NHS 24 **BOARD MEETING**	**8 OCTOBER 2020** **ITEM NO 9.2** **FOR ASSURANCE**

REDESIGN OF URGENT CARE

Executive Sponsor:	Director of Service Delivery
Lead Officer/Author:	Director of Service Delivery
Action Required	The Board is asked to note this progress update and the key risks identified in delivery of the redesign of urgent care. Further updates and detailed information will be provided to the Board and relevant Committees ahead of any final decision of the national programme board to go live
Key Points	Key points to note are : 1) This is a significant focus for NHS 24 ahead of this winter in both continuing to deliver the 111 out of hours service and national COVID pathway, but also in supporting the flow of patients into ED and Minor Injuries Unit (MIU) in phase one of the programme. 2) There are a number of challenges and risks for NHS 24, not least the pace and timescales involved, but also recognising the significant investment in our workforce capacity and infrastructure to deliver. It is important to recognise that this piece of work will be delivered not only on a whole system basis, but also by the full breadth of NHS 24 staff and functional areas.
Financial Implications	The projected costs for 2020/21 are expected to not exceed £10 million. A financial case has been submitted to Scottish Government and endorsed as part of the national programme of redesign of urgent care.
Timing	Current planning assumption is a launch date in November dependent on assessment of system readiness.
Contribution to NHS 24 strategy	Delivery of high quality sustainable services and improving access to services are key strategic priorities for NHS 24
Contribution to the 2020 Vision and National Health and Social Care Delivery Plan (Dec 2016)	The redesign of urgent care is a whole system programme and NHS 24 is contributing to that. The aim of this redesign work is to ensure patients and public can access urgent care effectively and ensure patient and staff safety is maintained during the ongoing pandemic.
Equality and Diversity	There are no immediate E&D issues within the paper. A full EDIA is being undertaken by the national programme.

1. BACKGROUND

1.1 This paper sets out the key elements of NHS 24's winter planning and preparedness. The Board will recognise that this is likely to be an extraordinary winter and, to reflect that, revised arrangements have been put in place.

2. UPDATE

2.1 The Board is aware of the focus of phase one of the redesign of urgent care programme and the role that NHS 24 has been asked to develop. Specifically, this is to offer a single national access to urgent care, 24/7 initially focussed on supporting the flow of patients into emergency departments (ED) and minor injury units (MIU) this winter. A key focus for NHS 24 has been to develop a national access route and pathway into local Board 'virtual' flow navigation centres able to both deliver secondary consultation and, where required, schedule into ED and MIU.

2.2 The key drivers for this redesign are helping people to access the right care first time and to maintain the necessary levels of patient and staff safety in healthcare settings in light of the ongoing pandemic. NHS 24 will not only develop that single access route through 111, but will also continue to strengthen and build on digital assets through NHS inform supporting increased self-care and self-directed care.

2.3 NHS 24 is part of a whole system programme of redesign of urgent care and, whilst there is clearly a lead role for us in developing access and pathways, we are working as part of a national programme lead by Scottish Government to deliver what is a significant programme of redesign. As the Board is aware, this reflects the positive benefits gained throughout the COVID-19 pandemic of a single access route through 111 to a national pathway, with enhanced local clinical decision making in every Board.

2.4 The pace and scale of this work is considerable and that is reflected in the key risks for NHS 24 and, indeed, the programme as a whole. The Cabinet Secretary has been clear in her commitment to this redesign work and the need to ensure it is in place ahead of this winter to minimise the risks for patients and staff accessing ED / MIU in terms of COVID-19.

2.5 NHS 24 is represented on all of the workstreams within the overarching programme, with one exception in relation to discharge from hospital. NHS 24 staff are leading on the access / triage and the public messaging workstreams. However, it is important to understand that this is as part of that wider national programme governance. As the programme is progressing, there are a number of workstreams working closely in tandem as the Board would expect, and there are weekly and fortnightly meetings in place at individual workstream level, with workstream leads and the strategic advisory group with oversight for the programme.

2.6 NHS 24 has established a fortnightly programme board to oversee implementation. IMT has assumed the role of an internal delivery team supporting the programme board. IMT meets daily and has strong representation from across the organisation. IMT has been responsible for the delivery of NHS 24's COVID-19 pandemic response and is also responsible for ensuring adequate winter preparations and planning; there is a clear synergy across all three components.

2.7 Internal workstreams and plans have been developed and are being progressed in line with the system-wide timetable for implementation. Internal workstreams are:

- **Estates**, including the focus on Lightyear and Lumina by end October to ensure sufficient capacity across our estate to accommodate a significant increase in frontline staffing and maintain physical distancing.
- **Technical system development**, primarily in ensuring all Boards are able to receive referrals from NHS 24 through the Adastra system 24/7 and changes required to the SAP system such as additional urgent care endpoints.
- **Clinical development – systems and content**, which is a key piece of work to agree the high level pathway from NHS 24 into the local Board flow navigations centres, ensuring a national consistency in both triage and outcomes.
- **Digital content and assets**, ensuring NHS inform is aligned to any changes in pathways and to support increased self-care and self-directed care.
- **Recruitment**, towards a target of 288FTE call operators and 58 FTE clinical supervisors.
- **Training**, within the timescales permitted, which will not only involve bringing in new staff but also converting existing call operator staff to be able to call stream any call to the 111 service as full call handlers.
- **Reporting,** to ensure NHS 24 is able to report on the effectiveness of the pathway and inform the development of whole system measures that reflect the redesign of urgent care.
- **Resourcing,** which will encompass the logistical and operational requirements of delivering this enhanced 111 service and understanding the true demand once the service is live.

2.8 All workstreams are progressing well as this stage. However, the timescales for delivery are challenging for all Boards, including NHS 24. A set of readiness criteria have been developed and shared with the Executive and implementation leads in each Board from Scottish Government. NHS 24 readiness criteria are reflected in the workstreams in 2.7 above, heavily weighted towards workforce and infrastructure as would be expected. Each Board is required to submit an assessment against the criteria fortnightly to the national programme team and a final go/no go decision will be based on that assessment.

3. RISKS

3.1 There are a number of risks for this redesign programme and for NHS 24, not least the challenging timescales for implementation. Specifically, our workforce requirements are considerable reflecting an anticipated 56% increase in call demand, primarily 8am-8pm. To mitigate this risk we are bringing in both additional call handlers and call operators, as we did through COVID. We are also converting existing call operators to call handlers able to stream all 111 calls. The key risks here are not in terms of recruitment, where we have seen unprecedented levels of interest, however the additional pressure this places on HR, service delivery and practice education teams within NHS 24 is considerable. Additional capacity has been brought in to support these teams.

3.2 In respect of recruitment, the more challenging component for us is the clinical supervision requirement. Through recruitment, we are reasonably confident we can attract around half the nursing workforce we require. In addition to this, we have also targeted clinicians who supported us throughout COVID, including GPs, pharmacists, and nursing colleagues, and we continue to make use of the NES portal, which currently holds registered interest from c1900 clinicians. We have also raised this risk with the national programme team, given the impact on the number of call handlers we can have online with a 1:5 supervision requirement, and set out an 'ask' through the national programme and other routes, such as the Scottish Executive Nurse Directors group (SEND), for development secondment opportunities.

3.3 At a whole system level, there is a clear risk that in hours, people choose to access urgent care through 111 rather than their GP. This is a very real risk and one that will be minimised through the reinforcement of the GP as the primary access route for urgent care in hours through national public messaging, but also in our 'referral' of callers back to their GP as currently, where this is the most appropriate route for them. We are keen to explore with primary care colleagues the opportunity for a more actionable referral back to in hours general practice as happens in other areas of the UK. However, this is unlikely to materialise ahead of this winter and we would look to begin those discussions rather than expect to conclude them this winter.

3.4 There is also a risk that out of hours comes under additional pressure as a consequence of this redesign work. It is important to acknowledge that this programme aims to route people to the right care and that may well be out of hours services rather than ED. That said, it is also recognised that this service is already under pressure in a number of Boards. NHS 24 will work with the national programme to ensure there is a clear understanding of the requirement for sustaining this service, but also a robust assessment of any changes in demand at each stage of the pathway. Whilst it is not for NHS 24 to determine how Boards ensure capacity and configuration of services locally, there is a clear need to ensure consensus of the national pathway for urgent care and the role that NHS 24 will play in supporting that to minimise the risk of individual Board variance and dispute of outcomes.

4. RECOMMENDATIONS

4.1 The Board is asked to note this progress update and the key risks identified in delivery of the redesign of urgent care. Further updates and detailed information will be provided to the Board and relevant Committees ahead of any final decision of the national programme board to go live.