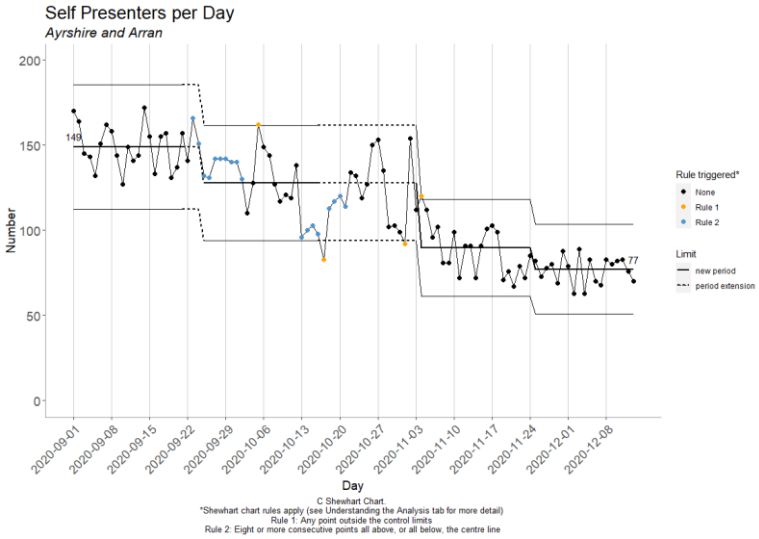
- A&A from beginning of 1 December shows 309 patients were referred to the FNC, of which 244 (79%) were referred to MIU/ED at UHA & UHC, of which almost half were to the MIU flow. The remaining 65 (21%) were telephone consultations only.
- Scotland NHS 111 weekend referrals to FNC approx. 200-250 per day. This is similar to Mon-Fri activity for the last 2 weeks with approx. 60% of the activity being in hours.

SUMMARY

1. NHS 24 In hours contacts have increased in Ayrshire & Arran with no measurable change in Fife and Scotland.
2. Self-presenters have gone down in A&A, in context of no change in total ED attendances during the pathfinder period to date. This emphasises the importance of disposition data for the FNC and appropriate coding within the ED IT systems.
3. Self-presenters have decreased in both Scotland and Fife, but to a lesser extent than Ayrshire and Arran. This emphasises the importance of disposition data for the FNC and appropriate coding within the ED IT systems.

Graphs on ED Attendances and Self Presenters per Day:




Self Presenters per Day
Ayrshire and Arran
200
150
100
50
0
Number
149
77
2020-09-01
2020-09-08
2020-09-15
2020-09-22
2020-09-29
2020-10-06
2020-10-13
2020-10-20
2020-10-27
2020-11-03
2020-11-10
2020-11-17
2020-11-24
2020-12-01
2020-12-08
Day
Rule triggered*
None
Rule 1
Rule 2
Limit
new period
period extension
C Shewhart Chart.
*Shewhart chart rules apply (see Understanding the Analysis tab for more detail)
Rule 1: Any point outside the control limits
Rule 2: Eight or more consecutive points all above, or all below, the centre line

Document 12 - Report -Update - Cab Sec

[redacted]
Roll out of RUC – primary care

- We issued a letter to GP leads network to inform them of the changes to Unscheduled Care in November. GP leaders were actively involved in developing the service. The comms plan was widely commented on from GP colleagues.
- SG primary care are picking up with SGPC after xmas around the formal referral into In Hours General practice from NHS 24. At this point GPs haven't been keen to offer slots but we are engaging with them in January to see if we can agree a process for this.
- SG Primary Care emailed [redacted] to confirm the concerns raised by [redacted] were not related to RUC.