NHS Scotland
Redesign of Urgent Care

First National Staging Review Report

1 December 2020 – 31 March 2021

June 2021

Scottish Government
Riaghaltas na h-Alba
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Contents

1. Executive Summary

The RUC programme by definition includes the entire patient pathway from the time of patient or carer need to the conclusion of that episode of care. This evaluation has therefore attempted to explore the whole patient journey in terms of data and feedback from stakeholder groups to understand both intended and unintended consequences.

The other major factors which impact on an analysis at this stage are the short time window from inception in December 2020 and the overlap with the second wave of COVID-19 and Winter. It is clear over this period the rate of innovation and staff responsiveness to the challenges has been outstanding and we continue to recognise this.

Based on this review key themes that have evolved fall in to two main headings:

a. Challenges or configurations of services that pre-date the RUC programme which have been highlighted as part of this review.
b. The potential impact of the NHS 24 111 and Flow Navigation Centre pathway which was central to Phase 1 of the programme.

a) <u>Challenges or configurations of services that pre-date the RUC programme</u>
By looking across the patient journey several factors have come to light. Existing services had challenges which pre-date the RUC programme. NHS 24 111 has expanded its offer as part of the COVID-19 response and also planned, for example, new mental health pathways and created new pathways to link to the new Flow Navigation Centres. Historically NHS 24 111 performance in time to answer and call abandonment rates are poorer at weekends (Sunday better than Saturday). This pattern persists and is poorer (2021 vs 2020) and cannot be directly attributed to weekend activity as this has remained unchanged (as expected) with the introduction of RUC which increased mid-week NHS 24 111 activity. RUC Phase 2 will increase focus on spreading and implementing Mental Health pathways.

GP OOH service activity has remained stable and not increased despite initial concerns pre Go-live in Dec 2020. Data coding and collection for GP OOH has not changed over this period but there is the additional impact of ‘shared staffing’ with the COVID-19 assessment hubs. As such the RUC programme has not impacted directly on GP OOH activity but has highlighted the more longstanding GP staffing issues which contribute to service fragility.

Data information infrastructures limit the ability to ‘read across’ the patient journey. This relates to both the IT systems in use, including suppliers, and the access to data as well as non-standardisation of coding. This impacts across all organisations and systems across the patient pathway including primary care (no routine data access), NHS 24, GP OOH and FNC as well as acute and community care data.

b) Potential impact of the NHS 24 111 and Flow Navigation centre pathway
All boards have established Flow Navigation Centres. The infrastructure including staffing levels vary and validated data remains limited. The FNC main functions are to maintain care closer to home by providing clinical advice including self-care and for those who require additional services to plan that efficiently. FNC's are currently largely dependent on referrals from NHS 24 111 and advertising this to the public has been part of a 'soft' communication plan through local mechanisms.

The new pathway was launched on December 1st 2020 and provides a single point of access. Overall the impact of the NHS 24 111 – FNC pathway to date is difficult to assess and may be contributing to up to 5% reduction in all ED attendances or potentially up to 10% of ED self-presenters. NHS 24 111 have increased their direct referral rate to ED mid-week consistent with the 24/7 service which may offset some of the potential gains.

The impact of stronger public messaging is likely to increase the NHS 24 111 – FNC pathway as the NHS 24 111 demand would increase. This represents a potential risk to both service delivery and quality of care. Opening the under 12 children NHS 24 111 pathway has potential to increase NHS 24 111 demand as families and carers begin to use the new pathway. This carries some risks and the impact will need to be actively monitored. Staffing challenges are recognised in several areas (NHS 24, GP OOH and overlap with FNC and COVID pathways) with competition for staff resources. *(The provisional launch date was 29th April 2021. An update has been submitted to Cabinet Secretary advising delay and fortnightly readiness assessments to determine all Board preparedness.)*

The previous pathway for patients presenting directly to ED was predominantly a one-stop-shop. In the new pathways the number of stops to complete the episode will vary. For those who complete at NHS 24 (1 stop), FNC (2 stops) and for onward referral including ED (3 stops).

These questions do not take into account potential improvement in patient experience (as yet to be measured) or if successful reducing overcrowding at various stages of the patent journey. They do provide a potential direction of travel for the RUC programme with a greater focus on the re-design of the pre-hospital and primary care aspects of the patient journey and linking it to the proposed interface care developments to minimise in-patient hospital care.

Summary of Recommendations

NHS 24 Capacity

- The NHS 24 Board must continue to bear down resolutely on current service pressures and seek to build on recent improvements in time to answer calls (TTA) and call abandonment rates. *(In the first instance, NHS24 are working towards a 10 minute TTA)*
- These endeavours include ongoing recruitment, retention, staff wellbeing and support, with external support as necessary.

- NHS 24 should undertake a readiness assessment and impact modelling before further national marketing goes live to provide assurance on their ability to manage additional demands.
- Decisions about future expansion of The RUC programme, including timing, for both adults and children, must be carefully considered by NHS 24 and SG, taking account of satisfactory service resilience and robust contingency measures. *(We are working towards full roll out in the summer)*

Flow Navigation Centres

- Effective planning and resource allocation to secure delivery of timely care for patients and carers to manage peaks and troughs of demand (this can be the same for NHS 24). Further expansion will require resource allocation
- Improve communications for patients arriving at ED around their expecting waiting time which should be more clearly communicated
- Maintain regular and robust communications and relationships between NHS 24, SAS and territorial Boards within Scotland to ensure continuous learning
- Formalise/standardise patient experience and staff evaluation approach at local level
- Ensure feedback mechanism in place to staff on progress and next steps
- Ensure robust clinical workforce resilience with a review of the balance of primary and secondary care staffing. Robust and agreed escalation processes must be in place.
- Strong and visible clinical leadership must be assured and the role/responsibilities of the senior decision maker (SDM) must be clearly defined and understood – including ready in-situ or remote availability, as required by local circumstances and needs

GP Out of Hours

- Address challenges in relation to staffing levels in GP OOH. given the risk to service delivery due to continuing COVID-19 pandemic and impact on staffing and resources as highlighted in the pathfinder report, a SG decision was taken to launch RUC nationally on 1 December 2020, on a minimum specification – with a readiness assessment to ensure agreed compliance by all NHS Boards
- Continue to monitor any impact of the RUC Programme on activity, including case mix and capacity

Future analysis

- More in-depth and a longer period of analysis are required to ascertain the true impact of the RUC Programme and direction of further re-design of urgent care.
- Data suggest that risks remain in the ability of NHS 24 111 to deliver urgent care pathways in relation to activity and timeliness.
- Improvements in data collection across the RUC pathway are necessary, particularly in relation to in-hours general practice/primary care and FNCs.
- Improved recording and monitoring of FNC should be assured including coding, time stamp data and care dispositions.
- The roles and contributions of community pharmacy and other primary urgent care services must also be considered, going forward.

Paediatric urgent care pathway

- All Boards must meet the minimum specification detailed in the Report reviewing the optimal RUC Paediatric Urgent Care Pathway before national roll out (Annex E).
- The overall impact of this redesigned pathway on FNC and ED activities will require close on-going monitoring, and clinical governance review.

Mental health pathway

- For the next (Second) Staging Report, due end September 2021, more detailed analysis of use and outcomes of rapidly evolving urgent mental health care services is recommended.

Person-Centred redesign

- An evaluation of Patient experience should be part of the planned external evaluation.
- Establish a process to collect more standardised locally and centrally available patient experience data working with HIS
- Boards to ensure they have the appropriate privacy statements and Data Protection Impact Assessment (DPIA) are in place which are clear and transparent about how personal information is used reflecting that patients may be contacted to discuss their experience.
- Ensure those likely to experience barriers to care are continually consulted with to shape, refine and improve pathways to better meet citizen's needs, mitigate against harm and minimise inequalities and inform national programme approach.

Public messaging and marketing

- Develop a revised national incremental public communication strategy.
- NHS 24 should undertake a readiness assessment and impact modelling before further national marketing goes live to provide assurance on their ability to manage the additional demand.
- Undertake an evaluation covering those elements which have been delivered so far, including social media, digital marketing and press advertising, as well as local comms, which would then give more formal data and inform a (more) effective campaign.

2. Purpose

To provide the First National Staging Review Report of the implementation of the Redesign of Urgent Care (RUC) Programme in Scotland.

This review reflects on Phase 1 of the RUC Programme (1 December 2020 – 31 March 2021), to assess the programme progress to date, in relation to the desired outcomes, including a preliminary view of the impact on staff and patient experience and to explore any wider system changes. Scottish Government (SG) established an Evaluation Group (the Group), with Professor Sir Lewis Ritchie and Professor Derek Bell as joint leads. The membership of the Group is outlined in Annex A, with input from Public Health Scotland (PHS), Healthcare Improvement Scotland (HIS), as well Scottish Government (SG) and broader stakeholders.

The learning and experience gained from RUC implementation in all territorial Boards in Scotland, NHS 24 and the Scottish Ambulance Service (SAS) is integral to the RUC programme and continues to evolve. The programme required additional Scottish Government (SG) funding with recurring costs, and it is recognised that an evaluation of cost-effectiveness and broader value is required but falls out with the scope of this present review of progress. This is planned as part of the brief for a broader future independent external evaluation (see below).

This First Staging Report seeks to provide an update of progress to date and to help inform and advise on early learning that can be shared and assimilated throughout NHS Scotland. It will also inform a further, Second RUC Staging Report, due end September 2021. An additional independent external evaluation process to augment these two Staging Reports will be commissioned to be finalised by end March 2022.

3. Background

For a number of years, NHS Scotland has been under pressure to manage increased system-wide demands for urgent/unscheduled care. Daily attendances at Accident and Emergency Departments (EDs) increased by approximately 8% between Jan 2016 and Jan 2020, before falling during the COVID-19 pandemic. As of end March 2021, ED attendances have nearly returned to previous pre-COVID-19 historical levels, with similar patterns for hospital acute admissions – see Annex B. This increase in demand with recognised longer waiting times in EDs, led SG officials during 2019/20, to explore alternative models of care drawing on national (UK) and international models, including experience from recent models of urgent care developed in Denmark, where most urgent care activity is managed through local hubs, with early access to a senior decision maker and arranged scheduled care, where required. The aim being to develop a model for NHS Scotland that aims to schedule urgent care where appropriate, to support care nearer to home and ensure the right care is provided at the right place and right time.

The COVID-19 pandemic has had unparalleled impacts on both elective and non-elective care, with specific concerns about the capacity of the whole system (acute hospital and other community-based emergency/urgent scare services) to respond to challenges. Conversely, the COVID-19 pandemic has offered new opportunities to explore and innovate new ways to respond to urgent care needs in Scotland. A specific example is a shift to virtual consultations to support social distancing and maintain essential services for patients. This includes the use of IT platforms such as 'Near Me.'

The RUC programme was created at pace to provide a safer patient experience and an alternative urgent care (RUC) pathway for the cohort of people who would otherwise have directly self-presented to A&E services. This recognised that many patients directly attending A&E services could be more safely and appropriately cared for in their home and community settings, rather than within an acute hospital environment.

The redesigned RUC pathway aimed to provide urgent care as near to home as possible by expanding and promoting NHS 24 (call 111), as the preferred initial contact for patients and carers who had an urgent care need, and to create local Board Flow Navigation Centres (FNCs), with rapid access to a senior decision maker to promote alternative, optimal pathways of urgent care. As necessary, patients would receive scheduled urgent care to the most appropriate place at the right time, improving care experience by reducing unnecessary crowding in A&E services and mitigating 'surge' presentations.

A Strategic Advisory Group chaired by Calum Campbell, CE, NHS Lothian and Angiolina Foster, CE NHS 24 was established to lead development of the redesign (RUC) programme. A conceptual Framework was developed, supported by all NHS Board Chief Executives with agreed principles for Phase 1 (see Annex C).

RUC aims to promote transformational change in how optimal urgent care can be delivered for the people of Scotland. While RUC offers a number of potential benefits in modernising wider urgent care (unscheduled care) pathways, it was recognised

that potential risks, including unintended consequences may exist or materialise. They must be clearly recognised, addressed and mitigated within an iterative programme. Independent of the RUC Programme, a number of challenges existed within the unscheduled care pathway in relation to workforce, system integration and data quality and availability. The COVID-19 pandemic combined with the RUC Programme have highlighted these areas including staffing pressures within GP OOH services (see detail in Annexe I) and NHS 24 111.

To support this service transformation NHS A&A agreed to be the first pathfinder site to test the conceptual model and the transferability of the model to a national roll out to all territorial Boards. A Rapid External Review of the NHS Ayrshire and Arran (NHS A&A) Urgent Care Programme Pathfinder site, was published on 30 November 2020. This report considered the impact on the wider system and recommendation to proceed with a national roll-out. The recommendations are listed in Annex D.

RUC launched nationally on 1 December 2020, on a minimum specification – with a readiness assessment to ensure agreed compliance by all NHS Boards (which all Board Chief Executives signed off). This was described as an incremental or 'soft launch and relied only on local media messaging to publicise the new urgent care referral pathways, rather than a high-profile nationwide media campaign

It was also agreed not to include children under 12 years in the broader NHS 24 and FNC pathways in this preliminary phase, to allow these new urgent care pathways, to be tested, to minimise any clinical risks, and to maximise safety. All children under 12 years would be referred directly to local ED services within 1 hour via NHS 24, rather than initial referral to a local FNC. A further review of optimal urgent care of children (paediatric urgent care) was recommended as part of the NHS A&A Pathfinder Rapid Review. SG commissioned this and copy of the report of this paediatric review is appended as Annex E.

Current Risks for RUC Programme

- GP in-hours data are not routinely available, which limits fuller analysis of the impact of RUC on general practices.
- There is an urgent need to improve data quality in relation to FNCs, to better understand their role and to provide consistent and nationally compatible/comparable automated reports, as part of ongoing data monitoring and evaluation.
- IT Infrastructure remains challenging, including consistent coding and access to routine operational data. This limits robust evaluation and elucidation of future areas for improvement. This includes ADASTRA, NHS 24 111 and GP In-Hours systems.
- The ability of NHS 24 111 to scale up resource to the levels required to be able to manage call times (time to answer [TTA]) calls and call abandonment rates. While NHS 24 111 have largely managed the weekday call demand, weekends have remained problematic.
- This is compounded by various factors including: COVID-19 staff shielding, high levels of sickness absence and increased average call handling times. Ongoing

NHS 24 recruitment and staff training endeavours are seeking to address these challenges.

- The resource and service performance challenges 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.
- Note: NHS 24 collects patient satisfaction data
- Workforce challenges:

    - NHS 24 (as above)
    - GP OOH services
    - FNC staffing
    - COVID-19 hubs and clinical assessment centres (CACs)
    - GP in-hours services

The latter four service elements have been significantly dependent on ongoing and re-deployed GPs, other primary care clinical and administrative staff, with competing demands.

- There is a proportion of the public who are unable to currently equitably utilise NHS 24 services, due to 111 telephone or NHS Inform internet access issues, described as 'digital exclusion'. These communication difficulties include language - where English is not the first or preferred language and other parameters of health inequality including: homelessness, disabilities, (including blindness/deafness and cognitive difficulties).
- Standardisation of mechanisms to better understand patient and staff experience to improve the RUC patient pathway.

Risks and mitigations for the RUC programme were continuously assessed at both national and individual Board level, by frequent readiness assessments. Mitigation is agreed at local level with the SG National team and the Board Implementation Leads. A full risk register is monitored and highlighted for discussion at each RUC Strategic Advisory Group meeting (SAG). SAG established a number of complementary workstreams, initially met weekly and more recently (as of April 2021) has met on a monthly basis.

To further support risk mitigation, the SG National Team established daily drop-in sessions with the Board workstream and programme leads for RUC, to seek to highlight any issues arising, actions or lessons learned. This has also included weekly national implementation meetings to share lessons learned and weekly local meetings to highlight any issues /actions taken at Board level. These meetings were chaired by the SG National RUC programme Director and included representation from SAS and NHS 24. Additionally, each Board was allocated a SG National Improvement Advisor to provide daily support, as required.

4. Key messages

The first phase of the Redesign of Urgent Care Programme (RUC) was adopted by all territorial Health Boards, NHS 24 and the Scottish Ambulance (SAS), and reports strong collaborative working. There are a number of key messages to be considered and shared:

1. NHS 24 111 have established a 24/7 service, with evidence of an increase in activity week-day (Monday-Friday) contacts, particularly in daytime hours (In-Hours).
2. All Boards have established Flow Navigation Centres (FNC's) since Dec 2020, with NHS Highland covering Orkney, Shetland and the Western Isles NHS Boards.
3. Weekly implementation meetings with all Board RUC Implementation Leads are now well-established, to support joint working and to help embed the new and evolving RUC programme.
4. Regular meetings between NHS 24 and local Board Clinicians were established to discuss clinical referral pathways and optimal joint working. Good engagement has been reported to date.
5. Activity Data:
   a) Apart from NHS 24 111, other urgent care services involved have seen relatively stable or experienced reduced activity. This excludes FNC activity, as these are new developments with no historical controls to allow comparisons.
   b) GP OOH activity appears stable since Go-Live. There was a perceived risk that GP OOH activity would be increased, however this is not evident in the data to date. It is recognised that COVID-19 Hub and CAC activity overlaps, particularly in relation to specific dependencies on GP workforce resources. Other experiential outcomes are considered later in this report.
   c) COVID-19 Hub and CAC activity was stable until a peak in January 2021, followed by monthly decreases since, as at end March 2021. (COVID-19 Hubs and CACs have contributed approximately one third of total COVID-19 and GP OOH mid-week activity, and one sixth of all weekend activity).
   d) Scottish Ambulance Service (SAS) activity (non-attended attended, conveyed) has remained relatively stable with minor fluctuations.
   e) For both total ED attendances and for patients who self-present, activity was reducing prior to Go-Live (December 1 2020) and has continued to show decreases until late February/early March 2021. More recent data show a new upturn, although activity remains below 20% of September/October 2020 baselines.
6. It remains difficult to assess the relative impact of changing public help seeking behaviour and overall NHS system response to the COVID-19 second wave. On the basis of available FNC and ED data, the new RUC pathway may be contributing about 5% of the reduction of total ED attendances.
7. Patient Journey Times (for the NHS 24 111/FNC/ED pathway):
   a) The median total journey time from NHS 24 111 contact to completion of ED attendance is approximately 217 mins.
   b) NHS 24 111: Time to answer calls (TTA) and call abandonment rates have increased, particularly over weekends, compared to historic data. It would appear there is an association between call abandonment rates and TTAs,

which requires further elucidation. Note: NHS 24 collects data patient experience data on ongoing basis. Despite longer call answering TTA times NHS24 complaints have not increased and patient satisfaction remains high.

c) FNC: From initial FNC contact the median call back time to contact patients is approximately 10 mins, across Scotland.

8. Paediatric (Children's) Urgent Care: Following consideration of the views of the Scottish Association of Medical Directors (SAMD), the Scottish Executive Nurse Directors Group (SEND), a majority consensus view of Board Chief Executives and as endorsed by the NHS A&A Pathfinder Report children <12 years were not included in the national RUC roll-out on 1 December 2020. Paediatric activity is more complex to interpret as patterns of activity are more variable. Changes in demand reflect also COVID-19 vagaries and associated distancing measures.

9. Mental Health Urgent Care: Some patient pathway re-design (Mental Health Hubs) was already in place (not RUC related) pre-Go-Live. Since Go-Live, demand has been relatively stable for all services with minor decreases. Note: ED attendances for mental health urgent care are again increasing but have not (yet) reached September/October 2020 baselines.

5. RUC Progress - First Staging Review Approach

Process and methodology

This First Staging Review covers the period from 1 December 2020 to 31 March 2021. It includes quantitative data based on the regular weekly and monthly reports prepared by the Data and Monitoring Workstream of the RUC Strategic Advisory Group, including Public Health Scotland, Information Services Division (ISD), NHS 24, Healthcare Improvement Scotland (HIS) and SAS engagement. There is presently limited qualitative information available based on NHS Board feedback (territorial and NHS 24 and SAS) including commentary regarding patient and staff satisfaction, which to date remains largely anecdotal. There are presently limited data on the establishment and response to the present limited communication strategy (public, patients and health and care staff). Implementation and data collection processes are also still in early stages of development and delivery.

Limitations of this First Staging Review

Limitations include the short time scale (a four-month evaluation period) of the nascent RUC programme. This impedes definitive interpretation. This is further complicated by the RUC initiation period overlapping with the second wave of the COVID-19 pandemic and the 2020/21 winter and festive periods. Further limitations include: lack of a standard national format to capture patient and staff experience. A longer period of analysis is required, combined with further data collection to assess capacity within care services (physical and human resources). Together with the NHS A&A Rapid Review Report, it is intended learning and data from this First Staging Review will influence the future design of the RUC Programme and the planned independent external review to include an economic impact analysis.

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 is also applicable to urgent social care provision. This is well-recognised and

hampers a full assessment of care flows, future changes in activity and trends analysis.

6. Patient Journey Activity Data Summary

The data described below are mostly from the monthly report ending 28 Mar 2021 and data provided for NHS Scotland (Annex F), largely taken from Public Health Scotland validated data sets. Monthly reports and a data prioritisation (Annex G) paper was produced for the RUC programme.

Background:
The COVID-19 pandemic has had a measurable impact on health care utilisation overall both in Wave 1 and Wave 2 although patterns vary. Due to a 'system re-set' after COVID-19 Wave 1, the previous year's historic data alone do not provide reliable background therefore September/October 2020 has been used as baseline for activity, as this was stabilising with comparative data from 1 December 2020 (Go-Live). Importantly, data interpretation is influenced by the Wave 2 of the pandemic and winter pressures (see earlier Limitations Section) with a background of falling ED attendances, including self-presentations pre-Go-Live. Fortunately, apart from the 'usual' festive period the changes seen were not as marked as expected in terms of increased activity, possibly in part because of the lack of a 'flu season' and minimal other seasonal respiratory viral infections. The main challenge is trying to attribute any changes to introduction of the RUC programme relative to the overall impact of the evolving COVID-19 pandemic.

Data challenges:
The data presented mainly focus on demand profile and do not explore illness severity or other factors influencing demand/capacity. Lack of GP In-Hours data remains a major limitation and prohibits fuller analysis with data challenges in relation to use of ADASTRA systems in particular, which impact on data quality, timestamp and disposition data, including data from FNCs. Further analysis is necessary for specific metrics including the use of digital communication systems, including telephony and Near-Me. In the interpretation of RUC activity for the services contributing to the RUC pathway there were three patterns seen, excluding any COVID-19 specific data:

- Activity that increased following RUC
- Activity that remained stable
- Activity that showed a decrease

Inclusivity:
Patterns of access by age and index of deprivation for NHS 24 111, SAS and ED attendances is similar to historical organisational experience. The pattern of use for all organisations is also similar, with SIMD Group 1 (most deprived) being most frequent users and SIMD Group 5 (least deprived) the lowest users. Further in-depth analysis will be part of future evaluations. Ethnicity data are improving but remain incomplete/patchy. Public Health Scotland in conjunction with SG and care providers are presently pursuing how this can be best remedied.

Pre 'Go-Live' (prior to 1 December 2020):
There were reductions in activity for most services suggesting a link to the onset of the second wave (NHS 24 111 mid-week, SAS, ED attendances, individual walk-ins/self-presenters, and Emergency Admissions).

Primary Care Out-of-Hours (OOH) activity (non-COVID-19):
This has remained stable mid-week and weekends. This appears reassuring as there were concerns that this service, which has known staffing pressures, would struggle if the RUC NHS 24 pathway increased referrals to OOH, as this is the dominant source of OOH referrals. This was not seen in overall numbers, but the impact of COVID-19 Hubs and Assessment Centres and case complexity require further analysis, including staffing resources.

COVID-19 hubs and CACs:
Activity in COVID-19 hubs and CACS demonstrated an initial increase in activity around the Go-Live period, but thereafter presentations have continued to decrease, consistent with the decline in Wave 2 of the COVID-19 pandemic.

SAS:
Patients attended and conveyed, with only minor variations, have remained stable from September/October 2020, which is reassuring in the sense this should represent the sicker sub-group of patients most likely to require hospital care in general.

After Go-Live:
NHS 24 111 all contacts saw an increase in activity mid-week which was dominantly in routine working hours. Weekend activity has remained stable, consistent with normal variation with a minor decrease January-March 2021.

Coincident with increasing COVID-19 positive cases there were ongoing reductions in activity for ED attendances, Self-Presenters and Emergency Admissions.

Current position as at 31 March 2021

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- Currently NHS 24, GP OOH contacts for mid-week and weekend are increasing
- SAS attended and conveyed incidents are also stable
- COVID-19 hubs and CACs activity continues to show a decrease
- ED attendances and self-presenting cases are steadily increasing as of end of March but have not reached Sep/Oct baseline levels

Patient Journey times:
The total journey time for the NHS 24 111 – FNC – ED patient pathway is currently 217 minutes. This does not include Time to Answer (TTA) times for NHS 24. Time stamp data are available for some areas of the patient pathway but is incomplete. Note: the NHS 24 process, accessed by phoning 111, has been recently re-designed and moved from a potential call back option, to answering and dealing with calls as quickly as possible, in one contact episode, avoiding the need for call back. This has been in place since early 2020, pre Go-Live, which impacts on comparative data interpretation.

NHS 24 Time to Answer (TTA) Incoming 111 Phone Calls

NHS 24 111 response times have three main patterns which appear to relate to call volumes and day of the week, including the impact of public holidays. Weekend and public holiday activity is greater per day compared to mid-week for current and historical patterns of activity. The most notable current changes are in TTA and call abandonment rates, most apparent at weekends with Saturdays being worse. TTA median response times (January-March 2021) for weekends were between 25-29 minutes on a Saturday, and 12-16 minutes on a Sunday, compared to mid-week 0-2 mins in hours and 2.5-9 mins out of hours (OOH). Call abandonment rates (January-March 2021) were 24-27% on a Saturday and 17-22% on a Sunday, compared with mid-week 9-14% in-hours 14-21% OOH. These difference between midweek and weekends reflect a historical pattern but were poorer in 2021 v 2020. There appears to be an association between TTA's and call abandonment rates. This analysis does not take into account call complexity, repeat callers or impact of staffing levels. Of note, the RUC Programme has had no obvious impact on call volume activity at weekends.

Flow Navigation Centres (FNCs):
FNCs were created as part of the RUC programme and all Boards have an FNC in place. A single FNC operates across NHS Highland and NHS Orkney, Shetland and Western Isles. As there is no historical data for FNC this is summarised from January-March 2021, as data collection has improved. Routine data that are validated are available for 7/11 NHS territorial Boards. Further discrepancies in these data may relate to data entry and training issues within the FNCs. Despite limited data, the overall pattern appears stable at approximately 250 contacts per day. This number is too low to impact on overall whole system activity.

FNC Response:

From initial FNC contact, median call back time is approximately 10min, with call duration 1 min for appointment scheduling and approximately 9 mins for clinical assessment.

Near Me as part of RUC FNC activity:
All territorial boards were supplied with IT infrastructure to support the rollout of Near Me within the RUC Programme and is operational in 11/14 boards. The median Near Me component of NHS 24 FNC activity is 17.4% (range 0-68%) with an average call duration for a consult of 6.4 minutes (range 4.7 to 8.1 minutes) in March 2021. NHS Forth Valley was the greatest user of Near Me 67.7% (n=511 from 1282 total Near Me FNC consults across Scotland).

FNC Disposition:

Data suggest approximately 36% of FNC activity is referred to ED/MIU (29%/7%), with approx. 30% of patients advised to self-care and approximately 16% referred to Primary care. Lack of In-Hours data hampers a better understanding of this pathway including referral quality.

A&E attendances pathway:
A&E attendances remain lower than September/October 2020 baseline and this relates primarily to a reduction in patients who self-present. However, analysis of the overall trends in ED activity and relating this to NHS 24 and FNC activity, suggests that most of the reduction in self-presenters seen to date, could be attributed to the impact of COVID-19 and associated social distancing measures and changing public urgent care help-seeking behaviours. Note: most recent data suggest activity is close to September/October 2020 levels and historical numbers.

The overall impact of the RUC programme to date could be attributed to the reduction of up to 5% of total ED attendances. It should be noted that NHS 24 111 onward referrals to ED mid-week have increased since Go-Live, consistent with increased NHS 24 111 activity.

Recommendation - Future analysis

- More in-depth and a longer period of analysis are required to ascertain the true impact of the RUC Programme and direction of further re-design of urgent care.
- Data suggest that risks remain in the ability of NHS 24 111 to deliver urgent care pathways in relation to activity and timeliness.
- Improvements in data collection across the RUC pathway are necessary, particularly in relation to in-hours general practice/primary care and FNCs.
- Improved recording and monitoring of FNC should be assured including coding, time stamp data and care dispositions.
- The roles and contributions of community pharmacy and other primary urgent care services must also be considered, going forward.

7. NHS Board FNC Self Assessments

To support understanding of progress at local level the National Programme requested that all NHS Boards undertake a local assessment of their system infrastructure for FNC, including impact at local level on the patient and staff experience, public behaviours and impact on the wider system. All submissions were collated in March 2021.

FNC board structure:
The majority of NHS Boards have located their FNC within an acute hospital setting, with two operating from community-based facilities. Seven FNCs are co-located with GP OOH services. Of the 11 Boards providing this service (excluding Orkney, Shetland and the Western Isles, covered by NHS Highland), all operate 7-day services supported by a senior decision maker (SDM). Five operate with SDM 24 hours/day, five provide SDM min 12 hrs/day and one has a SDM present 8hrs/day. Staffing infrastructures varied in terms of numbers of staff and professional groups and this will require further understanding as systems embed.

All Boards provide clinician to clinician contact (Professional to Professional), some using a combination of methods. Near Me was made available for patient contact to all boards as part of the roll-out. The majority use standard telephony services.

FNC Patient feedback:
There is limited patient ‘experience’ data for the FNCs being collected by some boards (6 of 11) using non-standardised approaches. Feedback has highlighted some areas which will require on-going monitoring and potential improvement, including:

- timeliness of telephony response and appointment scheduling, times & expectations
- correct disposition
- clarity about paediatric pathway
- access to near me and telephony
- the need to improve awareness
- transport including SAS
- number of steps in the pathway including imaging

Plans are ongoing to standardise patient experience collection nationally working with HIS to inform fuller evaluation. Overall feedback from patients and staff has been mixed and further external evaluation is required to fully understand the patient journey. The feedback that is available largely relates to limited assessment of satisfaction rather than experience. Common themes of observed benefits include:

- Patients feeling safer having been seen virtually, with reduced travel requirements
- Reduced unnecessary admissions for care home residents
- Easy direct access to direct medical specialties
- Shared decision making and agreed plans between patients and staff
- More personal, quick and efficient care

Staff feedback:
Staff highlighted the improved opportunity for communication and relationship building between territorial boards, NHS 24 and SAS and across multiple teams. Staff satisfaction has been reported as enhanced by enabling patients to undertake self-care or access care in the community and avoid unnecessary hospital attendance.

Concerns raised included technological challenges including being unable to connect when calling a patient back and general IT issues, although the role of virtual communication was well received. FNCs can at times experience very few calls, particularly overnight, and the benefits of a 24/7 service provision were queried given small patient numbers.

Recommendations – Flow Navigation Centres

- Effective planning and resource allocation to secure delivery of timely care for patients and carers to manage peaks and troughs of demand (this can be the same for NHS 24)
- Improve communications for patients arriving at ED around their expecting waiting time which should be more clearly communicated
- Maintain regular and robust communications and relationships between NHS 24, SAS and territorial Boards within Scotland to ensure continuous learning
- Formalise/standardise patient experience and staff evaluation approach at local level
- Ensure feedback mechanism in place for staff on progress and next steps
- Ensure robust clinical workforce resilience with a review of the balance of primary and secondary care staffing including links with GP OOH, with robust and agreed escalation processes must be in place.
- Ensure strong and visible clinical leadership with clearly defined roles and responsibilities of senior decision maker (SDM) including in-situ and/or remote availability, as dictated by need
- Ensure Clinical Governance arrangements and case reviews are in place and monitored.

Urgent Care Pathway - Paediatrics

Following the NHS A&A RUC Pathfinder Rapid External Review (which included children of all ages in the new urgent care pathway), concerns were raised by some clinicians notably, SAMD and SEND, about the potential safety risks of including urgent children's (paediatric) care in NHS 24 referrals to FNCs, until pathways were robustly established. Following discussions, Board Chief Executives reached a majority consensus that children should initially not be included. It was agreed to initially exclude all children under 12 years in referrals from NHS 24 to FNCs.

A rapid review was commissioned and undertaken (Professor Stephen Turner, Chair - see Annex E). Recommendations were developed which were discussed and agreed by SAMD,

SEND, Board Chief Executives and the broader stakeholder representation of the Redesign Urgent Care Strategic Advisory Group (SAG). This included a minimum specification for all territorial Boards to meet before children <12 years are to be included in the new pathways.

All NHS Boards much be fully compliant with the minimum specification based on their readiness assessments before this pathway is included in the referral to FNC. The provisional launch date is 28 April. All Board readiness assessments are currently being reviewed by SG officials, at the time of writing.

Data Analysis - Urgent Care Paediatric Pathway (under 12 years)

- The paediatric pathway for children (<12 years) was not re-designed in this initial phase of the RUC programme and is more complex to interpret, as patterns of activity are more variable. Paediatric activity data patterns differ from overall urgent care activity.
- Paediatric ED attendances were declining pre-Go-Live and continued to decline, consistent with waning of Wave 2 of COVID-19. However, in March 2021, activities have started to return to pre-COVID-19 levels 'normalise'.
- NHS 24 111 and SAS contacts have shown some reductions, probably consistent with Wave 2 COVID-19 before and after Go-Live. However, again recent activity has started to return to pre-COVID-19 levels.

Recommendation – Paediatric urgent care pathway

- All Boards must meet the minimum specification for the RUC Paediatric Urgent Care Pathway (Annex E) prior to launch
- Monitor impact of redesigned pathway on FNC and ED activities, including clinical governance review.

Urgent Care Pathway - Mental Health (MH)

Mental Health was not part of the initial phase of the RUC Programme and therefore while data is available this was not a major part of the current evaluation. Going forward, the RUC recognised the importance of improving integration of physical and mental health within the urgent care setting. New mental health pathways were being developed in parallel including the NHS 24 Mental Health Hub inception in March 2019 to support the integration of mental health pathways and services.

All stakeholders are working to integrate and support mental health and psychological wellbeing services to enhance existing or develop new pathways. This work will include:

- Embedding pathways between the NHS 24 Hub, FNCs, Mental Health Assessment Services and the Mental Health Enhanced Pathway.
- Embedding mental health unscheduled care pathways for children and young people.
- Continuing to develop Mental Health Assessment Services, including agreeing consistent data collection.
- Establishing multi-disciplinary team test sites to support those with Complex Psychosocial needs.
- Supporting people in distress by continuing the national roll-out of Distress Brief Intervention including an evaluation.
- Continuing to build mental health capacity within primary care settings with a view to implementing Primary Care Mental Health teams
- Further enhancing mental health service delivery through digital innovation.

Data Analysis:
Call demand for the Mental Health hub has increased from approx. 2,000 calls per month in March 2020 to over 10,000 calls per month in March 2021.

Since January, NHS 24 111, SAS and Primary Care OOH mental health activity have shown minor decreases (Note: overall numbers are small which limits interpretation). Note: NHS 24 collects further in-depth mental health data which will be part of further study.

Pre-Go-Live mental health ED attendances were decreasing, with further decrease around the time of Go-Live, but activity has now started to increase, consistent with overall ED attendance data.

Recommendation - Mental health pathway

- For the next (Second) Staging Report, due end September 2021, more detailed analysis of use and outcomes of rapidly evolving urgent mental health care services is recommended. This should include the degree of integration with other services and patient and staff experience.

8. Person Centred Redesign

Equitable access for all citizens is central to the RUC Programme. An Equality Impact Assessment (EQIA) of the national policy consulting with relevant stakeholders to assess the potential impact this service change has been undertaken and will be published following the election period.

A number of engagement exercises have been carried out:

Discovery Project:
This was undertaken to 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 the change in service may have on vulnerable citizens.

The research suggests utilising digital alternatives to ED attendance may create additional barriers for vulnerable groups. Suggested actions to mitigate this include: improving digital access; improving telephone services for those with language barriers; ensuring call handlers are trained to support equitable care; targeting national messaging at vulnerable groups and ensuring collaborative working with partner agencies.

The analysis performed suggests that those who encounter little or no difficulty interacting with current urgent care services may experience benefits from the changes including:

- 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
- Minimising risk of infection
- Minimising crowding in waiting areas
- Avoiding unnecessary travel and the cost of transport
- Source of reassurance

Broader public engagement is planned by Healthcare Improvement Scotland (HIS) Spring/Summer 2021 to support the co-design and communication strategy. This work will concentrate on equalities-related engagement gaps identified in the EQIA focusing on protected characteristics and marginalised communities to deepen understanding of potential enablers and barriers to accessing urgent care services.

The Community Engagement's network will collate comments and experiences from across Scotland to provide local, regional and national perspectives. A range of methods are planned including focus groups, interviews, questionnaires and events. Findings will be available by June 2021.

An RUC Citizens Panel will be established in Summer 2021 focusing more widely on general population, to explore the redesign of urgent care including the service configuration, barriers to access, and opportunities for improvement.

Recommendations - Person-Centred redesign

- Patient experience should be part of the planned external evaluation.
- Establish a process to collect more standardised locally and centrally available patient experience data
- Boards to ensure they have the appropriate privacy statements and DPIAs in place which are clear and transparent about how personal information is used reflecting that patients may be contacted to discuss their experience.
- Ensure processes are in place to continually consult with those likely to experience barriers to care to shape, refine and improve pathways to better meet citizen's needs, mitigate against harm and minimise inequalities and inform national programme approach.

9. Public Messaging and Communications

A robust communication and engagement strategy is critical to the success and viability of the RUC Programme. Key to this success will be influencing public and staff behaviours to encourage adoption of the new model of care to support the strategic objectives of the RUC programme and introduce the *Right Care, Right Place* approach to service delivery. The communications strategy was intended to reach as many people as possible with a clear narrative for the public to understand the new pathways of care and potential benefits.

The campaign aimed to target all adults in Scotland and redirect the 20% of attendees to ED who would be better served by alternative service. Clear objectives were set to evaluate the penetration of the campaign including:

- Deliver prompted campaign recognition of 60% among the target audience.
- Ensure 40% of those who have seen the campaign agree with the following measures: the advertising feels relevant to me, makes it clear what we need to do.
- Encourage at least 40% of those who have seen the campaign to say they would take a relevant action if they needed to (eg, phone NHS 24 111 or visit NHS Inform).
- Ensure that at least 25% of those who have seen the campaign agree the advertising explains why it is important to phone NHS 24 111.

Additionally, the communication approach aimed to ensure communications reached groups with limited access to digital, TV etc.

It should be noted that agreed timelines for implementation of each element have been delayed and postponed several times to reflect emerging impacts on services including moving from a nationwide big bang approach to a more regional soft launch approach. This impacted on the analytic approach initially planned and the overall RUC Programme pace.

Local marketing and Social Media:
National assets were developed to give a consistent message to the public on a National NHS24 111 service for urgent care as the first response including that GP remained the default provider and only if intending to visit A&E to contact NHS 24 111 first.

National Door Drop Leaflet:
The national door drop leaflet/mailer was circulated to every household in Scotland in January 2021. The leaflet included a broad range of information on all available NHS services available, including a section on the new pathway for urgent care via NHS24 111. All campaign communications were sent to NHS 24's extensive network of 500+ community contacts for dissemination in relevant languages/formats.
Analysis revealed:

- 66% of people recognised the door drop.
- 9/10 agreed it was clear which healthcare services were available, and where to go to get the most appropriate care for different types of medical condition.
- 85% of those who had read the leaflet said they would do something differently in the event of needing urgent care – most likely considering another service with NHS 24 being most common and/or using NHS Inform.

TV and radio publicity:
These elements of the campaign were due to take place in April/May; however this was delayed due to the service demands already on NHS 24 and deemed too high risk to proceed.
A TV campaign was felt to pose most risk,

Recommendations – Public messaging and marketing

- Encourage boards to maintain and step up local communications.
- Develop a revised national incremental public communication strategy based on risk including NHS 24 111 undertaking a readiness assessment prior to further national marketing to provide assurance.
- Undertake an evaluation covering those elements which have been delivered so far, including social media, digital marketing and press advertising, as well as local comms, which would then give more formal data and inform a (more) effective campaign.

10. Present and Future NHS 24 Capacity

One of the key risks identified in the NHS A&A Pathfinder Review, was additional pressures on the capacity and performance of NHS 24 by potential significant increased urgent care demand. This risk has since materialised following national Go-Live on 1 December 2020. NHS has experienced considerable strain on the

capacity over the week and more lately consistently during weekday in-hours periods and weekends, resulting in increased time to answer (TTA) 111 calls and higher call abandonment rates. This is due to a number of factors, as indicated previously. Despite an extensive recruitment campaign there presently remains a risk to service delivery and further extension of the RUC Programme, including large scale publicity plans and inclusion of the revised urgent care pathway as discussed in Section 7 above and in Annex E.

NHS 24 is undertaking modelling exercises to review capacity, demand and optimise scheduling of capacity to manage existing 111 call demand and future expansion plans for expanding the RUC programme for both adult and paediatric urgent care.

Recommendations – NHS 24 Capacity

-
- The NHS 24 Board must continue to bear down resolutely on current service pressures and seek to improve time to answer calls (TTA) and call abandonment rates.
- To include ongoing recruitment, retention, staff wellbeing and support, with external support as necessary.
- NHS 24 should undertake a readiness assessment and impact modelling before further national marketing goes live to provide assurance on their ability to manage additional demands.
- Decisions about future expansion, including timing, of the RUC programme, for both adults and children, must be carefully considered by all organisations working with NHS 24 111 and SG, including robust service resilience and contingency measures.

11. Redesign of Urgent Care – Future Steps

Phase two of the Redesign of Urgent Care Programme continues across 2021/22, building on the initial specification. In addition to the Phase 1 – public access core principles a further 6 principles of care focus on widening access to professional groups and specialty pathways of care: improved interfaces with GP in hours; mental health hubs; closer working with community pharmacists, professional referrals from and to Scottish Ambulance Service (SAS) and development of specific pathways such as for Musculoskeletal services. These principles will be underpinned by improving health technology opportunities (Annex H).

Public Health Scotland are currently scoping how equity of access in the context of the redesign of urgent care can be evaluated and quantified. The focus of the scoping exercise is threefold:

- Identifying those equality and vulnerable groups for whom routine urgent care data is available.
- Fine-tuning the precise evaluation question(s) that could / should be asked around equity of access.
- Assessing the availability of data with which to compare changes in access to and use of urgent care to the population's needs for urgent care, taking account of variation across equality and vulnerable groups where possible. A key

anticipated challenge is the interpretation of any trends observed, and to what extent they can be (partially) attributed to RUC in light of the impact of the COVID-19 pandemic and other factors.

12. Independent External Evaluation

There is a commitment to commission a robust external evaluation of the national Redesign of Urgent Care which will contain formative and summative evaluation. This will determine an appropriate evaluation plan, with a set of core research questions, in spring 2021 under the governance of an Evaluation Advisory Group (EAG). A mixed methods approach will be expected that is proportionate and timely; make best use of existing evidence; through primary research. It will include existing monitoring data from the RUC programme and related organisations including PHS and HIS. Board and other stakeholders' opinions will be collated.

Areas of focus will include an analysis of:

- Patient experience
- Staff Experience
- Inclusivity
- Value of programme including cost-effectiveness
- Broader overview of process, clinical outcomes and whole system impact

An update on progress will be included in the next (Second) staging report at the end of September 2021. This will include extensive consultations with staff.

Acknowledgements

We are particularly grateful to members of the Evaluation Group as listed in Annex A. We are indebted to colleagues based at the University of Strathclyde who helped formulate ideas for future evaluation of the Redesign of Urgent Care. Colleagues within Scottish Government have been instrumental in their support, with specific thanks to Jessica Milne and Jill Pender for their invaluable input and professionalism throughout. With thanks to Dr Milla Marinova, Imogen O'Connor for their in depth analysis and contribution to the report.

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April 2021

ANNEX A

Evaluation Group Membership

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Professor Derek Bell
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Tony McGowan – NHS Healthcare Improvement Scotland
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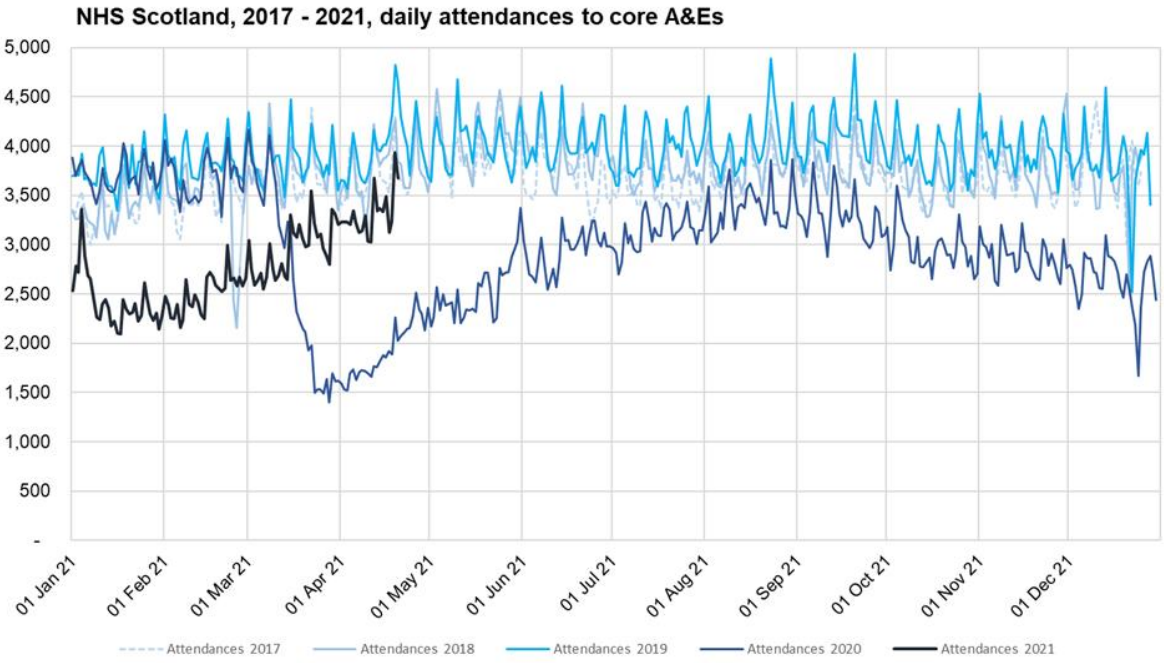
Carol Goodman – Scottish Government
Fiona MacKenzie – Public Health Scotland
Fiona MacDonald – Scottish Government
Heather Campbell – Scottish Government
Jessica Milne – Scottish Government
Jill Pender – Scottish Government

ANNEX B

A&E Attendances overview



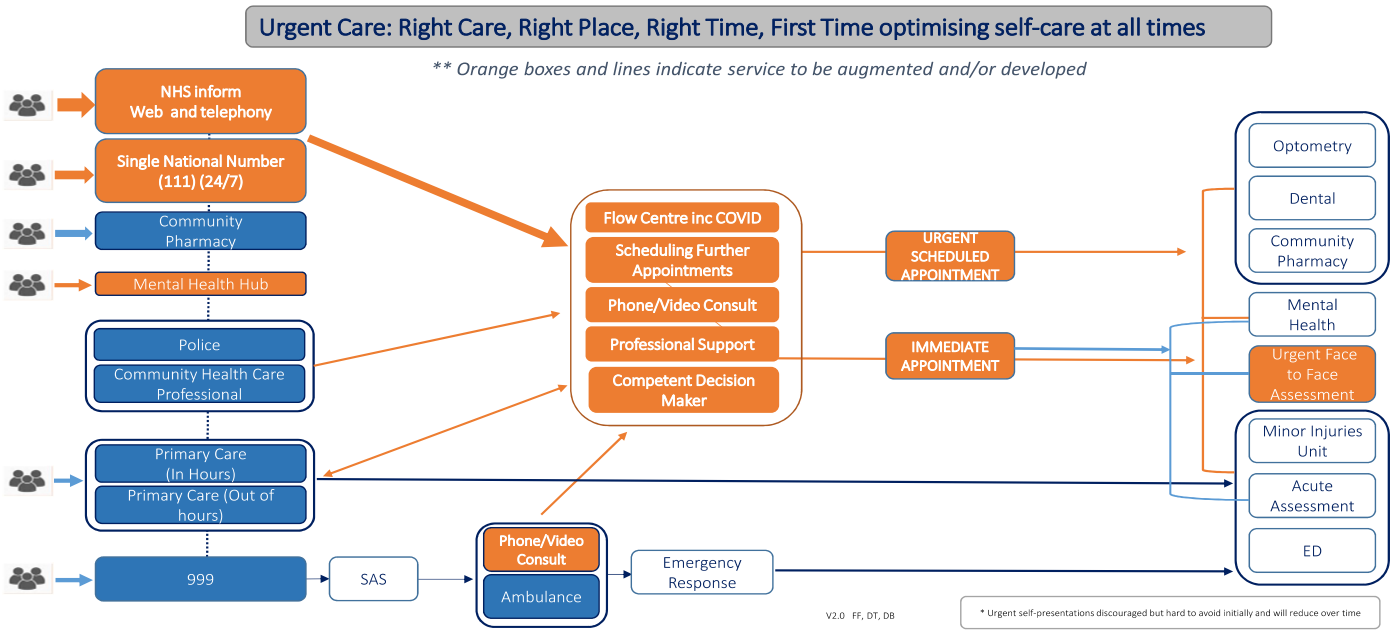
Note: figures for previous years are plotted agaisnt the equivalent day of the week in 2021. I.e attendances on Friday 25 December 2020 are plotted against Friday 24 December 2021.

Source: unvalidated management information from the Scottish Government Unscheduled Care Database

ANNEX C

Conceptual Framework and Phase 1 principles

Conceptual Framework V2.0 Final



Aim
Right Care, at the right place, at the right time.
Vision
Collaborate across the whole health and social care system to design and implement a safe, sustainable, patient and outcomes focused system of urgent care access, pathways and treatment in Scotland that delivers better health, care and life outcomes for our patients, staff, their families and the wider community in which we all live, grow, learn, work and play.

Principles	
Minimising the risks of moving patients around the system Establishing an emergency care system that benefits everyone Delivering a new model of care that is national, simple, effective and safe for all Making the best use of scarce resources Aligning closely with wider winter planning work	Addressing inequalities Patient and staff safety is out priority across the whole system Supporting staff training and organisational development Keeping the access route as simple and as clearly defined as possible

Strategy #1 Scheduling Attendances	**Strategy #2** National Messaging	**Strategy #3** Access, Triage & Flow Centres	**Strategy #4** Virtual Technology
Delivering care as close to home as possible by minimising unnecessary face-to-face contact and maximising access to a senior decision maker Effective management and scheduling of the flow of self-presenters to Emergency Departments and local Board services Taking a multi-agency, multi-professional approach to scheduling, directing patients to the most appropriate professional and place and for their needs Patients receive the care they require closer to home by optimising existing pre-hospital patient care and developing new	Delivering strong public messaging to support any changes to care to allow the public to use the system responsibility and ensuring that it is linked to self-care and management and healthier life choices Focused public messaging linked to responsive health care systems Planning and delivery will take a while-systems approach and will not be 'owned' by one part of the system	Ensuing patients are seen in the most appropriate clinical environment by the most appropriate clinician to minimise the risk of harm and ensure safety Reduction in self-presenters to Accident and Emergency when care can be delivered more appropriately in another setting by another professional Reducing numbers of patients attending Emergency Departments by providing alternative care pathways Establishing a single national access route which delivers simple clear access to patients Developing an approach that appropriately and	Maximising and building upon digital solutions Enhancing the use of digital health through NHS Inform NHS24 / 111 Increasing the use of virtual consultations by NHS 24, SAS and new Local Flow Centres Adopting a digital first approach that defaults in the first instance from face to face triage and consultation to digital Focusing on improving outcomes for those most in needs, including disadvantaged groups who use Accident and Emergency due to difficulty accessing other parts of the Health and Social Care system

systems based on COVID-19 learning		sensitively responds to mental health issues Increased use of the role of General Practitioner in urgent care	

ANNEX D

NHS Ayrshire & Ayrshire Pathfinder Rapid External Review: Summary & Recommendations

Rapid External Review of the NHS Ayrshire and Arran (NHS A&A) Urgent Care Programme Pathfinder site, published on 30 November 2020

Recommendations and Risks identified in Pathfinder

Risks

- 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
- 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 (EQIA) is currently being undertaken by SG and all Boards who have been asked to complete an EQIA. The national EQIA will also include socio-economic status and digital exclusion.
- 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.

Recommendations

- Scotland wide, SG should look to maximise the engagement of Quality Improvement Fellows (QIFs) and Scottish Clinical Leadership Fellows (SCLEFs).
- 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.
- 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.
- 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
- 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,

- webpage. In summary, Workstream 1 concludes in the first three weeks of operation, that:
- 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.
- 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.

ANNEX E

Paediatrics Report – Summary Recommendation

The full paediatrics report is available on request.

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 flow navigation centres was tested in NHS Ayrshire & Arran (A&A) between 3 and 23 November 2020 helping inform national rollout on 1 December 2020.

ANNEX F

Data Report - Extract

The full data report is available on request.

For ED 4-hour standard the data definitions remain the same as in the pre-Pathfinder period. Comparative data utilised is from 1 December (Go-Live). Scottish data is given for comparison with individual board data. Statistical Process Control (SPC) chart data is available for all described data and for all boards. Further data is necessary for the ongoing analysis of specific metrics. Monthly summaries may show slight variation in table baseline numbers reflecting the increased number of data points available for analysis. The role of digital consultations including 'Near Me' in relation to RUCP currently being reviewed.

Data challenges: GP in hours data is not routinely available which limits fuller analysis. There is an urgent need to improve data quality in relation to the FNC's to better understand their role and provide automated reports as part of ongoing data monitoring and evaluation. In addition to improving disposition coding and time stamps, there is a need to reconcile the large difference between the NHS 24 111 recorded FNC activity and the currently available data from the board related FNC IT systems. An FNC process map covering the full patient journey is in development.

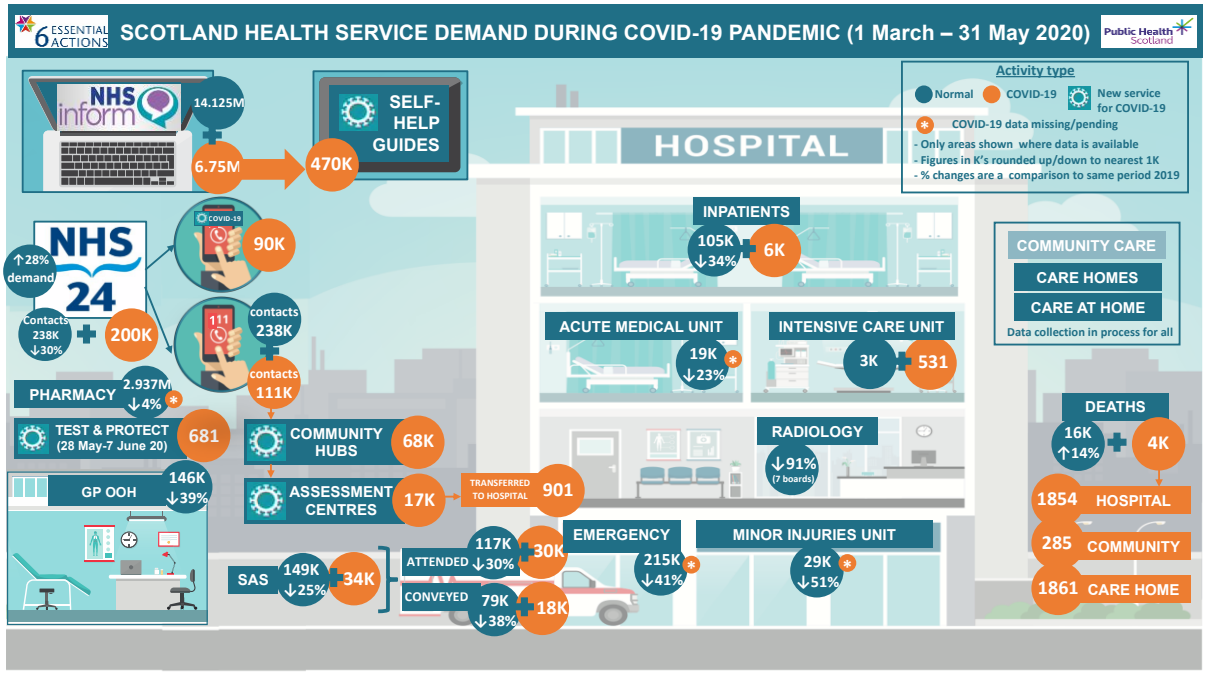
14 Board level summary: See tables for individual board summary data (slides 7-11), which compares data from Sep/Oct 2020 baseline and Go-Live. Summary below relates to Sep/Oct baseline.

- NHS 24 Mon-Fri all contacts: 11 boards have shown increased activity, with 1 remaining stable and 2 showing a decrease. Most of the increase has occurred in relation to NHS 24 in hours, as shown by 10/14 boards showing an increase (4 remaining board activity remained stable).
- NHS 24 Sat-Sun: Activity remains stable for 8 boards, 2 boards show an increase and 4 a decrease in activity.
- GPOOH Mon-Fri: remains stable for 7/14 boards, 4 boards show an increase and 3 a decrease in activity.
- GP OOH Sat-Sun: activity remains stable for 11/14 boards, 2 boards show an increase and 1 board a decrease in activity.
- SAS attended: activity remains stable in 5/14 boards, 8 show a decrease in activity and one board an increase.
- SAS conveyed: activity is decreased in 8/14 boards, 1 shows an increase and 5 remain stable.
- ED Attendances: 14/14 boards show a reduction in attendances.
- ED Self-presenters: 14/14 boards show a reduction in self-presenters
- ED Performance: Performance decreased in 8/14 boards, 3 boards remain stable and 3 show an increase.
- Emergency Admissions Mon-Fri: 12/14 boards show decrease, 1 an increase and 1 stable.

ANNEX G

Prioritisation

Figure: Scotland Health Service Demand during COVID-19 Pandemic (1 March – 31st May)
The full paper, which includes a larger graphic, will be available on request.



ANNEX H

Phase 2 principles

<table>
<tr><td colspan="2">Aim
Right Care, at the right place, at the right time.

Vision
Collaborate across the whole health and social care system to design and implement a safe, sustainable, patient and outcomes focused system of urgent care access, pathways and treatment in Scotland that delivers better health, care and life outcomes for our patients, staff, their families and the wider community in which we all live, grow, learn, work and play.</td></tr>
<tr><td colspan="2">Principles</td></tr>
<tr><td>Minimising the risks of moving patients around the system
Establishing an emergency care system that benefits everyone
Delivering a new model of care that is national, simple, effective and safe for all
Making the best use of scarce resources
Aligning closely with wider winter planning work</td><td>Addressing inequalities
Patient and staff safety is out priority across the whole system
Supporting staff training and organisational development
Keeping the access route as simple and as clearly defined as possible</td></tr>
</table>

Strategy #1 Community Pharmacy Providing access to the same levels of care, close to home and with an emphasis on self-care by integrating community pharmacy into urgent care	**Strategy #2 Primary Care** Streamlining referral pathways for patients requiring urgent care by maximising and building upon clinician to clinician communications	**Strategy #3 Mental Health** Delivering an integrated system to support mental health and wellbeing by utilising existing mental health services and enhancing their pathways for unscheduled mental health presentations	**Strategy #4 Scottish Ambulance** Delivering care closer to home for people requiring urgent care, with equality of access to urgent, primary and community services	**Strategy #5 Musculoskeletal** Providing a specialist Physiotherapy resource in the assessment of acute and urgent medical needs to enhance the patient journey
Integrating community Pharmacy services into care and referral pathways GP (in and out of hours) and Flow Navigation Centres Increasing the use of the role of Community Pharmacy in urgent care Signposting patients with minor illnesses to Community Pharmacy where their needs would be more suitably addressed in a convenient, safe and effective manner	Establishing a join approach to decision making between urgent and primary care to reduce unnecessary hospital attendances Providing secure, rapid, two-way, digital communications, advice and guidance between professionals (GPs and Emergency Departments) Taking a professional approach to a senior clinician seeking advice from another professional on	Focusing on improving the integration of physical and mental health within the urgent care setting Strengthening and expanding the use of asynchronous digital consultations including Near Me for Mental Health presentations Exploring the use of professional to professional pathways to support rapid access to advice and support Continued establishment of mental health assessment services/ centres for patients presenting	Providing direct access to Flow Navigation Centres for referral, scheduling and professional to professional advice Enhancing the ability to refer into primary care services Building on the ability to refer to community pathways Increasing the ability to care for more patients closer to home through professional to professional advice	Reducing onward referrals to Flow Navigation Centres via MSK Physiotherapy resource within NHS 24 Promoting the role of Physiotherapy in urgent care services Reducing the demand on urgent care services and reducing admissions to hospital through MSK Physiotherapy Adding to the availability of clinical decision makers within urgent care through specialist MSK Physiotherapy Reducing the demand to primary

Ensuring referrals methods to Community Pharmacy are effective, efficient and timely Enhancing and better understanding the role of community pharmacy	the appropriateness of a referral for patients before or instead of making a referral (e.g whether to refer, or what alternative care pathways exist) Providing direct access to Flow Navigation Centres for referrals and scheduling	with urgent mental health needs Developing a pathway for unscheduled presentations for people with psychosocial/complex care needs Providing the appropriate support to people quickly, meeting their mental wellbeing needs through an evidence-based care package of care	Further developing the ability to access and share patient information across all health boards to improve continuity of care and patient safety	care and hospital based MSK services

ANNEX I

Primary Care OOH Services Overview

Primary Care OOH services are covered by a relatively small number of GPs and other multidisciplinary team members. The number of participating GPs has decreased over the years due to a variety of factors, including terms & conditions issues, pension pressures and increased requirements for day-time workforce capacity. The advent of COVID-19 hubs and CACs have placed further demands on redeployed GPs and primary care staff. It was envisaged and requested by SG that Flow Navigation Centre (FNC) staffing should draw both on primary and secondary care clinicians and support staff. In reality, the significant majority of RUC FNC medical staff to date have been GPs, as has been the case for COV-19 hubs and CACs. Many of these GPs have been previously working for Primary Care OOH services, risking serious destabilisation of the latter. As witnessed in pre-COVID-19 times, even a small reduction in GPs working regularly in OOH services can have disproportionately negative consequences, as recognised in the National Review of Primary Care Out-of-Hours Service in 2015. That Review advocated resolute action to rapidly develop and swell a GP-led, multidisciplinary team approach to OOH urgent care service delivery. This presaged a similar approach to the future development of in-hours GP services, as determined by the revised GMS Contract in 2018.

A small reduction in the number of GPs prepared to work for GP OOH services will have a disproportionate and significant impact on the ability of services to deliver care. As rotas become increasingly pressured, this may lead to rota shifts becoming more challenging and currently participating GPs may opt to do other (urgent care) work instead. Changing patterns of NHS 24 and RUC referrals with injury/trauma to OOH services, previously routed to or self-presenting to EDs may also pose difficulties for OOH services, including patient transport constraints. This underpins the earlier discussion above - that impacts on service and performance (in this case OOH services), cannot be fully ascertained on the basis of numerical attendances and episodes of care alone.

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