NHS Ayrshire and Arran

Redesign of Urgent Care Pathfinder Programme

Rapid External Review

29 November 2020

NHS Ayrshire and Arran: Redesign of Urgent Care Pathfinder Programme Rapid External Review

Purpose

To provide a rapid external review (the Review) of the implementation of the Redesign of the NHS Ayrshire and Arran (A&A) Urgent Care Programme Pathfinder site to inform decisions on the national roll-out, anticipated start date: 1 December 2020. The key focus of the Review has been on monitoring preliminary issues and impacts of this transformational redesign across all care sectors within NHS A&A, which seeks to help inform and advise on early learning to be shared throughout Scotland.

Background

The Redesign of Urgent Care (RUC) programme seeks to promote significant transformational change in how optimal urgent care can be delivered for the people of Scotland. The programme offers a number of potential benefits in modernising our wider urgent care (unscheduled care) pathways, but also carries implementation risks, which need to be recognised, addressed and mitigated.

It is acknowledged that not all Boards were in the same state of readiness as NHS A&A to undertake urgent care reform. Initial issues reported and considered by the Redesign of Urgent Care Strategic Advisory Board (chaired by Calum Campbell, Chief Executive NHS Lothian and Angiolina Foster, Chief Executive NHS 24), include: sustainability of local GP Out of Hours (OOH) services, Covid-19 hubs and clinical assessment centres (CACs). The potential longer-term impact of changing public access and use of urgent care services within in-hours periods may impact on increased service demand for NHS 24. These issues are considered within this report.

In preparation for the RUC programme all territorial Boards, NHS 24 and SAS have been conducting detailed and regular readiness assessments for many weeks and these have been scrutinised in detail by Scottish Government (SG) officers. In addition, SG officers have been meeting each Board on a weekly basis to discuss in detail plans and issues arising. Weekly meetings of all Board RUC implementation leads are also taking place to share learning, plans, issues and solutions.

The Cabinet Secretary for Health and Sport examined several options offered to her in October 2020 and concluded that a local pathfinder approach should be undertaken, rather than immediate national full or partial roll-out in all Boards. NHS Ayrshire and Arran (NHS A&A) was agreed to be the founding pathfinder site, implementing the full specification of the redesign programme from 3 November 2020, onwards. It is envisaged that roll-out of the RUC model will take place throughout Scotland, in early December 2020, if deemed safe and appropriate by SG to do so. Learning and experience arising from the NHS A&A pathfinder continues to be assimilated and disseminated to all Boards in Scotland, on an ongoing basis.

Process and methodology

This rapid review process incorporates both quantitative/numerical data (including changes in service presentations (demand); service response (workforce resilience and buy-in); communications/messaging to both the public and to colleagues who provide care to the public; public expectations and responses to service change. The assessment considers the early NHS A&A pathfinder findings, alongside the experience of NHS 24 and SAS. The state of readiness of all territorial Boards across Scotland is also under continuous review by SG.

The review considers how to assimilate RUC development and delivery throughout Scotland, informed by evolving findings from NHS A&A. It will also be important to incorporate learning from comparable models elsewhere both within the UK and beyond. The limitations of this present review process need to be stated clearly from the outset. A SG purview of early progress in NHS A&A and the readiness for further roll-out across Scotland is also being informed by all territorial Boards, NHS 24 and SAS internal individual readiness assessments.

The terms of reference of the Review are included as Annex 1; the Review engagement process is listed in Annex 2; the adjunct data analysis which informed the Review can be found in the supporting files section of the web page; a specific focus on urgent mental health care is discussed in Annex 3; and a rapid literature review of evaluation of models of urgent care, undertaken by Healthcare Improvement Scotland (HIS) can be found in the supporting files section of the webpage.

Guiding Principles

In conducting this review eight guiding principles below have been considered, borrowing from the National Review of Primary Care Out of Hours Services*: Pulling Together: Transforming Urgent Care for the People of Scotland*, published in November 2015.[1]

Urgent care services should be:

- Person centred - both for those who receive care and also for those who deliver care
- Intelligence led - making the most of what we know about the population and their needs.
- Assets optimised **-** making best use of all available resources, workforce and infrastructure
- Outcomes focussed **-** ensuring best decisions for both the care of population and those who deliver it

[1] *Pulling Together: Transforming Urgent Care for the People of Scotland*
Summary Report of the National Review Primary Care Out of Hours Services - gov.scot (www.gov.scot)

In addition, these services should be:

- Desirable - high quality, safe and effective
- Sustainable - resilient on a continuous basis
- Equitable - fair and accessible to all, according to need
- Affordable - making best use of public funds and securing value for money

Key Messages

The Urgent Care Redesign (RUC) pathfinder model adopted by NHS Ayrshire and Arran, NHS 24 and the Scottish Ambulance Service (SAS) has involved unprecedented close and harmonious working, together. The RUC model has been implemented well with no major pitfalls encountered, to date. Initial concerns about workforce resilience have been resolved but longer-term vigilance will be required to ensure ongoing stability. Data (adjunct data report in supporting files section of the webpage) have shown that during this initial three-week review period, use of services is stable, with a slight expected increase in out of hours (OOH) referrals and as yet, no unintended consequences have been reported.

At present in NHS A&A, significant diminution in ED self-referred (walk-in) attendances have not (yet) been confirmed. Encouraging emerging data have been presented, which may signal this prospect. These are early days; progress is under continuous review, both by comparative local NHS A&A (NHS 24 and SAS) and national data analysis. Any assessment of significant change (or otherwise) in urgent care access patterns require sufficient time to elapse from the NHS A&A RUC pathfinder instigation and ongoing comparison with other territorial Boards, NHS 24 and SAS.

To date, changes in arrangements for access to urgent care help for the local A&A populace have been largely signalled in limited and local, social media messages. Only more recently in A&A has local hard copy (newspaper advertisements) been deployed, in the absence of national publicity for a RUC NHS Scotland roll-out. Changes in help seeking behaviours by the public will occur gradually and any assessment of progress must fully recognise that.

Early and evolving learning continues to be assimilated from the NHS A&A pathfinder site and has been discussed and shared throughout Scotland, facilitated by SG officers. This forms a key component part of Scottish Government (SG) RUC readiness assessment for all Boards:

- Good governance arrangements within NHS A&A appear to be in place along with regular system-wide feedback. NHS A&A is undertaking ongoing vigilance, due diligence and scrutiny, as local public awareness and access to the redesigned RUC programme expands
- Initial daily and subsequently twice weekly meetings with GP Practices have enabled regular dialogue to help understand the impact of the service change.

- No negative feedback has been reported by GP Practices of this new model to date.
- There has been an initial indication that there has been a small shift of activity to in-hours (daytime) general practice – the numbers however remain small.
- A regular 'safe space' for clinicians working in the urgent care service to discuss individual cases and resulting dispositions has proved valuable to all involved.
- Significant and ongoing senior medical and management resource has been invested in the NHS A&A pathfinder with benefit, in the early inception of RUC. This is a key learning point for all Boards.

All territorial Boards have signalled to SG that they are ready for a RUC launch on 1 December 2020. If SG endorses an early December national launch of RUC, as expected, it is suggested that all other territorial Boards adopt a gradual but resolute start (a 'soft launch' approach), as in the NHS A&A pathfinder. In effect, this would pursue the same start-up route taken by NHS A&A, assimilating and sharing learning from growing local A&A and broader pan-NHS Scotland experience.

All territorial Boards face local and sometimes unique circumstances and challenges (for example remote and rural issues). Further Covid-19 uncertainties, winter pressures and the festive period public holidays also loom large.

A 'soft launch' approach, with limited initial local publicity as in NHS A&A, should assist other Board Flow Centres to be fully stood up and to be stabilised in both workforce (induction, training, resilience, leadership support) and operational terms (IT and other infrastructure, bedded in and performing well).

If a 'soft launch' approach is agreed by SG, the decision for, and timing of a further full or 'hard' NHS Scotland RUC launch/roll-out, with associated large-scale national publicity drivers and messaging, should be judiciously considered in the light of changing circumstances and accrued experience, in the weeks ahead.

This external review considers the optimal 24/7 urgent care for the whole populace, but rightly there is a specific focus on best urgent care for children in Scotland.

There have been a number of discussions about optimal children's (paediatric) urgent care and whether the RUC model should be confined to adults only, in early inception. The NHS A&A pathfinder model incorporates both adults and children. To date, albeit with small numbers only, there is no evidence of children being adversely affected by the RUC model of care. Early feedback from parents in A&A has been positive, including scheduling of appointments and in some cases avoidance of hospital attendance altogether.

Public messaging, which should be as consistent as possible, may be compromised by mixed messages for adult and paediatric care. This issue, predicated on safe and effective care, continues to bring differing professional views, including the views of Board Chief Executives, the Scottish Association of Medical Directors (SAMD), the Scottish Executive Nurse Directors (SEND) and the paediatric clinical community. At a meeting of Board Chief Executives on 24 November 2020 a decision was reached on how to proceed. This is discussed in more detail later.

Findings and Recommendations

Operational Issues

- Initial feedback from the local public regarding the NHS A&A pathfinder site has been positive, including venue of care and scheduling of attendance. (There have been no informal or formal complaints to date, in this early inception stage).
- Processes have been in place in NHS A&A to manage phone calls where there is a requirement for British Sign Language or translation services to be engaged.
- Initial feedback from NHS A&A staff working in the Flow Centre has been broadly positive. Further discussions with NHS A&A colleagues working in both primary care and secondary care have expressed caution about ongoing staffing resilience, tempered by Covid-19 uncertainties.
- Robust feedback mechanisms are apparent within NHS A&A for key stakeholders to raise any issues arising, during the immediate implementation phase.
- Managerial and clinical leadership have been readily in place within NHS A&A to rapidly identify and address any issues arising during the immediate implementation phase. The omnipresence of a senior clinical decision maker was a key recommendation of the 2017 Public Holiday Review[2] for service resilience over public holidays.
- Scotland wide, SG should look to maximise the engagement of Quality Improvement Fellows (QIFs) and Scottish Clinical Leadership Fellows (SCLEFs).
- Scottish Directors of Public Health have also signalled their support for RUC and desire to be more engaged going forward.
- The role and engagement of Healthcare Improvement Scotland (HIS) in the RUC programme needs to be defined and agreed.
- Clinical review of the circumstances and outcomes for individual cases should be scrutinised regularly on a systematic basis, to ensure robust clinical governance processes in all Boards,
- NHS A&A has been conducting GP practice local calls every day, for the first two weeks of implementation and twice weekly thereafter, to inform, seek advice and to diminish uncertainties. This approach should be taken forward by all territorial Boards. This process should be replicated in acute and other care settings to ensure that all clinical and support colleagues engaged in the RUC programme are fully informed of emerging and evolving issues.
- NHS A&A has had good engagement with local/regional SAS crews and this approach should be replicated by all territorial NHS Boards.
- Some issues have been identified regarding optimal transport of individuals who are advised to attend an ED or Minor Injury Unit (MIU) but who do not have ready access to transport. NHS A&A are continuing to explore this and this needs to be resolved nationally.

[2] *Improving Health and Social Care Resilience Over Public Holidays*
Improving health and social care service resilience over public holidays: report - gov.scot (www.gov.scot)

- NHS A&A had the opportunity to test their Business Continuity Plans in place, following a short IT system outage in the first two weeks of the RUC programme. NHS A&A has indicated this experience was valuable and has strengthened their Business Continuity Plans. It is recommended all Boards test their Business Continuity Plans in the early stages of RUC implementation.

Workforce Issues

- There are key workforce risks for the establishment and sustainability of Flow Centres, while preserving the Covid-19 pathway and Primary Care Out of Hours (OOH) Services. While NHS A&A have mitigated these risks and stabilised these services in these early stages, continued monitoring is required with expected additional changes and volumes in urgent care flows. This applies to all territorial Boards.
- This also holds true for NHS 24, where unexpected changes in urgent care help seeking behaviour over time may result in significantly increased demand and call volumes.
- Induction and staff training issues for Flow Centre staff in NHS A&A should continue to be shared across NHS Scotland.
- Workforce resilience may be further enhanced by identifying appropriate skillsets, multidisciplinary teams including advanced nurse practitioners (ANPs), clinical pharmacists, paramedics and allied health professionals (AHPs).
- Workforce resilience may also be bolstered by maximising flexible home working opportunities, using *Near Me* and similar technologies, to optimise the best balance between in-person and remote/virtual care. This needs to be evaluated further.

Data Issues and Communications

- NHS A&A, in conjunction with NHS 24 has undertaken daily assessment of numbers of all care episodes and dispositions and has been reporting on a daily and weekly basis. There have been no unforeseen data issues of note.
- Communications and relationships between NHS A&A, NHS 24 and SAS have been of a high order. This needs to be maintained and promulgated throughout Scotland, However the high levels of regular oversight by NHS 24 and SAS Executive Directors will not be possible for 14 Boards simultaneously, therefore robust alternatives will need be in place. From discussions with NHS 24, SAS Executive teams and SG officers, I understand that these are in hand.

Workstream 1: Data & Intelligence was established by the Redesign of Urgent Care Advisory Group (Workstream Chair: Professor Derek Bell). He and his group (of which I am a member) have supported the work of this review. Analysis is continuously ongoing and the NHS A&A pathfinder will inform data collection and interpretation for, and assist all Boards, going forward. Early findings are appended

as an Adjunct Data Report which can be found in supporting files section of the webpage. In summary, Workstream 1 concludes in the first three weeks of operation, that:

- There is no evidence that the RUC programme has disadvantaged any individuals in terms of age, gender or index of deprivation, compared with historical organisational patterns of demand, since the inception of the NHS A&A pathfinder on 3 November 2020
- NHS 24 contacts have increased since the beginning of the NHS A&A pathfinder. This in part reflects the measurable increase in NHS 24 in-hours contacts, as expected
- There has been a small increase in referrals to GP in-hours services (Monday-Friday), as well as a small increase in GP Out of Hours (OOH) activity, compared to the baseline period
- Covid-19 Hubs and Clinical Assessment Centres (CACs) activity have been stable over the study period
- There has been a small decrease in both SAS cases attended and conveyed
- As yet, there is no significant change in ED attendances or target performance since 3 November 2020
- There is an early indication that the number of people who self-present to Emergency Departments (EDs) and Minor Injury Units (MIUs) is decreasing during the early NHS A&A pathfinder experience. Further analysis is ongoing to fully establish this and to monitor trends
- Respiratory data remain stable for both SAS and NHS 24
- Mental health data remain stable for ED attendances – see also Annex 3.

Unlike all other NHS care sectors, there is presently an absence of knowledge and understanding of activity data within general practice and primary care in Scotland. This hampers a full assessment of care flows, future changes in activity and trends analysis. This is well recognised and is presently being addressed by SG.

Public Messaging

- Public messaging within NHS A&A and nationally has been developed and tested in conjunction with public participation groups. Feedback from focus groups has influenced the design and message to the wider public. It is recommended that this is closely monitored and that any change in messaging is developed with the public.

Evaluation

- Transformational change on this scale and impact must be underpinned by robust evaluation, going forward, in terms of health services and economic impact. In major transformational change, robust health services research and economic evaluation will be required. It is recommended that this is formally commissioned by SG, via the Chief Scientist Office (CSO). This should include systematic surveys of public and staff experience, to help

determine both advantage and any unforeseen disadvantage. This should also embrace, as appropriate, the eight guiding principles, cited earlier, which have informed this review.

- NHS A&A, supported by Healthcare Improvement Scotland (HIS), are carrying out a quality improvement approach to the new RUC model of urgent care. I understand that their preliminary findings have been shared with SG.

Mental Health and Wellbeing

Because of its key importance, a separate section on Mental Health has been included in this report.

The document: Role and Management of Psychosocial Wellbeing in the Redesign of Psychosocial Wellbeing in the Redesign of Urgent Care was commissioned and provided by Mr Jacques Kerr and Craig Whyte.

It is attached as Annex 3. It indicates that over the period 2014-19 (Public Health Scotland - PHS) statistics show a 4.1% increase in all ED attendances compared to a stark 68.4% increase in mental health attendances over this period. It flags the impact of the Covid-19 pandemic, not only on physical health presentations but also on psychosocial wellbeing. It describes redesign of urgent care initiatives in place or underway to promote closer collaboration between health, social care, third sector and justice.

NHS 24 has and will continue to play a pivotal role for mental health care via its longstanding Breathing Space service and more recent Mental Health Hub, both integral to its overall service. The NHS 24 Mental Health Hub commenced part-time operation in March 2019 and moved to 24/7 full time operation in July 2020. Optimising urgent mental health care is an intrinsic part of the broader RUC programme and should be promoted and carefully monitored.

Key Risks and Mitigations for All Boards

Risks and mitigations for the RUC programme are being continuously assessed at both national and individual Board level, by frequent readiness assessments, as indicated before. SG and individual Boards must continue to regularly seek assurance, via robust governance mechanisms, as the RUC programme is introduced, implemented and further evolves. The early encouraging and ongoing pathfinder experience from NHS A&A is being disseminated and will continue to inform progress throughout NHS Scotland.

It is suggested that are a number of key (but not exhaustive) risks for RUC implementation, requiring adequate recognition and effective mitigation:

- Covid-19 uncertainties
- Failure to sufficiently assimilate on-going findings, issues and solutions from the NHS A&A Pathfinder Programme by other territorial Boards in Scotland
- Workforce planning (including induction and training) and resilience for Flow Centres, with competing requirements from Covid-19 Pathways and Primary Care Out of Hours services
- Inadequate communications with staff and stakeholders. NHS A&A has invested heavily in regularly communicating with staff, including GPs and other independent contractors. This has paid dividends, by providing feedback and diminishing uncertainties
- Insufficient clinical leadership and administrative support at the launch of the programme and ongoing. NHS A&A has invested intensively and productively in this, with benefit
- Unforeseen Information Technology and electronic records transfer issues
- Robust Clinical Governance mechanisms must be in place and regularly scrutinised to ensure safety and quality of care
- Potential changes in urgent care help seeking behaviour by the public over time, may put undue and growing pressures on the capacity of NHS 24, particularly during the in-hours (daytime) period. The majority of in-hours urgent care should continue to be appropriately provided by GP practices and by community pharmacies (Scottish Pharmacy First Programme), as is happening at present. Persistent concerns about this matter have been expressed to SG, by GPs and other community practitioners. Public messaging must fully embrace these issues. Going forward, in-hours case flows as well as OOH flows must be closely monitored, as is intended, to determine and adequately respond to any changing patterns and trends
- Diversions of urgent care away from ED/MIU self-referrals ('walk ins') towards community-based alternatives, as envisaged by the RUC model, may divert significant numbers of individual urgent care episodes towards in-hours GP and OOH services. The latter service is more vulnerable to capacity and resilience issues. Again, this needs to be closely monitored by all Boards, so that sufficient workforce capacity and capability is present across the whole spectrum of the urgent care service on a 24/7 basis
- There is a potential risk of widening health inequalities, including digital exclusion – this should be formally assessed. An Equality Impact Assessment (EQUIA) is currently being undertaken by SG and all Boards who have been

asked to complete an EQUIA. (Note: EQUIAs focus on legally protected characteristics, which do not include digital exclusion, those with communication problems, or are otherwise vulnerable)

- It is possible that an additional step (Flow Navigation Centre) in the urgent/emergency care pathway may lead to optimal treatment delay for some individual presentations. This needs to be closely monitored and evaluated - in relation to safety, quality and public experience.

Key decisions for Scottish Government

Should the Redesign of Urgent Care programme be rolled out to all NHS territorial boards on 1 (early) December 2020?

Early experience (3 weeks and growing) from RUC pathfinder launch in NHS A&A has not produced any unforeseen issues, has provided good internal learning for NHS A&A but also for the rest of NHS Scotland. The decision to conduct this pathfinder approach was prudent. NHS A&A was already in a high state of preparedness, and possibly more advanced than any other territorial Board in Scotland. There may a 'readiness bias' and/or 'volunteer bias' at play here, which must be taken into consideration by SG.

All territorial Boards throughout Scotland have indicated that they are ready for a 1 December 2020 RUC roll-out. While this view is encouraging, there may be the possibility of RUC implementation 'optimism bias'. That concern has been recognised and is being positively addressed and mitigated by ongoing assiduous SG scrutiny of Board readiness assessment revisions.

At this time, the nascent RUC programme has not yet been 'stress tested'. In the NHS A&A pathfinder, numbers routed via their Flow Centre are small but will grow with the passage of time. Forthcoming service 'stressors' include: increased service volume demand from winter pressures, Covid-19 uncertainties and the festive period ahead. Regular monitoring and internal assessment must continue to be undertaken by all Boards, adequately mitigating all known and emerging risks.

The immediate experience of NHS A&A cannot be assumed to cover the circumstances of all Boards, and particularly for the larger Boards in Scotland. SG must be assured that sufficient risk mitigation is in place before national RUC roll-out occurs. Equally importantly, assurance is a matter for individual Boards and their Accountable Officers. At the time of writing (29 November 2020), I understand that all Board Chief Executives have signed off a readiness assessment for a putative 'go-live' date on 1 December 2020.

If SG agrees, as expected, to proceed with a national roll-out, in early December 2020, as for NHS A&A, it is recommended that all territorial Boards should undertake a gradual start. This will help identify any issues they may experience and to resolve these, sharing their individual experiences for the benefit of all. Further findings from the NHS A&A RUC pathfinder, should continue to be assimilated and disseminated. This has been described as a 'soft' launch approach, with no large-scale publicity and national public messaging. This decision is also tempered by Covid-19 uncertainties, winter pressures and the festive holiday period ahead. The optimal timing of any proposed 'full' launch in 2021, should only be determined once SG is satisfied that the service is sufficiently resilient for that to happen, following further assiduous evaluation of benefits and risks.

My report offered here is a snapshot assessment of early findings of the NHS A&A RUC pathfinder and falls far short of a rigorous evaluation. It is one part of a much broader assessment. Growing experience from the NHS A&A Pathfinder and its

own internal evaluation processes, positive readiness assessments from all territorial Boards and internal SG evaluation are imperative.

Should the national rollout include both adults and children?

There are a number of ongoing discussions around optimal urgent care for children and whether the RUC model should be confined to adults, at this early stage. There have been differing views expressed within the Chief Executives' Group, the Scottish Association of Medical Directors' Group (SAMD) and the Scottish Executive Nurse Directors' Group (SEND).

The NHS A&A pathfinder programme has included both adults and children and to date, in its earliest stages, no adverse impacts have emerged; rather, positive public/parent experiences have been reported. These early findings are encouraging but are limited and should be tested in all territorial Boards, NHS 24 and SAS, at the commencement of and during intended national RUC roll-out.

The arguments are finely balanced but need to be elucidated further.

SAMD and SEND have taken the view at this time that a cautionary single (adult only) approach is appropriate for the safe urgent care of children. They have proposed that the present urgent care pathway should be preserved for children, while the RUC programme is initially implemented and tested for adults only. Once experience and confidence are gained for the adult pathway, a holistic all-age pathway should be reconsidered.

If this single option is preferred by SG, a clear definition of the age determinant of children in this specific context must be agreed and ratified quickly.

Alternatively, some paediatricians and others have expressed a view that a joint adult and children pathway is appropriate and safe to be implemented, as originally envisaged for the RUC programme and currently in place in the NHS A&A pathfinder site.

A Rapid Short Life Working Group (SLWG) has been mooted to give broader clinical input to this matter. As SAMD has identified, the issue is broader than clinical decision making alone, which is paramount. This should also be reflected in the membership of the proposed SLWG, if agreed. The Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) must be involved in this process.

A critical point here is the capacity and expertise of staff available at local Flow Centres at any given time and the imperative to minimise delay and maximise call-back response times for the urgent care needs of children. Experience from the NHS A&A pathfinder will inform this, but the scope and scale will be different, particularly in the larger territorial Boards. The potential risks and benefits of both single (adult only) and joint (adults and children) options should be fully explored.

I was present at the Board Chief Executives' Group meeting on 24 November 2020 to hear the debate and outcome about their views on RUC. Board Chief Executives

came to a majority consensus that the prevailing views of both SAMD and SEND should be heeded and that children should not (initially) be included in the RUC programme, as yet. I concur with this cautionary view and recommend that a rapid Short Life Working Group, as discussed above, should be established with dispatch, to advise on the way forward, in order to secure the best urgent 24/7 clinical care for children in Scotland.

Acknowledgements

I have appreciated working with colleagues in NHS Ayrshire and Arran, NHS 24, SAS and within Scottish Government. Their teamwork has been exemplary and their labours long and intensive. I have taken part in a number of meetings and discussions (Annex 2) and am grateful to colleagues for their time and assistance throughout. I am indebted for the specific help of Derek Bell, Immogen Connor-Helleur, Fiona MacKenzie, Michael Fox, Milla Marinova for the Adjunct Data Report, Jacques Kerr and Craig Whyte (Annex 3). I thank Karen Ritchie and colleagues within Healthcare Improvement Scotland (HIS) for undertaking a rapid literature review of urgent care models). I am also grateful to my immediate SG support team, Karin Agnew and Katie Morris.

Professor Sir Lewis D Ritchie OBE FRSE
James Mackenzie Professor of General Practice
University of Aberdeen

29 November 2020

Annex 1

Terms of reference

1. Purpose

The Chief Executive of NHS Scotland has commissioned an external review of the implementation of the Redesign of Urgent Care Programme Pathfinder site to inform decisions on the proposed national roll out of the programme from 1 December 2020 to all territorial NHS Boards throughout Scotland.

It is anticipated that there will be a number of impacts across the whole care system. The evaluation process will help to inform risk mitigation steps required and further improvements to the agreed RUC model before proceeding to national roll out. Evaluation of NHS A&A Pathfinder site

The review will offer independent advice to the Chief Executive NHS Scotland, the Health and Social Care Management Board (HSCMB) and the Cabinet Secretary for Health and Sport to inform decisions to proceed with a national rollout on 1 December 2020, as previously envisaged, or otherwise, including any suggested amendments.

2. Background

The Redesign of Urgent Care (RUC) programme promotes a significant change in how we best serve the people of Scotland to provide safe and effective urgent and emergency care on a 24/7 basis.

The RUC programme potentially offers the potential of significant benefits to modernising our wider unscheduled care pathways to ensure the public have access first time to best clinical advice and care from the right professional.

The RUC Programme also carries significant risks to successful implementation, Scotland-wide. Outwith NHS A&A, not all territorial Boards will be in the same prior state of readiness as NHS A&A – baselines differ. A straightforward comparison and recommendation to proceed across Scotland will not be readily possible, so a careful balance of judgements will be required.

These include: The readiness of staff, trained and available to provide new and enhanced services. These new pathways of care will require the readiness of multidisciplinary clinical and support colleagues from both acute and primary care sectors to rise to, and contribute to the occasion and at times depart from former agreed and well understood roles in non-Covid-19 times.

Regarding the care needs of the people of Scotland - guiding and supporting public behaviour to access the right urgent care, in the right place, at the right time, on a 24/7 basis.

Professional concerns have been expressed about the viability and sustainability of existing urgent care services in the light of these proposed (RUC) reforms. Primary care clinical professionals have been to the fore in this regard, both in terms of in-hours and out-of-hours (OOH) services.

Diversion of self-presenting attendees at Emergency Departments (EDs) and Minor Injury Units (MIUs), albeit prioritised and filtered, beyond self-care, will impact on both in-hours OOH general practice/primary care services.

Moreover, there might be over time, a societal change in help seeking behaviour, which may detract from day-time general practice services as being the prime source of urgent care during normal working hours towards NHS 24 111. This should be recognised and closely monitored, with agreed mitigations in place.

Due to the variation across Boards in the reported sustainability of local GP OOH's and COVID assessment centres, a local pathfinder approach is being undertaken which enables one Board to be supported to implement and act as a pathfinder site for boards across Scotland.

3. Pathfinder Site

NHS A&A offered to become the first Board to implement the full specification of the RUC programme from 3 November 2020. NHS 24 will begin testing the system on Monday 2 November 2020 to prepare for launch. NHS A&A will provide a local flow navigation centre 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 a local level. The NHS A&A – Redesign of Urgent Care (RUC) Review Group will closely monitor the implementation process as a test of change to inform further roll-out in territorial Boards throughout Scotland. The key focus of this review will be on monitoring, in the short time available, the potential impacts of this redesign of urgent care service provision, particularly where the change may risk to overwhelm other existing urgent care services; ensuring where redirection occurs there is sufficient capacity in other parts of the system to deal with the demand. This will include assessing the initial behaviour change from the public at a local level while taking cognisance of the planned national campaign which will reach a much wider audience. This will inform areas for further improvement and any risk mitigation that needs to be considered before wider roll.

The National Programme team will provide on-site support and support real time evaluation of the pathfinder to inform NHSS Chief Executive and Strategic Advisory Group of progress.

4. National Readiness

All NHS Boards are now working toward a proposed national roll-out date of 1 December 2020 with agreement to implement the *de minimis* specification that presents a national public access to NHS 24 with transfer of clinical referral to a local Flow Navigation Centre providing early access to a senior clinical decision maker

within a multidisciplinary team. Utilising all opportunities for digital consultations and scheduling of attendances where possible.

To inform the decision to progress a full understanding of the wider capacity and capability will need to be considered across NHS Scotland. Each Board submits a readiness assessment on a weekly basis and contributes to the Implementation Leads network sharing progress and compliance with the minimum specifications. The summary of the readiness assessments are considered by the RUC Strategic Advisory Group.

5. Role and Remit

- Identify issues arising in the NHS Ayrshire and Arran recommendations for national implementation of the Redesign of Urgent Care Programme
- To identify and explore any early changes in public behaviour
- To explore the impact of the Redesign of Urgent Care on all parts of the healthcare system
- Use data to help identify if individual members of the public are receiving optimal care

Although outwith the immediate remit of the Review close collaboration with the SG Officers supporting the Unscheduled Care Programme will be required to support the Review, which will explore overall impact and provide a quality improvement approach.

6. Leadership and support

The Review will be chaired by Professor Sir Lewis Ritchie with support from

(i) Core team:

- Katie Morris, Acting Programme Director, Scottish Access Collaborative, Scottish Government
- Karin Agnew, Project management and secretariat

(ii) Other expertise as identified by the team

7. Governance

The Review reports to John Connaghan, Chief Executive NHS Scotland. The Review will investigate and implement any activity within its Terms of Reference. It is authorised to seek any information it requires from organisations across Scotland where necessary to deliver the purpose agreed in the Terms of Reference.

8. Meetings

The Technical Reference Group (Workstream 1 Core Group Meeting) will meet weekly to review data and management information from across the system.

The Ayrshire and Arran SG Internal Review Group will meet twice weekly to discuss key aspects of the evaluation and receive updates from Scottish Government personnel.

The Redesign of Urgent Care Advisory Group (Calum Campbell, Angiolina Foster co-chairs) will be consulted with during the 3 week initial review period.
The Chair will report to the NHS Scotland Chief Executive weekly on progress.

9. Outputs

The Review will report to John Connaghan, NHS Scotland Chief Executive on 23 November 2020 to provide cumulated advice on an anticipated national rollout on 1 December 2020, or if any alterations and or amendments are recommended to proceed.

Annex 2

Review Process - Meetings Attended and Discussions Held

Week 1	
Redesign of Urgent Care Implementation Meeting	3 November 2020
Board Chief Executives Meeting	3 November
A&A Evaluation Group Meeting	3,5 November
Data & Monitoring Group (Technical Reference Group)	4 November
A&A Redesign Urgent Care pathfinder meeting	4,5,6,8 November
Call with Chair and Chief Executive NHS A&A	5 November
NHS Highland, Orkney, Shetland & Western Isles Board readiness assessment meeting	5 November
Week 2	
Redesign of Urgent Care A&A weekly update	9 November
Meeting with Deputy CMO (Acute)	9 November
Ayrshire & Arran Redesign Urgent Care pathfinder meeting	9,10,11,12,13 November
Redesign of Urgent Care - Weekly Implementation Meeting	10 November
Discussion with Chief Executive, the Alliance	10 November
Board Chief Executives' Meeting	10 November
Data & Monitoring Group (Technical Reference Group)	11 November
Ayrshire & Arran Evaluation Group Meeting	11 November
Lothian Readiness Assessment meeting	11 November
RUC Group Meeting	11 November
Review of readiness assessment process with Redesign of Urgent Care Programme Director, Scottish Government	12 November
Forth Valley Readiness Assessment meeting	12 November
Meeting with Deputy Nurse Director NHS A&A	12 November
Highland Readiness Assessment meeting	12 November
Redesign of Urgent Care Health Inequalities meeting	13 November
Strategic Advisory Group Meeting	13 November
Week 3	
Redesign of Urgent Care A&A Weekly Update	16 November
NHS Borders readiness assessment meeting	16 November
Ayrshire & Arran RUC programme meeting	16 November
NHS Lanarkshire readiness assessment meeting	16 November
Discussion with Chair, Scottish Association of Medical Directors SAMD	16 November
Meeting with IJB Chief Officers A&A	16 November
Discussion with Director Royal Pharmaceutical Society Scotland	16 November
Redesign of Urgent Care Board Chief Executives meeting	17 November
Ayrshire & Arran Redesign Urgent Care pathfinder meeting	16,17,18 November
Board Chief Executives' Meeting	17 November
Discussion with CE Community Pharmacy Scotland	17 November
Discussion with Chair Directors of Public Health	17 November
Discussion with Chair Scottish Executive Nurse Directors SEND	17 November
Redesign of Urgent Care - Weekly Implementation Meeting	17 November
Redesign of Urgent Care – Deep Dive	18 November

Meeting with Executive Management Team NHS24	18 November
Redesign of Urgent Chair Group Meeting	18 November
Discussion with Chair of Directors of Pharmacy	18 November
Meeting with SAS Executive Team Members	19 November
Academy of Medical Royal Colleges and Faculties in Scotland meeting with Chair and subgroup of Council Members	19 November
Week 4	
Redesign of Urgent Care A&A Weekly Update	23 November
Ayrshire & Arran Redesign Urgent Care pathfinder meeting	23 November
Redesign of Urgent Care Board Chief Executives meeting	24 November
Meeting with Chair/Former Chair of AHP Directors	25 November

Annex 3

The Role and Management of Psychosocial Wellbeing in the Redesign of Urgent Care National Programme

Jacques Kerr, Senior Medical Officer, Scottish Government
Craig Whyte, Project Manager, PGMS, NSS

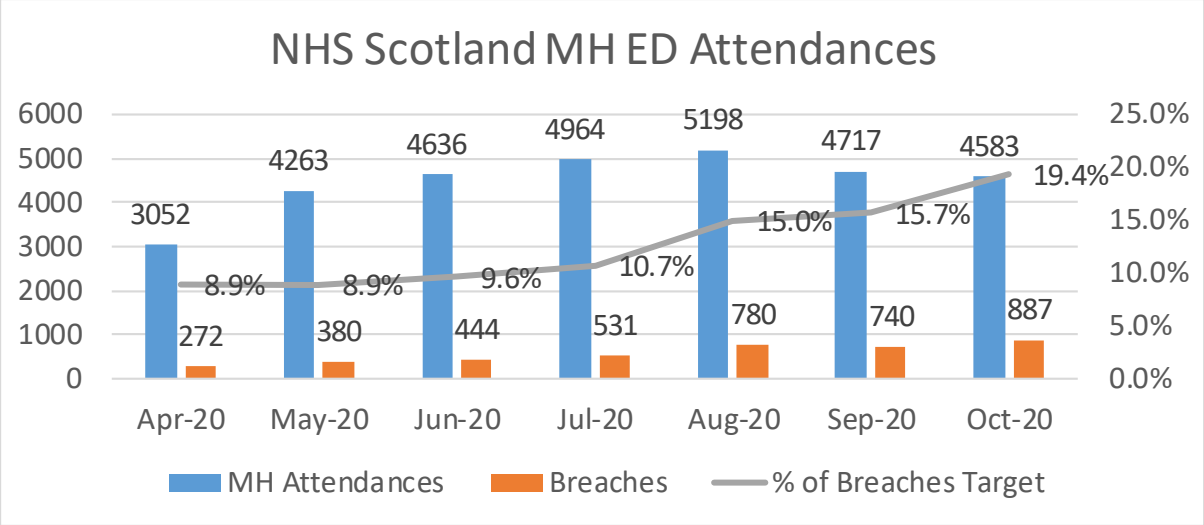
22 November 2020

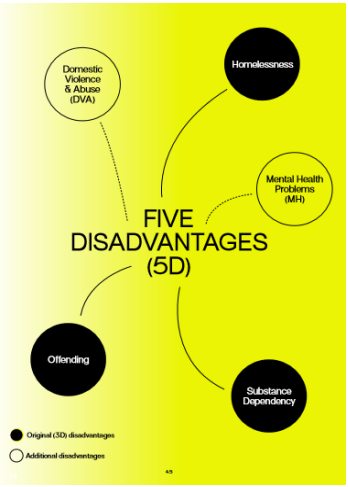
1. Data from the period 2014-2019 (Information and Statistics Division/Public Health Scotland; ISD/PHS) have shown an apparent 68.4% uplift in Mental Health (MH) attendances to emergency departments (ED) versus a 4.1% increase in all ED attendances. The table below shows the number of MH attendances and all ED attendances over this period:

Financial Year	ED Attendances (All Sites)	ED Attendances (Episode Level Data[1])	MH Attendances[1]	Proportion of Attendances with MH Diagnosis[1]
2014/15	1,639,991	1,535,934	37,944	2.5%
2015/16	1,606,682	1,505,042	42,089	2.8%
2016/17	1,622,272	1,522,477	45,878	3.0%
2017/18	1,645,849	1,551,190	55,456	3.6%
2018/19	1,691,952	1,598,651	63,891	4.0%

[1] Patients attending EDs with a mental health diagnosis can only be identified from sites that submit episode level data, the proportion calculation in the table above relates to episode level data. A list of these sites can be found at the following link: https://www.isdscotland.org/Health-Topics/Emergency-Care/Emergency-Department-Activity/Hospital-Site-List/

2. Performance against the four-hour standard where MH presentations are concerned has gradually deteriorated over the last six months (April-October 2020; data source: ISD/PHS):

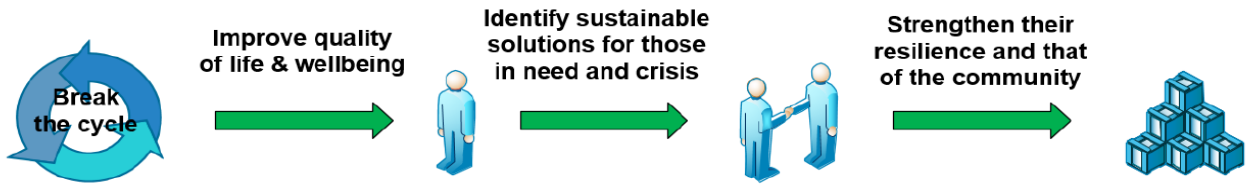




3. The COVID-19 pandemic has had a significant impact, not only on physical health presentations, but also on *psychosocial wellbeing* as a consequence of the necessary suppression measures resulting in increased social isolation and deprivation. Societal impacts on mental health presentations have been highlighted previously as reported in the Hard Edges Scotland publication from 2019: (https://lankellychase.org.uk/wp-content/uploads/2019/06/Hard-Edges-Scotland-summary-report-June-2019.pdf). Affected individuals access services regularly, often through an unnecessarily linear process with multiple hand-offs between Police Scotland (PS), Scottish Ambulance Service (SAS) and Emergency Departments (EDs).

4. As one NHS board-level example, the '*Glasgow 80'* are the most 'frequent attenders' who presented to Glasgow Royal Infirmary's (GRI) Emergency Department between October 2018 and September 2019. This cohort accounted for 1,940 attendances to GRI, which represents 1.98% of all GRI ED attendances (total 97,912). At an allocated baseline minimum cost of £206 per attendance, these targetable attendances may be conservatively estimated at a current cost burden of £2,768,846, and with an identified mortality rate within this group of 15% there is a strong moral as well as fiscal case for improving their care.

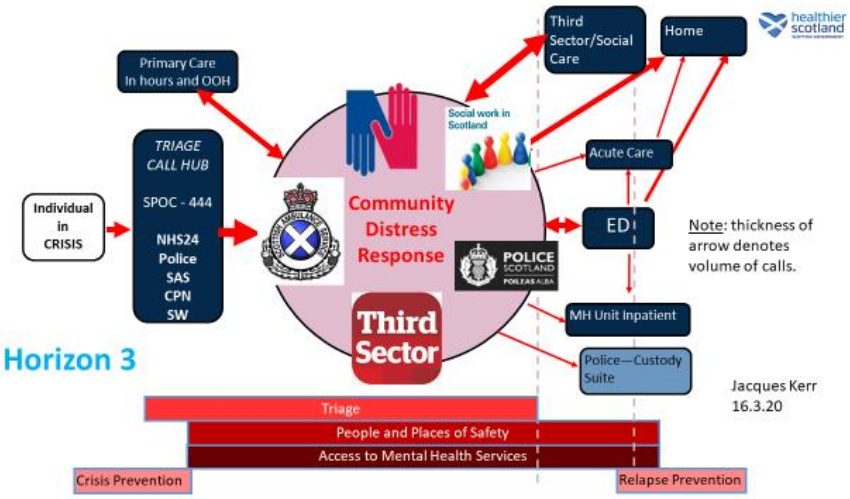
5. Police Scotland established the Quality of Life Group in the north west of Glasgow in 2016 to help build stronger partnerships with Police Scotland, statutory services, primary care, third sector organisations and a range of private sector housing providers in Glasgow to offer better support to those with complex needs and vulnerabilities around problematic substance use, mental health and social isolation. The QoL Delivery Model has the following four steps:



6. The Redesign of Urgent Care National Programme (RUC**)** is taking forward the implementation of Flow Navigation Centres (FNCs) across Scotland to divert unnecessary attendances at EDs so that individuals get the right help at the right time from the right service. There is clearly the potential for partner agencies (PS, SAS and acute health) to work collaboratively in the acute management of individuals with complex needs through these new FNCs. This will align with the pledge made in this year's Programme for Government (page 72) to managing distress more effectively in the community across partner agencies:

'We will ensure that services from across our health, justice and social care systems are brought together to focus on the needs of any person experiencing distress, particularly those with multiple complex needs. Our direction of travel is that people in distress with complex needs who find our various systems difficult to access will be quickly identified and supported by a clearer referral pathway to the intervention that they need. We will explore the adoption of a model of support akin to the COVID-19 Hubs used during the pandemic – an immediate and multidisciplinary response, triaging and navigating pathways for appropriate and compassionate care'.

7. The conceptual model put forward by the National Distress Group back in January 2020 illustrates a potential approach which takes in the above initiatives around collaborative working between health, social care, third sector and justice:



To achieve this operationally will require the following:

1. significant and sensitive change management
2. regular data updates on the activity of the FNCs
3. stakeholder engagement across health, social care and justice with close involvement of partner agencies
4. *effective use of linkworkers and the Navigators service to ensure real-time connectivity with appropriate services, rather than defaulting to the current over-medicalised model of care*
5. *robust and GDPR-compliant data-sharing agreements, both real-time at the point of contact, but also in terms of data analytics*

8. **Project management** began on this work in mid-October and to date the following have been achieved:

a) Stakeholder Engagement

- Regular meetings held with MH leads from the following boards: Ayrshire & Arran, Borders, Forth Valley, GGC, Lanarkshire, Lothian, Tayside and Western Isles. All leads have been positive when taken through the proposed approach and no concerns raised at this time
- Exploration of digital possibilities with Chris Wright (National Advisor for Digital Mental Health) and how technology might be used to enhance the hubs' reach through interconnectedness *between* boards thus addressing potential resource and workforce capacity issues
- Meetings with the MH and suicide prevention lead, and the Strategic Collaboration Manager, for Police Scotland and an invitation to present to the Assistant Chief Constable and Deputy Chief Constables in early December to develop further engagement across partner agencies as well as adopt an approach that involves co-production
- Engagement with the Criminal Law and Justice Group, chaired by the Chief Executive of Turning Point Scotland, to pioneer tests of change involving those with complex needs.

b) DPIA development

- Calls held with IG Leads to discuss previous attempts at data sharing between services in order to use these as lessons learned for the adoption of the required DPIAs
- Approach agreed to write a national DPIA with principles that must be met to allow Boards to develop local DPIAs in line with their current agreements

c) Navigators

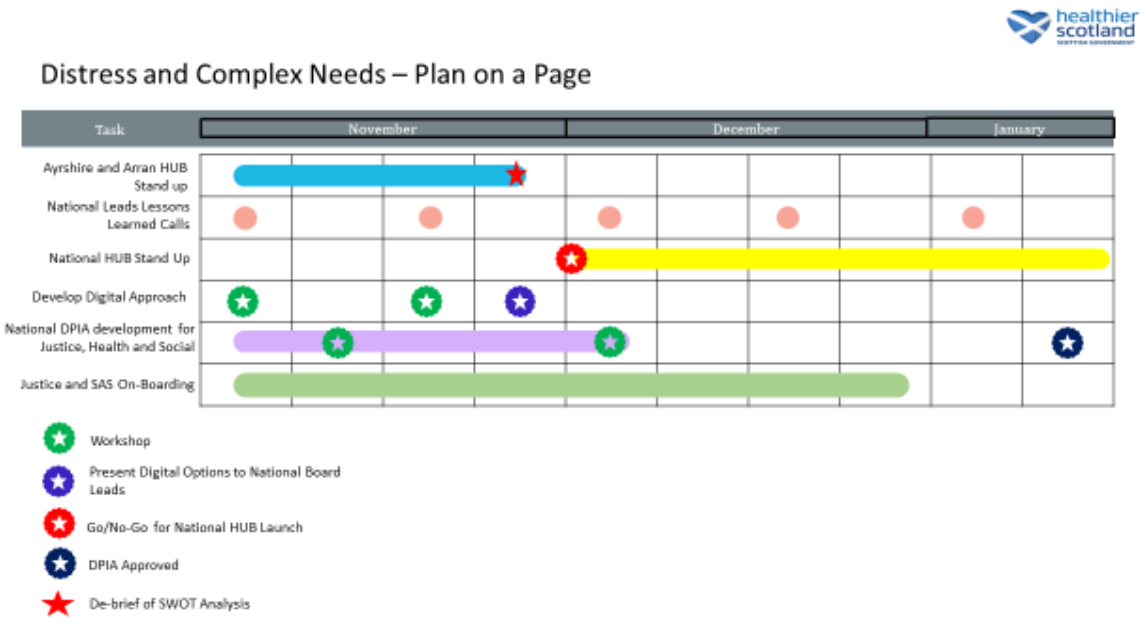
- Multiple sessions held with the Navigator team to understand the reach of their work and the significant difference they can make to people currently stuck in a loop of recurrently attending ED with psychosocial distress
- Introducing the Navigators to MH leads from Boards they currently do not operate in. Ayrshire and Arran have been offered the opportunity to allow a Navigator do some nightshifts to provide them with evidence of what can be achieved

d) Process Mapping

- The development of draft driver diagrams as part of an improvement methodology approach supported by key improvement leads within SG and HIS
- Supporting MH leads in mapping their current pathways and offering advice and solutions on how to improve these by using the Flow Navigation Centres

9. Provisional timelines for the work are predicated on an approach that is person-centred, intelligence-led, assets-optimised and outcomes-focused as per the guiding principles used in the Primary Care Out of Hours Review – Pulling Together: Transforming Urgent Care for the People of Scotland

(https://www.nls.uk/scotgov/2015/9781785448799.pdf). A draft Gantt chart for the work is given here and is built on a *phased approach* that places paramount emphasis on the safety and wellbeing of staff and individuals. Given the time taken to construct robust and effective data protection impact assessments it is likely that this will only begin to run operationally from March/April 2021, at the earliest:



10. **Key deliverables**

- Improved individual & staff experience
- Improved MH metrics such as a reduction in MH presentations at EDs and improved compliance with the four-hour standard
- Reduced police presence in secondary care systems
- Reduced unnecessary ambulance conveyance
- Enhanced compliance with MH Quality Indicators, as per the MH Strategy 2017-27
- Reduced variation – engagement with the Realistic Medicine team around the potential use of atlases of variation will be invaluable here.

Further information –
Any comments should be returned to RedesignUrgentCare@gov.scot and further information is available on the Scottish Government Website.