NHS Scotland Redesign of Urgent Care Second National Staging Report

April – September 2021

December 2021

Right Care Right Place

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1. Executive Summary

Context: This is the third of three reports assessing the Scottish Government Urgent and Unscheduled Care - Redesign of Urgent Care Programme (RUC). The first report assessed early progress of the NHS Ayrshire & Arran RUC Pathfinder[2] in November 2020. The subsequent report, the RUC First Staging Report[3], covered the period December 2020 - March 2021. This report, the RUC Second Staging Report, covers the period April 2021 to September 2021. The Scottish Government National Urgent and Unscheduled Care Programme is in the process of commissioning an independent external evaluation of RUC, which will examine public and staff experience, care outcomes and will also include a health economics assessment. This independent evaluation is planned during 2022.

Impact: At present, it is not possible to fully assess the impact of the RUC Programme on patient needs and care responses across NHS Scotland although there are evident patterns. The RUC national launch (December 2020) coincided with the second wave and subsequent unprecedented and ongoing COVID-19 service pressures for both urgent and elective patient care throughout NHS Scotland. Assessment of the impact and worth of RUC in this Second Staging Report provides a further assessment of progress. Data have been analysed and collated with monthly reports to the RUC Strategic Advisory Group (SAG) from January to September 2021. The main purpose of this Second Staging Report is therefore:

1. To inform and improve iteration of the present RUC model by using patient pathway data and incorporating the experience and views of the Scottish public and care professionals
2. To assist in the provision of optimal 24/7 urgent care for the Scottish public and to nurture and support all multidisciplinary teams who deliver essential care

Acceptability: Focus group discussions undertaken as part of this Report, indicate that there is broad-based professional support for the intent and principles of the RUC programme. However, there were notable exceptions and caveats from some groups. Specific challenges remain across the RUC pathway including:

- Workforce resilience - different operations of 24/7 Flow Navigation Centre (FNC) operations/working across Scotland. This needs to take into account local circumstances including scale, critical mass, remote and rural issues, and specifically impact on other Primary Care urgent care services, particularly Out-of-Hours (OOH) services
- Clinical leadership (Senior Clinical Decision Maker (SCDM) role) and how to optimise
- Unresolved Information Management & Technology (IM&T) incompatibilities and how to urgently resolve

[2] https://www.gov.scot/publications/nhs-ayrshire-arran-redesign-urgent-care-pathway-finder-programme-rapid-external-review/ (November 2020)

[3] https://www.gov.scot/publications/nhs-scotland-redesign-urgent-care-first-national-staging-review-report-1-december-2020-31-march-2021/

- Relevant public messaging, in all aspects, to support the Scottish public to secure optimal urgent care in the right place at the right time.

Progress: Increasing use of NHS 24, as one of several entry points to urgent care, has been well adopted by the Scottish public as promoted by recent national media publicity. As yet, significantly increased call demand for the NHS 24 111 service, primarily during in routine working hours (0800-1800, Monday-Friday), has not translated into major changes in demand for A&E services. Activity across other parts of the RUC programme is largely stable except for FNCs, where activity has grown and is stable over recent months. The additional step of seeking immediate help for urgent problems via NHS 24 (111 service), diverted to local FNCs may add to the complexity and length of the care journey for some patients. This requires further elucidation about the nature of recent changes.

NHS Boards are all at different stages of implementing RUC, which may be partially explained by size, geography and organisational capacity. There is scope for greater collaboration across all NHS Boards, adopting a partnership approach, continuing to actively involve NHS 24 and Scottish Ambulance Service (SAS).

Risks and mitigations: The most significant risk identified is workforce resilience and capacity. There is an overall sense of skilled and experienced staff being moved around the urgent (unscheduled) care system as a whole and staff working across or between services. Ongoing challenges of responding to the COVID-19 pandemic continue unabated for both urgent and elective care. These pressures are significantly impacting on staff fatigue levels, with high levels of short-term sickness, often compounded by longer term vacancy factors. System capacity and capability to manage the overall RUC patient pathway demand remains a concern in relation to the timely assessment and management of patient needs. These risks need to be addressed urgently by engaging all stakeholders in improving the existing pathway, ahead of the imminent winter pressures.

Future/Next Steps: Overall, this Second Staging Report suggests a need to refine and optimise aspects of the RUC programme, rather than increasing activity/volume across the whole pathway. Going forward, encouraging all NHS Boards to take a locality ‘place-based’ approach - focused around the specific needs of communities - should enable the development of appropriate local services and encourage further partnership working. This must include: consideration of distinctive remote, rural, urban, sociodemographic and equity/accessibility requirements. As the RUC Programme evolves, it will be imperative that shared learning of implementation issues and solutions should continue to be assimilated and effectively deployed throughout NHS Scotland.

2. Background

The focus patient population for the RUC programme is a sub-group of patients who historically self-presented to A&E services (includes Emergency Department (ED) and Minor Injuries Unit (MIU)) who may be safely managed through patient pathways with alternative entry and exit points to health and care services. The RUC programme has been developed at pace during the COVID-19 pandemic.

The RUC pathway (Figure 1) aims:

- To increase care nearer to home for patients and carers
- To convert some unscheduled care activity to planned care activity
- To reduce patients who self-present to A&E services
- To reduce overcrowding in A&E services

The RUC pathway includes 3 main Interventions:

- Public messaging to encourage patients and carers to use NHS 24 111 more frequently including routine working hours
- Increase capacity in NHS 24 111 service to:
    - manage increased demand and
    - create appropriate options and pathways for patients including to FNCs.
- Establish new local FNCs to:
    - help navigate patients to most appropriate local services and provide rapid access to a SCDM by phone or digitally to provide self-care advice or as necessary onward referral.

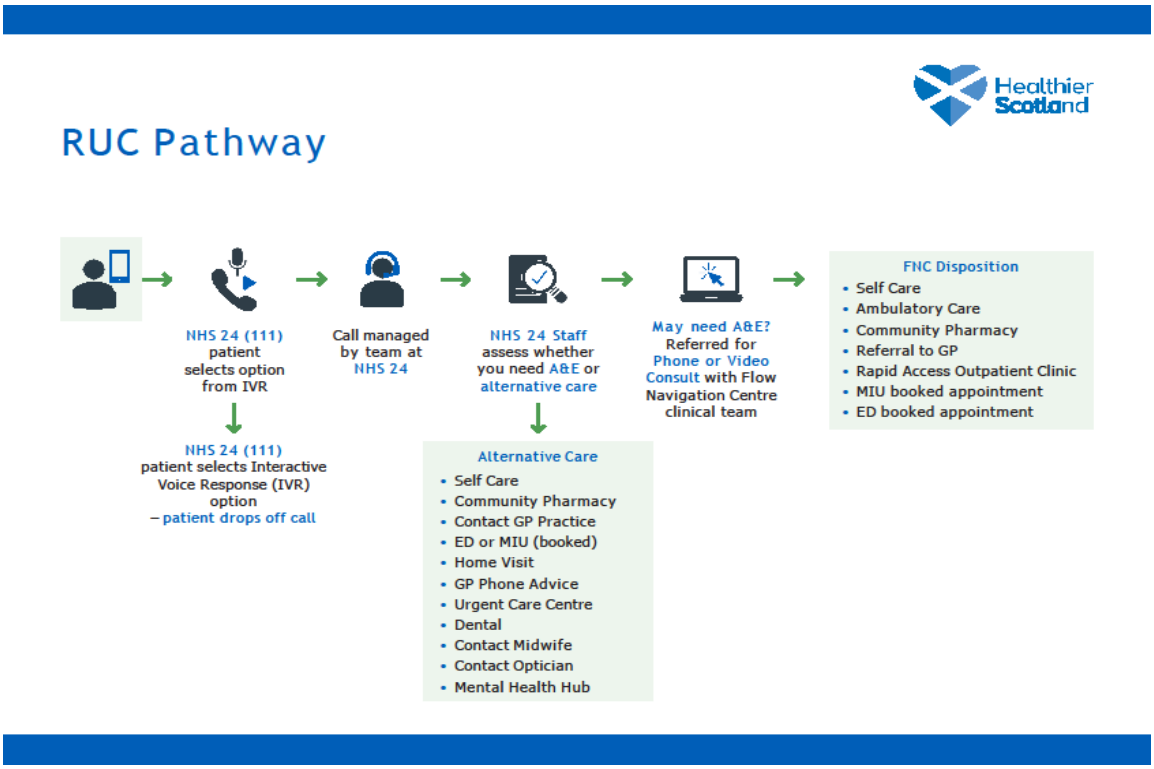

Figure 1 - RUC Pathway

To inform the development of the new pathway, the Scottish Government explored different UK and international models, including Denmark[4] and the RUC SAG (Appendix A) was established to lead the development of a conceptual model tailored for NHS Scotland.

NHS Ayrshire and Arran [5] acted as a pathfinder board to test the conceptual model. Followed by the First RUC National Staging Report (December 2020 to March 2021) [6] reviewing progress after the RUC pathway based on a minimum specification was 'soft' launched nationally on 1 December 2020 (Appendix B).

The evaluation programme is overseen by the RUC Evaluation Advisory Group (EAG) (Appendix C) which reports to the RUC SAG.

This Second National Staging Report covers the period April 2021 – September 2021.

An independent external evaluation is being commissioned by Scottish Government during 2022. This will focus on the experience of staff, patients, and carers using the RUC pathway and will include economic impact and return on investment.

The RUC Programme is provided by the Health Performance and Delivery Directorate, Scottish Government under the wider Urgent and Unscheduled Care Programme which aims to deliver the 4-hour emergency access standard by; reducing attendances, reducing admission and length of stay and optimising discharge. The Urgent and Unscheduled Care programme now aligns to the work plan of the Centre for Sustainability Delivery (CfSD).

CfSD aspires to be an internationally recognised centre of excellence, promoting and embedding best practice through a 'Once for Scotland' approach and enabling redesign programmes to support a sustainable health and care system which is aligned with the priorities of the Scottish Government.

[4] The Danish prehospital emergency healthcare system and research possibilities – Nov 2019

[5] https://www.gov.scot/publications/nhs-ayrshire-arran-redesign-urgent-care-pathway-finder-programme-rapid-external-review/ (November 2020)

[6] https://www.gov.scot/publications/nhs-scotland-redesign-urgent-care-first-national-staging-review-report-1-december-2020-31-march-2021/

3. Purpose and approach

The purpose of this Second National Staging Report ('The Report') is to review the progress of the RUC pathway implementation, opportunities, challenge, lessons learned and to make recommendations to inform how the pathway is further developed.

The report brings together data, information and intelligence from a number of commissions, activities and sources including:

- Review the risks and mitigations from the NHS Ayrshire & Arran RUC Pathfinder Report[7]
- Review progress with recommendations from the RUC First National Staging Report[8]
- Management information using a structure of key touchpoints across the RUC pathway and health system
- Review of Public Heath Scotland (PHS) data on equity of access
- Listening exercise undertaken to understand the lived experience of the NHS Scotland staff involved in the RUC pathway
- The Redesign of Urgent Care Gathering Views Report, Healthcare Improvement Scotland[9] (HIS, September 2021), to understand what matters to people more likely to experience barriers or disadvantage when accessing the RUC pathway via NHS 24 111
- Update on the national RUC public messaging campaign
- Review to gain greater insights and understanding of how the RUC pathway is working
- Care Opinion[10]
- Reports to the RUC SAG
- Feedback from the RUC EAG

The report strives to provides as comprehensive a picture as possible. However, the timing of this report means that some information is not currently available:

Citizens Panel:

The RUC pathway will be included in the forthcoming Citizen's Panel led by Healthcare Improvement Scotland (HIS), which brings together a large, demographically-representative group of citizens to assess public preferences to inform and influence key decisions about Health and Social Care policy and services. The findings will be available early 2022.

Health Board Patient Experience data and information:

[7] https://www.gov.scot/publications/nhs-ayrshire-arran-redesign-urgent-care-pathway-finder-programme-rapid-external-review/
[8] https://www.gov.scot/publications/nhs-scotland-redesign-urgent-care-first-national-staging-review-report-1-december-2020-31-march-2021/
[9] https://www.hisengage.scot/media/2042/gathering-views-on-redesign-of-urgent-care-sep21.pdf
[10] https://www.careopinion.org.uk/

The RUC Programme, in collaboration with HIS is co-designing a national patient experience framework for RUC services. This aims to better understand the experience of service users and their carers. Lived experience data is a critical element to understand local pathways from a user's perspective and identifying where improvements are required.

Although most NHS Boards capture some user experience and/or satisfaction data, work is needed to standardise and provide more consistent and real-time data at a local and national level.

To note:

Children 18 months to <12 years:

All children 18 months to <12 years were only included in the RUC pathway from 1 June 2021. A short life expert working group reported on progress at the end of September 2021. This present report only provides very preliminary data.

People with urgent mental health needs:

This report does not include specific findings and recommendations about people with mental health needs accessing care via the RUC pathway. Other RUC management information activity data is provided. Work is proceeding on urgent mental health care and this is also being monitored by SAG.

4. Findings

4.1. NHS Scotland Management information findings

The focus patient population for the RUC programme is a sub-group of patients who historically presented to A&E services (ED/ MIU), who may be safely managed through alternative patient pathways.

4.1.1. High Level Summary

Activity and Time related performance summary for NHS Scotland. (Note data caveat section below and related focus group feedback sections).

1. The public and patients have responded to the messaging to increase contact for urgent care needs through increased use of NHS 24 111 (call demand and contact records) as envisaged by the RUC programme.
2. This is evident by the marked increase in NHS 24 111 call demand and contact records (ED, Mental health and COVID-19), most significant Monday - Friday in routine hours/ in-hours (IH), with a smaller increase for OOH demand Monday - Friday. Total call demand has increased to a much greater extent compared to patient contact records.
3. Patient disposition from NHS 24 contact records to GP OOH, GP IH, SAS and A&E services as defined by total activity is similar or increased compared to historical patterns (June - August 21 and June – August 19). These pathways all include COVID-19 activity. GP, particularly OOH, should be considered with COVID-19 activity which demonstrates increased activity, due to potential workforce overlap.
4. Patient disposition activity from NHS 24 111 to self-care/other is similar to historic patterns.
5. SAS (attended and conveyed) activity is broadly similar to historical levels. The non-attended component is increasing (almost double historical levels), requiring on-ongoing review.
6. NHS 24 111 to FNC disposition activity has increased over time since the introduction of FNCs and has stabilised in recent months.
7. The level of patient activity through the RUC - FNC pathway is relatively small (circa 400 patients per day across Scotland). Based on exploratory linked analysis approximately half of those referred to FNC are seen in A&E services and half offered alternative care. This varies by NHS Board.
8. The FNC pathway in its current format may reduce total A&E services demand by approximately 5% of patients per annum across Scotland, as defined by patients being managed by the RUC - FNC pathway who do not attend A&E services. See point 9 below.
9. Considering the overall activity of the RUC pathway, including all referral routes to A&E services suggests a lesser impact on the overall RUC pathway (see 3 and 8 above).
10. Overall, A&E services (planned/unplanned) activity is similar to historic activity. Self-presenters are lower than in 2019 and remain the major group attending A&E services; this needs to be taken into context with point 9 above. Planned attendances are currently approximately 5% of total A&E services activity.

11. Patient admission to total A&E services attendance ratios are very similar to historic values at approximately 27%.
12. Performance, based on time stamp data:
    - For NHS 24 111, call responsiveness has deteriorated and remains a challenge at weekends and OOH Monday - Friday in particular.
    - For patients accessing the RUC-FNC-A&E services pathway (approximately 150-200 per day) the available time stamp data (patient journey time, which excludes NHS 24 111 call response times) appear efficient. Improved and more complete data to better understand scheduling versus immediate onward referral of FNC-A&E services is needed.
    - Performance against the 4-hour emergency access standard has deteriorated. Delays on transfers of care (delayed discharges) are increasing and may be contributing to the decrease.
    - Ambulance handover times have deteriorated. This is likely related to the decline in the 4-hour emergency access standard which may reflect reduced flow for patients who require hospital admission.
13. Paediatrics data is very preliminary as only 3 months' data are available for comparison. There has been an increase in NHS 24 111 contacts, with evidence of increased referrals to GP OOH and FNCs as expected, predominantly Monday - Friday. FNC activity remains relatively stable at approximately 50 patients per day, with 22% being referred to A&E services.
14. Mental health was not part of phase 1 of the RUC Programme but early data shows patterns similar to adult non-mental health patients. Notably, mental health patients have a higher number of contacts per episode.

4.1.2. Data caveats for both adults and children

- The RUC programme launch coincided with the second wave of the COVID-19 pandemic, with on-going effect.
- Data does not consider case acuity, complexity, outcomes, or workforce challenges.
- The pandemic and associated public health interventions continue to influence urgent care services for both COVID-19 and NON-COVID-19 related healthcare.
- COVID-19 activity is included in all relevant touchpoints including Primary Care. Note that it is understood a proportion of patients being referred through the pathways have non-COVID-19 related symptoms, e.g. respiratory.
- Primary care In-Hours data are not routinely available; urgent work is under way to resolve this.
- GP OOH activity includes all consultations directly related to a case contact. For example, one case may have several consultations.
- FNC data quality and completeness problems remain for disposition and time stamp data.
- Analysis is on-going for patient journey times and contacts.
- A&E services data quality and coding requires further improvement.

- Data periodicity (patterns) highlight the importance of temporal analysis. Urgent and unscheduled care varies by day or time of week. This is important for analysis and design of systems. If analysed together, data may be misinterpreted.
- Paediatric total numbers are less than adults with a shorter time period since Go-Live (June 2021). Data should be interpreted with caution until more data points become available.

4.1.3. Approach across key touchpoints in the patient journey

Analysis was and continues to be compiled by Workstream 1 Data and Monitoring Group (see Appendix D for group membership). The group produces monthly RUC data reports, and an earlier Prioritisation Paper [11]outlined data recommendations and priorities.

This section includes quantitative management information data collated through the Evaluation Advisory Group (EAG) and supported by PHS and stakeholders. This section shows activity, performance and time stamp data based on patient touchpoints (Figure 2). Activity and demand data covers the period from January 2019 to end of August 2021 (including RUC National Go-Live on 1 December 2020).

The diagram in figure 2 displays the various touchpoints through the RUC patient pathway. Patients can access the RUC pathway by dialling 999 or contacting NHS 24. From there, dependent on the nature of their condition, the patient can be referred onto a number of services including but not limited to Scottish Ambulance Service, Primary Care GP (in-hours/out-of-hours), Flow Navigation Centre (FNC), or COVID Hubs and Assessment Centres. The patient can then either be referred back to their GP, given self-care advice or if necessary advised to attend A&E services if required.

[11] Review of the COVID-19 data compared with historical data to support future service design and understanding of the unscheduled care pathway for NHS Scotland", December 2020

Redesign Urgent Care (RUC) Patient Touchpoint

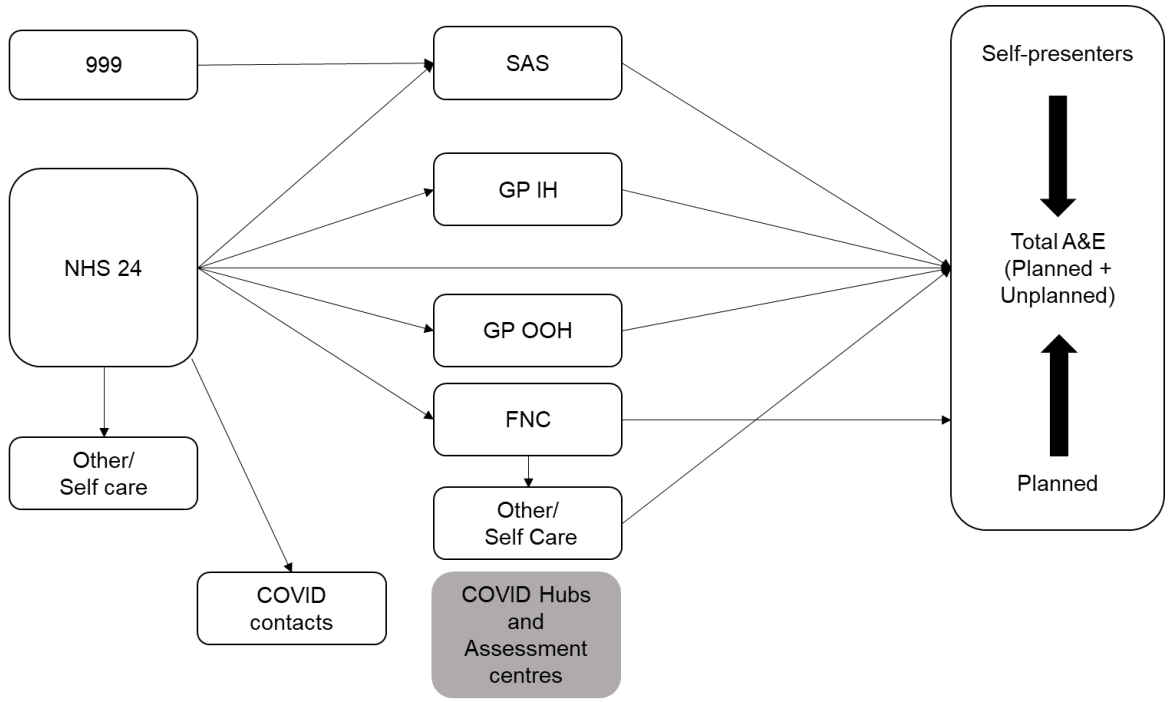

Figure 2 - RUC Patient Touchpoints

Statistical Process Control (SPC) charts, as recommended by NHS Scotland and NHS Improvement (Making Data Count, 2018[12]) are used as the main analytic approach (example in Figure 3). They highlight process change and patterns at Scotland and board level. Supporting comparative data is provided (as appropriate) between Jun - Aug 2019 with Jun - Aug 2021 (also the current SPC pattern period referred to in this section), as these two periods are broadly stable. Daily data is used to improve understanding of demand patterns to support service provision.

[12] https://www.england.nhs.uk/publication/making-data-count/

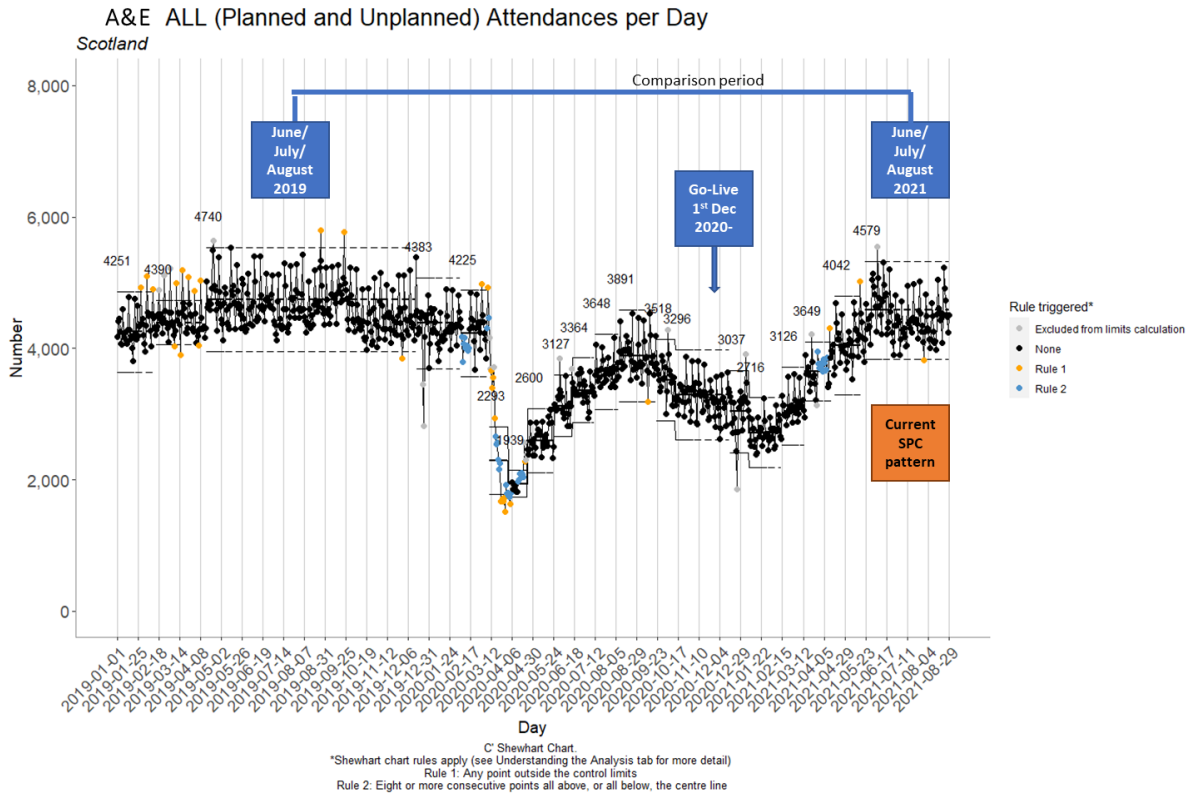

Figure 3 - Exemplar Statistical Process Chart showing comparison periods for data analysis

4.1.4. Data findings for touchpoint comparison between June - August 2019 to June - August 2021 for Monday-Sunday (Figure 4). Monday-Friday and Saturday-Sunday (Appendix E). This expands on the summary findings above.

- The public have responded by calling NHS 24 111 more frequently (call demand increased by over 40% comparing 2021 to 2019), as envisaged. Mostly in-hours Monday - Friday.
- Contact records (calls answered, a case record created) have increased to a lesser extent, approximately 15 - 20%. For this group it is estimated contacts may be 10 - 15% higher representing repeat calls as part of the same episode of care.
- Contact record disposition in 2021 is 46% to GP OOH (50% 2019), 23% to Other/self-care (25% 2019), 10% to FNCs, 8% direct to A&E services (10% 2019), 8% to GP IH (9% 2019) and 5% to SAS (6% 2019). Of all 2021 NHS 24 111 contact records, 19% had a COVID-19 tag.
- Total A&E services (planned + unplanned) activity in 2021 is approximately 4% lower than 2019.
- Self-presenters are 15% lower than 2019 and continue to be the major group attending A&E services.
- Patient admission to total ED attendance ratios remain similar to historic values at approximately 27%.
- For all A&E services attendances (excluding self-presenters), SAS contributes 27% (29% 2019), GP IH 8% (5% 2019), NHS 24 111 7% (7% in 2019), planned attendances 5% (1% 2019) (approximately two thirds from FNCs), FNCs 3% and GP OOH 1% (2% 2019).

- Planned attendances have increased from 1% to 5%. This is related to FNC referrals and improved A&E services coding. There remains a need to better understand scheduling, time to appointment, time to completion & comparison with non-planned attendances and further improve A&E service coding.

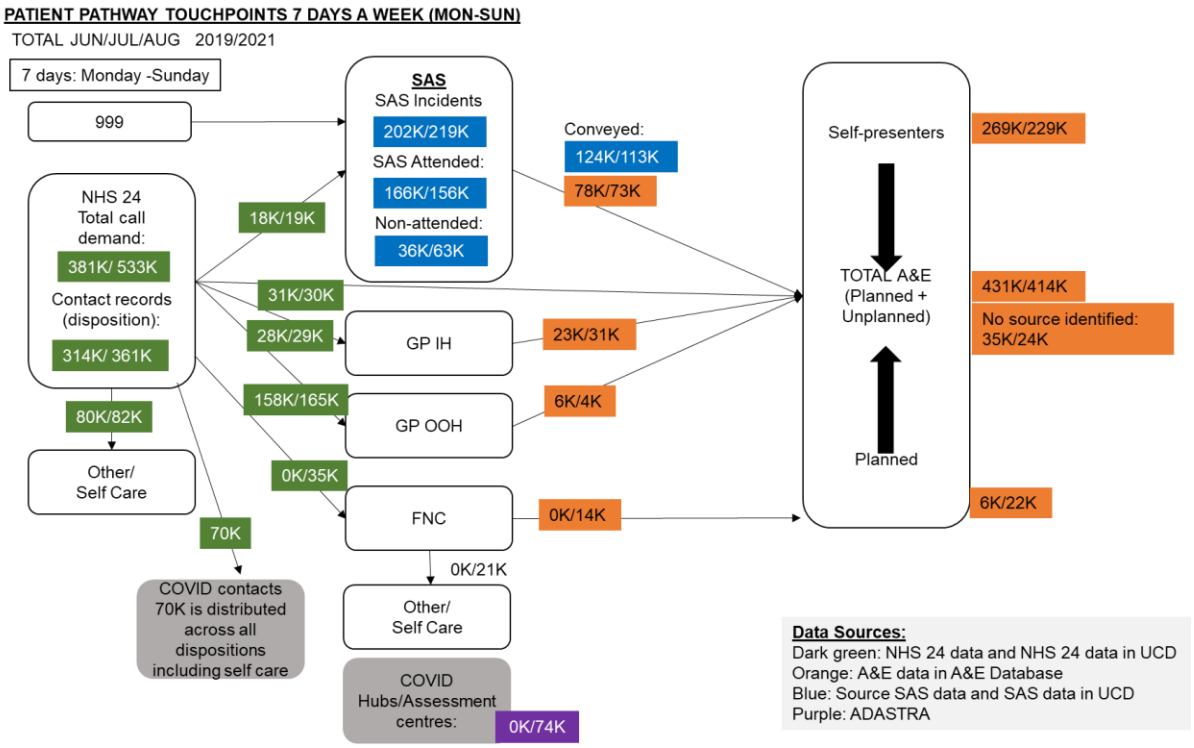

Figure 4 - Data findings for touchpoint comparison between Jun-Aug 2019 to Jun-Aug 2021

4.1.5. Understanding the impact of the RUC pathway on A&E services attendances (Using June-August 2019 and June-August 2021 data)

- Figure 4 shows the total number of patients in June to August 2021 against June to August 2020 at each touch point in the RUC Pathway.
- Total A&E services attendances (planned and unplanned) reduced by 17K compared to 2019 (annualised 68K).
- Self-presenting attendances are reduced by 40K, compared to 2019 (annualised 160K).
- Total planned activity to A&E services is 22K (16K higher than in 2019), of which 14K (or 56K annualised) can be attributed to the FNC referral pathways.
- There has been an increase in Primary Care referrals to A&E services by 6K (annualised to 24K).
- A potential impact of the RUC pathway on A&E services self-presenting attendances, given the current context and taking into account the increase in planned activity and increase in Primary Care referrals, gives a potential net benefit effect between 48K to 74K per annum. The FNC component of this would equate to 28K annually.
- NHS 24 111 self-referral patterns are similar to historic levels.

- One area that requires further evaluation is the interaction between NHS 24 111 and Primary Care (both IH and OOH), in relation to patients being referred onwards to A&E service.

4.1.6. The Scotland Data Table August 2021 (Appendix F) (with predicted activity related to the RUC pathway) focuses on SPC analysis and recent trend data.

Appendix F shows the envisaged impact of the RUC Programme on activity against current data. Percentage change data is a time point comparison (August 2021 and August 2019) using SPC and touchpoints. Individual NHS Board summary data (Appendix G).

4.1.7. Time related system variation (Periodicity (Scotland Data Table August 2021))

4.1.7.1. NHS 24 111

- Data periodicity shows 4 patterns of NHS 24 111 activity: Monday - Friday in-hours 0800-1800, Mon-Fri OOH (1800-0800), weekends and public holidays. Public holiday activity is stable over the last 32 months.
- Total call demand and contacts increased in line with RUC planning. Call contacts activity has markedly increased Monday - Friday in-hours, with smaller increase OOH and weekend activity stable. NB:10 - 15% of calls are repeat calls, not generating a new contact.
- NHS 24 111 to A&E services referrals are higher Monday - Friday compared to 2019. Referrals to SAS are higher Mon-Fri.

Other patient touchpoints including GP OOH, A&E services attendances and emergency admissions also show Mon-Fri/weekends periodicity.

4.1.8. Performance (Scotland Data Table August 2021)

4.1.8.1. 4-Hour Emergency Access Performance

Performance for August 2021 76% compared to 89% in August 2019.

4.1.8.2. SAS to A&E services Turnaround Times

Turnaround times have been increasing since 2019, with a further increase from April 2021 (August 2019 30 minutes versus August 2021 41 minutes), impacting available crew hours.

4.1.8.3. NHS 24 (111) Time to Answer (TTA) & Call Abandonment Rates (Appendix H)

- Response times have three main patterns which relate to call volumes, day of the week, and public holidays. Weekend and public holiday

activity is greater than Monday-Friday for both current and historical patterns of activity.

- TTA and call abandonment rates have increased and remain challenging particularly OOH's and at weekends.
- This analysis does not consider call complexity, repeat callers or staffing levels. Note, average handling time (AHT) has increased over time since January 2020.

4.1.8.4. RUC/Flow Navigation Centre/A&E Services Pathway (exploratory analysis)

- The NHS 24 111 call process was re-designed from a potential call back option, to responding to all calls as quickly as possible in one contact episode and put in place early 2020 to improve the patient journey (pre 1 December 2020 national RUC Go-Live date). This impacts on comparative historical data interpretation.
- FNC referred activity represents 8-10% of all NHS 24 111 contacts.
- Exploratory data linkage suggests approximately 50% of FNC activity is referred to A&E services.

4.1.9. Time stamp data (Figure 5) process map (excludes NHS 24 111 call response time)

- Median total journey time to A&E services discharge 221 minutes (upper 95th percentile 1186).
- Median time from end of FNC consultation to being seen in A&E services is 90 minutes. This is part of on-going work at NHS Board Level to understand the proportion of patients referred immediately versus a planned appointment.

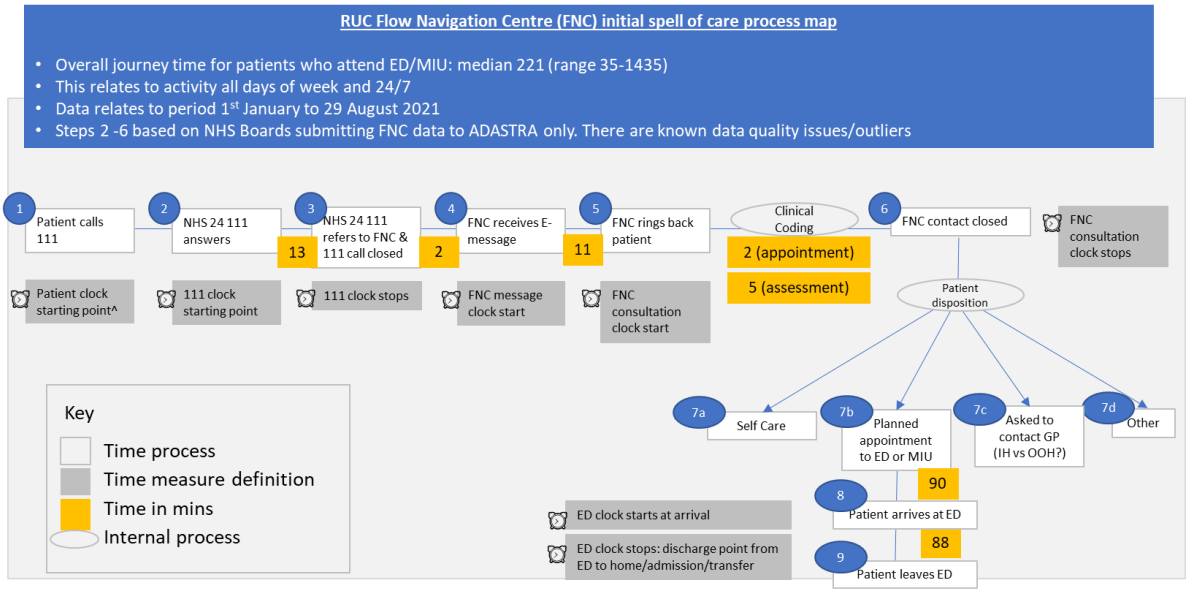

Figure 5 – Exploratory analysis: RUC FNC Care Process Map

4.1.10. Near Me Utilisation as part of FNC pathway (operational in 11/14 NHS Boards)

- Between December 2020 and July 2021, across NHS Scotland Near Me consults accounted for 13% of FNC contacts.
- Average call duration for a Near Me consult in Scotland was approximately 6 minutes.

4.1.11. Paediatrics (age 18months – 12 years)

Data is preliminary as RUC paediatric programme only went live June 2021. Available data awaits final validation and therefore there may be some minor variations. For most touchpoints data, total patient numbers are relatively low compared to adults and the SPC charts suggest activity is not stable yet.

4.1.11.1. Data findings for Paediatric touchpoints for total activity for the period. Comparison between June-August 2019 to 2021 for Monday-Sunday (Figure 6), Monday-Friday and Saturday-Sunday (Appendix I)

- NHS 24 111 call contact records (calls answered and a case record created, with disposition) have increased by 38%, when comparing June-August 2021 to 2019. Note: as per for adults, repeat calls for same episode are not included. The increase occurs Monday-Friday.
- Of all NHS 24 111 contact records (47K), 40% had a COVID-19 tag, which is higher than adults.
- Total paediatric NHS 24 111 referrals to FNC were 4,199, representing 9% of all NHS 24 contact records, of which 75% of contacts are Monday-Friday.
- Since July 2021, NHS 24 111 to FNC data appears relatively stable at approximately 50 referrals per day, with 11 (22%) of this group being referred to A&E services from FNCs.
- There is a small increase to GP OOH as expected; this is most evident Monday-Friday.
- Total A&E services activity is similar to historic levels, although self-presenters as a group are slightly lower.

Figure 6 shows the total number of paediatric patients (children aged 12 and under) in July to August 2021 against June to August 2019 at each touch point in the RUC Pathway.

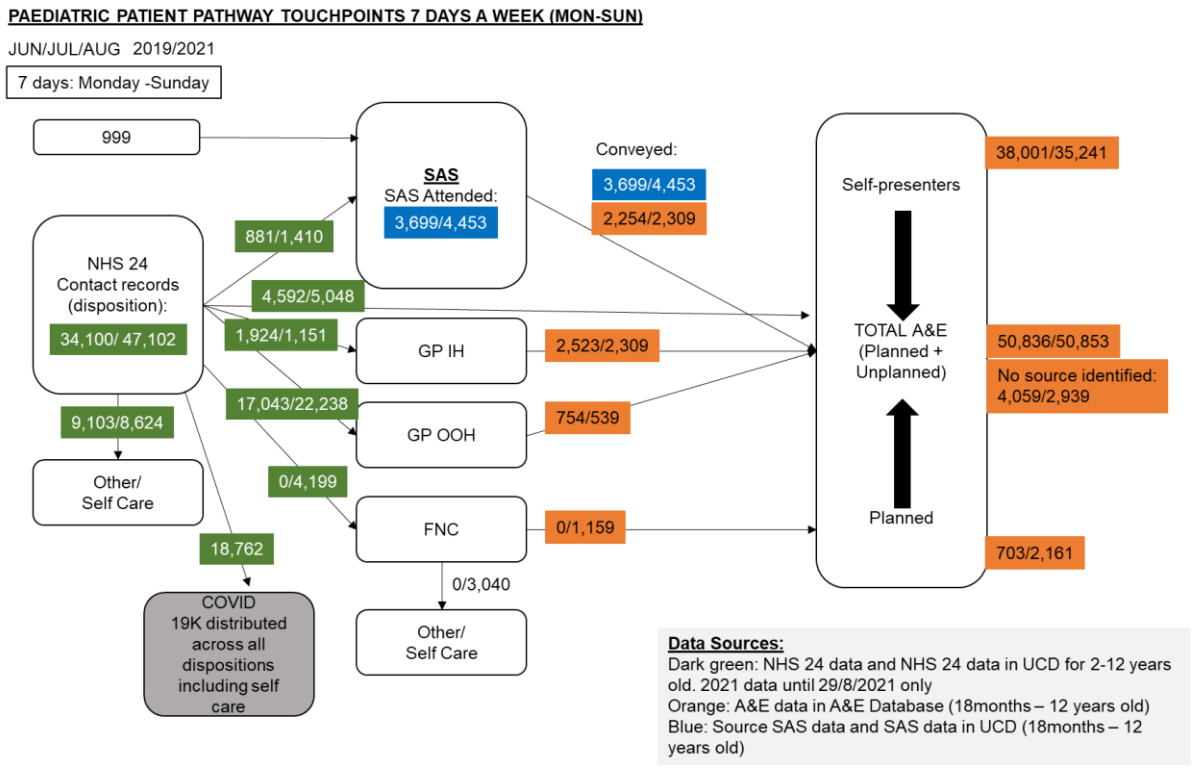

Figure 6 - Data findings for touchpoint comparison between Jun-Aug 2019 to Jun-Aug 2021 for Mon-Sun

4.1.12. Mental Health

The Mental Health pathway is not part of this formal evaluation as it was not part of Phase 1 RUC Programme. A high-level summary position is represented here:

- NHS 24 111 contacts, GP OOH and SAS attended have remained stable since September 2020.
- A&E services attendances gradually increased in 2021 but remain below historical levels.
- Marked differences between mental health and physical health related calls to NHS 24 111, with those calling for mental health being 5 times more likely to be frequent callers.
- Mental health patients are 10 times as likely to have patient journey with 5 or more steps compared to general population contacting NHS 24 which is likely to reflect complex needs.

4.2. Equity of Access

This section is split into three parts, showing different studies, as it was important to monitor to avoid a negative impact of RUC implementation on equality of access to urgent care services.

4.2.1. Age and Deprivation index and ethnicity (Appendix J)

These data compare August 2021 to 2019 by monthly average.

- The pattern of access by age and index of deprivation for NHS 24 111, SAS and A&E services attendances is similar to historical organisational patterns.
- For NHS 24 111, SAS and A&E services attendances the pattern of use is similar with the Socio-demographic group 1 (most common) and Socio-demographic group 5 (least common). The pattern of service use by age differs historically for these three services. Consistent with increased NHS 24 111 activity, there has been a small increase in NHS 24 111 contacts across all age groups.
- NHS 24 111: most common age groups (by 5-year band) are 0-4, 80-84 and 85+, recent data is similar though 0-4 and 85+ contacts may be less.
- SAS incidents: increase with age and most common age bands are in the > 65 age groups; this is unchanged.
- A&E services attendances: The most common age groups (by 5-year band) are 0-4, 75-79, 80-84 and 85+; this is unchanged.
- Ethnicity data remains suboptimal. Across Scotland it is only recorded for 70% of A&E services attendances, with variation across health boards. 92% of attendances, where recorded as Scottish or Other British.

4.2.2. Equity of Access, following RUC implementation (Appendix K)

PHS have completed a more in-depth analysis looking at age, sex and level of deprivation. These were broken down into 3 age bands (under 18, 18-64, 65+), 5 quintiles and male/female gender. Analysis undertaken for four different urgent care access pathways (A&E services self-presentations, A&E services attendances, OOH contacts and NHS 24 111 calls).

For the purposes of this analysis different time periods were used which differs from the daily time point analysis in section ii above.

- There was no evidence of differences in A&E services self-presentations, A&E services attendances or total contacts between levels of deprivation. There was evidence of a Scottish Index of Multiple Deprivation (SIMD) gradient for OOH contacts, NHS 24 111 calls (higher percentage drop for levels of use in the most deprived areas) and NHS 24 call terminations (higher number of terminations for more deprived areas).
- There was no evidence of a gender gradient for A&E services self-presenters, A&E services attendances and OOH, except with NHS 24 calls (higher percentage increase for males).
- There was evidence of an age gradient for pathways (higher percentage drop for under 18s) and for NHS 24 call terminations (higher number of terminations for the 18-64 age group).

This initial exploratory analysis is narrow and provides insights but does not seek to give a definitive answer to the question of whether any changes in access have been the direct result of the redesign process or whether they represent an improvement or worsening in equity of access to urgent care following redesign.

The RUC Programme will continue to engage PHS further to fully understand any impact from RUC on equity of access of urgent care.

4.2.3. Groups who are more likely to experience barriers or disadvantage when accessing urgent care services

The RUC Programme commissioned HIS - Community Engagement, to undertake a 'Gathering Views' exercise in May 2021[13], to elucidate what matters to groups more likely to experience barriers or disadvantage when accessing urgent care services by calling NHS 24.

Groups identified from national Equality Impact Assessment (EQIA) included: people with addictions, asylum seekers, refugees, unpaid carers, disabled people, those from minority ethnic groups, homeless people, LGBT+, elderly, and those living in remote or rural locations.

Participants were asked questions about experience of using the new urgent care service, their feelings about using the service in the future, and how the service might be promoted.

Details of the findings and themes are included in the full report and a summary of recommendations can be found in Appendix L.

4.3. Listening exercise NHS Scotland staff

Between 11th August – 9th September 2021, 12 focus groups were held to engage with a wide range of staff across NHS Scotland to hear their lived experience of the RUC pathway. The focus groups were facilitated by the RUC Evaluation Programme Senior Responsible Officers together with an experienced facilitator, for continuity.

The sessions provided an environment for open and honest conversations, posing two questions about the RUC pathway:

- What works well?
- What needs to be improved?

There were 112 attendees, from across the territorial NHS Boards, NHS 24, SAS, National Education Scotland (NES) and professional bodies. The approximate split between clinical (including those in leadership and management), management and/ or programme roles was approximately 60:40.

Thematic analysis identified some clear and consistent messages. However, there were also areas of differences or inconsistencies.

To note:

[13] https://www.hisengage.scot/informing-policy/gathering-views/redesign-of-urgent-care/ and summary of recommendation

- Attendees in leadership and management roles tended to be more positive about acceptability, progress and impact. Although support for the RUC programme was broad based, there were notable exceptions, with caveats expressed by some professional groups, particularly regarding implementation challenges.
- Tendency for conversations to focus on the FNCs rather than the whole pathway, with more limited feedback about the initial patient journey from first point of contact.
- SAS were not formally part of Phase 1 implementation, although they were actively engaged in focus group conversations.
- It was difficult at times for attendees to distinguish between urgent, emergency and unscheduled care, which may reflect their lived experience. It also highlights the complexity of the care system and that change in one part of the system may have impacts and consequences in other parts of the system.
- Attendees consistently commented on the difficulty of understanding the impact of the RUC pathway during the changing dynamics of the COVID-19 pandemic.

Findings are presented as key themes and where appropriate at touchpoints in the patient journey to enable read across to the management information presented.

4.3.1. Workforce

Significant concerns were expressed about the sustainability and resilience of the workforce, posing a substantial risk to the delivery of urgent care services.

We heard about reduced staff morale, tired staff coping with the ongoing effect of the COVID-19 pandemic. This includes staff who are still redeployed from key change management and patient experience roles and concern about staff ability and capacity to engage in ongoing change.

There was an overall sense of skilled and experienced staff being moved around the urgent /unscheduled care system. Some on are temporary/short term contracts, with many NHS Boards supplementing the short-term National funding posing a risk to sustainability of current services. Frequent short-term sickness and absence is compounding longer-term vacancy factors.

4.3.2. RUC Pathway Touchpoints

4.3.2.1. Urgent care access

Staff told us that they feel there is far greater potential for people and carers to access self-care advice via NHS Inform and Community Pharmacies as a first point of contact.

4.3.2.2. NHS 24

Staff were positive about the creation of safe space conversations between NHS 24 and NHS Boards, as a forum to build relationships and trust and for mutual problem solving. However, there were concerns about:

- managing surges in demand and the impact of backlog in call answering on system flow, overall waiting times and user experience
- the number of 1-hour and 4-hour pathway dispositions
- the numbers of people referred to self-care
- the level of understanding of local provision and geography, especially in remote and rural communities.

4.3.2.3. Flow Navigation Centres (FNCs)

There is wide variation across NHS Boards in the way FNCs are functioning, including:

- core operating hours
- dedicated clinical resource. Staff described differences in the level of dedicated clinical staffing especially in smaller NHS Boards, where SCDMs often have other clinical commitments, especially out-of-hours. In some instances, SCDM slots are voluntary and often reliant on the same people.
- assessment and SCDM roles. Staff described differences in competence, confidence and the professional regulations governing staff in assessment and clinical decision-making roles. The role is largely undertaken by ED Consultants, GPs and Advanced Nurse Practitioners but staffing models and skill-mix varies and it is unclear whether this is in line with clinical need.
- where FNCs operate with limited face-to-face contact with members of the FNC delivery team there may be less opportunity for team building, learning, collaboration and shared risk taking.

Clinical staff highly valued professional to professional calls and clinical decision support offered through FNCs, to discuss clinical risk and identify safe alternative pathways. However, there is a need to further widen the access and support for more professional-to-professional discussions.

The use of digital (remote) consultations was felt to improve clinician and patient confidence, effective clinical decision making and provides more patients with appropriate alternative care pathways. Digital consultations may be under-utilised, possibly because of time pressures, ease of access and user confidence.

Planning and scheduling of urgent care is gaining acceptance but needs to progress at scale to have impact. There is a need to extend access to, and further invest and develop community-based alternatives and urgent outpatient provision. People referred to A&E services with a scheduled time slot often find they joined the queue on arrival and experienced further delays to their care.

FNCs are diverting some patients to alternative pathways but the actual numbers were perceived to be lower than anticipated and often FNC activity is below available capacity. Some staff talked about the need for FNCs to be effectively resourced to operate consistently and increase productivity, in order to demonstrate impact at scale to provide a more cost effective and efficient service model.

4.3.2.4. Minor Injury Units (MIUs) and Emergency Departments (EDs)

There were differences in feedback about the impact of RUC on local minor injury pathways. Some feedback suggests improved pathways while others report that they had a good minor injury pathway prior to RUC and the new RUC pathway is now more complicated, with longer overall waiting times as patients now have to access A&E services via NHS 24 111 and the local FNC.

A&E services staff described people referred via the RUC pathway arriving later in the day when access to diagnostics is more limited and staffing levels lower, some of whom could have been offered alternative pathways. There are still significant numbers of self-presenters and an overall sense of unmet need and pressure building across the system, especially for musculoskeletal care and longer-term injury.

The feedback is similar for Primary Care IH and OOH, with staff feeling they are managing increasing demand and changes in urgent care health seeking behaviour. There was an unverified sense that some patients may be trying multiple routes to access urgent care for the same episode of care and are being redirected around the care system, resulting in multiple patient encounters.

The urgent care system is presently complicated by ongoing unprecedented COVID-19 services and measures. Concerns were expressed commonly about planning for surge and winter resilience and the need for clarity about national planning guidance.

4.3.2.5. Person-centred redesign

There were examples shared about specific initiatives to improve the pathway for people with urgent mental health needs, working in partnership with the police and non-statutory organisations to provide care closer to home.

There was consistent feedback about people experiencing multiple triage and assessment, highlighting duplication, potential waste and pathway inefficiencies. Resultant waits and delays may erode public confidence, especially if people end up being sent to A&E services when other pathways could have provided more appropriate care closer to home.

Some staff talked about the need to understand the added value of each step in the urgent care journey and the collective investment in NHS 24 and FNCs.

Some NHS Boards are considering a more whole-system approach, integrating FNCs with other services including GP OOH and Social Care with the potential to create a more flexible, responsive and cost-effective urgent care model.

Staff described opportunities to develop regionally based provision, in collaboration with NHS 24 and SAS. It was suggested that collaboration between smaller NHS Boards, could possibly generate economies of scale and more efficient and cost-effective workforce solutions.

4.3.2.6. Digital infrastructure, data and information

There were differences in opinion about how well the different elements of the digital infrastructure work. There are challenges with system interface and intra-operability issues; staff training, working across multiple screens and systems and risk with multiple data entry.

This also impacts on ability to have accurate data and information for improvement and to manage whole systems demand and capacity.

There is a need to accelerate the development of the (electronic) single shared care record and access to the clinical portal, especially important to work effectively with SAS and Community Pharmacies.

4.3.2.7. Public messaging and confidence

There was consistent feedback from staff that in their experience of how public messaging about urgent care has changed it is unclear and there is a need to align national campaign and locally nuanced messages relevant to the local care system.

To build local public understanding and confidence, there needs to be a common understanding, consistent communication and signposting by all staff at patient touchpoints in the pathway.

There were also expressed concerns that current public messaging is creating an unrealistic expectation for 24/7 access, with insufficient expectation of scheduled care provision as ‘the norm’, driving up demand across the whole care system, not just NHS 24.

4.3.2.8. Transformational change

There was support for the intent and principles of the RUC pathway, which has been largely seen as a catalyst for change and focused necessary attention on creating alternative options to A&E services attendance. However, concerns were expressed by some about RUC, particularly

implementation challenges. Partnership working across multidisciplinary and multi-agency teams is perceived as having improved communications, building relationships and trust.

There is however a tension experienced between what staff describe as a nationally-mandated approach, driven at pace and a more-lengthy journey of transformational change, creating the culture for the scale and duration needed to fully achieve the RUC ambition.

Transformational change takes time and support, including local improvement, change management and organisational development. Robust local feedback loops are needed to help staff understand the impact of changes in practice. National networking opportunities are welcomed to more widely share learning across NHS Boards, clinical teams and professional groups.

NHS Boards are still working through phase 1 operational and clinical change. Staff spoke about a sense that some services have been put in place before there was a unified vision of the whole urgent care pathway. Some NHS Boards have taken an improvement approach and using tests of change and incremental development.

Many of the issues were felt to be with implementation of, rather than with the RUC programme itself. However, the perceived primary focus on A&E services might undervalue the role of Primary Care and other community partners. Some A&E services staff expressed views that the apparent prime focus on self-presenting patients was not addressing the main problem they experience of delays in admitted pathways.

There are variations throughout NHS Scotland in how the RUC Programme has been adopted and the scale of ambition, local engagement and improvement focus. Staff from some NHS Boards with fewer urgent care presentations have questioned the return on investment, which prompts questions about economies of scale and opportunities for greater integration on a regional or joint NHS Board partnership basis. Some staff described the broader fundamental change with more widespread inclusion of Social Care and care home independent and third sector partners.

4.3.2.9. Island Heath Boards

Representatives of island NHS Boards (Orkney, Shetland, Western Isles) felt that there was a need to progress RUC in the broader context of planning sustainable care services for the unique circumstances and challenges of remote communities.

Island NHS Board staff expressed high regard for the support from NHS Highland that provides their FNC service (from Inverness). However, island-based services (availability of Senior Clinical Decision Makers (SCDMs), diagnostic and treatment facilities) do not match those on the mainland. Urgent care protocols and pathways must closely align with the

actual availability of SCDMs, the range of accessible services and diagnostics capability.

A clear view was expressed of the importance of taking a system wide approach, including a more proactive approach to anticipatory care. There are opportunities to collaborate to provide 24/7 services across the islands, building public confidence and managing care expectations.

Moving forward, many staff felt the need to clearly build and articulate the vison for local people and create a positive narrative about widening access to optimal urgent health and care provision closer to home.

4.4. Review of RUC - FNC pathway in Greater Glasgow and Clyde

To gain greater insights into the effectiveness of the RUC pathway and the experience of users, a pathway review was prototyped and tested in NHS Greater Glasgow and Clyde (NHS GG&C).

Between 30 August 2021 and 5 September 2021, a 25% sample from approximately 400 patients and carers (age range 5-88 years) who accessed care through NHS 24 and who were referred to the FNC were identified for clinical review of the appropriateness of the pathway. The sample was a timed series across the hours of operation of the FNC (10.00-22.00) within a 7-day period.

104 of the 105 patient records sampled were identified as appropriate for referral to the FNC. One person was more suited to referral to Primary Care services and was referred accordingly.

The onward referral of patients is shown in figure 7. Most patients (57%) were scheduled to attend A&E services and 36% to self-care or other services.

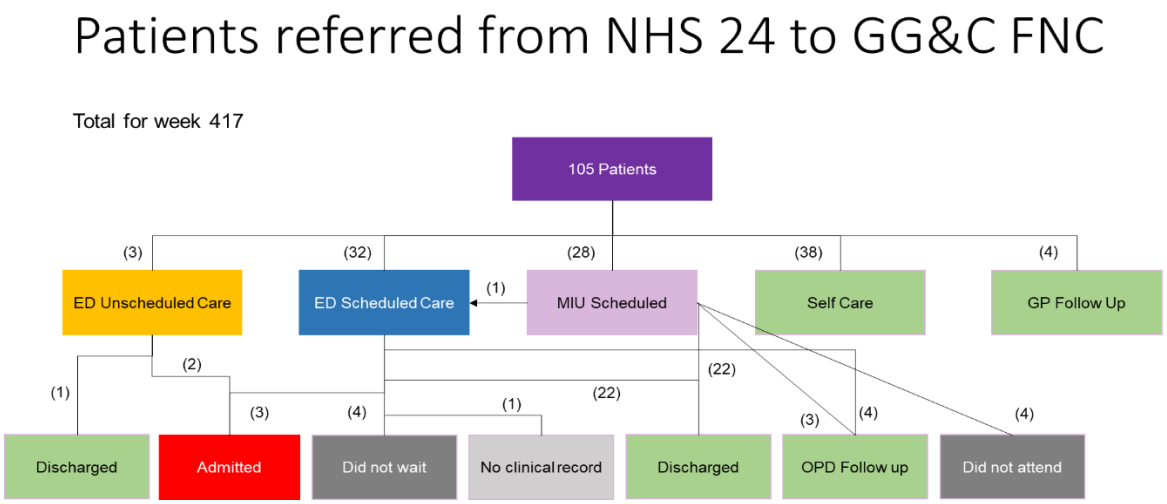

Figure 7 – Onward referral of patients from FNC

51 of 105 individuals with referrals to all areas, participated in a follow up telephone questionnaire by NHS GG&C Patient Experience team to understand their experience of RUC.

There was wide variation in the length of time from the start of triage at NHS 24 to the end of treatment for patients not admitted (range 29-20 hours) with the 10 longest waits for patients with care scheduled for the following day. It was not possible to capture call waiting times at NHS 24.

The following themes were identified from telephone questionnaires in order of most common:

1. Efficient pathway
2. Effective care
3. Good communication from professionals in the pathway
4. Long waiting times negatively affects patient experience at all points of the journey
5. Positive person-centred approach

A full report[14] of the patient pathway review, including recommendations for improvements in the review process can be found on the CfSD website.

4.5. Patient Experience

In the absence of comprehensive and comparable patient data from NHS Boards a review of the numbers of positive and negative posts to Care Opinion[15] has been undertaken for April – September 2021 and the same period 2019 pre the COVID-19 pandemic and launch of RUC. See Figure 8.

Month	Positive	Negative	Total
April 2019 April 2021	42 32	4 2	46 34
May 2019 May 2021	51 42	2 9	53 51
June 2019 June 2021	31 42	6 8	37 50
July 2019 July 2021	34 31	6 14	40 45
August 2019 August 2021	31 36	3 11	34 47

Figure 8 – number of positive and negative post

[14] https://www.nhsgoldenjubilee.co.uk/cfsd/unscheduled-care-programmes
[15] https://www.careopinion.org.uk/services/nhs-scotland

There has been a slight increase in the proportion of negative comments this year, which largely relate to time delays and staff attitudes or communication. These data will be kept under continuous review.

4.6. Right Place, Right Care, public messaging campaign

As part of the Urgent and Unscheduled Care - RUC Programme, Scottish Government commissioned the Right Care, Right Place public messaging campaign in winter 2020. The campaign aims to raise awareness of the new process to access urgent care with a view to diverting the approximate 20% of people that self-present at A&E services, to more appropriate NHS services for their care needs.

The first campaign ran from the end of November 2020 until end of March 2021 in what was described as a soft launch, with local messaging and a national door drop in January 2021. Evaluation of this period demonstrated that digital, press and local communications campaign have been effective and fostered high levels of engagement.

The communication toolkits were updated based on the findings and shared with NHS Boards to use locally.

Field work for the second campaign was undertaken in May 2021 and the campaign ran during July and August 2021. An evaluation of the campaign to date was carried out in August – September 2021.

Overall, the campaign performed well, with recognition exceeding average campaign levels and the campaign is reported as being clearly understood. Key findings from the evaluation are:

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

The key recommendations were to continue with the current media strategy. People who have seen the campaign through four or more communication channels are more likely to act positively and next steps are to proceed further with a multi-channel approach, using posters, TV, radio and social media.

5. Summary and Next Steps

The recommendations have been developed to inform the Scottish Government Urgent & Unscheduled Care Programme and NHS Boards on the next steps of the RUC programme as it continues to evolve. Ahead of further development, the RUC Programme needs to obtain full compliance from NHS Boards with the recommendations in the RUC First National Staging Report (Appendix N) and consider how best to integrate FNC roles into the broader health system and reduce delays in the care pathway.

The potential benefits of the RUC programme to date are as yet not realised. Assurance of the responsiveness and resilience of the individual components of the patient pathway is required, prior to increasing activity through any of the patient pathways (touchpoints).

Phase 2 (Appendix O) is currently in development and design and should consider the recommendations fully. The plans for phase two correlate with consistent engagement from a number of stakeholders as part of the focus groups who will be essential partners in the next stages of development, in particular Community Pharmacy, GP's and SAS.

Mental health pathways will continue to be an important part of future developments. Improvement goals will need to be developed for all pathways with ongoing evaluation and monitoring.

To fully understand the effectiveness, efficiency and user experience of the current RUC pathway, it is recommended that the RUC Programme supports all NHS Boards to undertake a pathway review, taking forward the approach and learning from the NHS GG&C test. This will enable the necessary improvements in the patient pathway, ahead of Phase 2 launch and further investment by Scottish Government.

6. Recommendations

The RUC-FNC-A&E services pathway in its current format requires review and rapid refinement to deliver benefits for patients and the system. This includes recognising the different levels of activity and service effectiveness over time, known as periodicity, which exhibit different patterns between in-hours, OOH and at weekends to inform further design and improvement.

1. Utilise person and carer centred redesign and equity of access based on evidence - including patient experience

It is important at all times, to maintain a person-centred approach to urgent care redesign, with a focus on what matters to people and carers. This includes support and valuing of all staff and organisations who provide that care.

a) Health Boards should continue to use agreed national standardised questions to monitor patient experience
b) The RUC Programme and NHS Boards should implement the recommendations of the HIS Gathering Views report to ensure a focus on equity - what matters to people who may experience barriers or disadvantage when accessing urgent care services
c) PHS should continue to monitor data on the impact of the RUC Programme on equity of access, to identify relevant trends, risks and issues
d) The external independent evaluation being commissioned by Scottish Government Urgent and Unscheduled Care Programme will include a health economic assessment including value for money and an independent assessment of patient experience.

2. Ensure there is clear workforce planning to support sustainable services for patients

a) NHS Boards should identify the risks to sustaining local services that are currently provided through use of non-recurrent funding and temporary/short term/voluntary staffing
b) The RUC Programme should support the development of data driven sustainable workforce plans to build multiagency, multi-disciplinary teams
c) All NHS Boards to collaborate closely to develop a multiagency multidisciplinary development programme for local delivery in both secondary and Primary/Community Care settings to:
    - build capability, capacity and confidence in virtual patient assessment and decision making
    - build resilient teams, improving relationships and trust, and supporting continuous learning and improvement

3. Review of NHS 24 staffing and call processes

As the primary first point of contact, NHS 24 is designed to ensure that there is responsive, efficient and effective care. NHS 24 should:

a) Continue to build with urgency, sufficient workforce capacity and capability, optimally aligned to meet timely and responsive urgent care demand 24/7 - across in-hours, out-of-hours, weekends and public holiday periods
b) Continue to review at pace clinical disposition pathways and outcomes, working with key partners and stakeholders, including SAS and local NHS Boards. This includes ongoing work to review the appropriateness of the use of 1-hour, 4-hour and 12-hour pathway dispositions – see Recommendation 4.

4. Patient pathways and dispositions

The evaluation and data from focus groups, undertaken as part of this report, suggest there is a need to review the patient pathways (dispositions) at all relevant touchpoints described within the RUC Programme.

a) All stakeholders should work collaboratively to optimise existing care pathways and dispositions to improve the patient care journey
b) This must involve the public (service users) and care professionals (service providers) and should recognise the needs of local populations, service configuration and available resources, including best use of public health skills and assets.

5. Locally-led care

a) All NHS Boards should continue to focus on right care, right place, right time and widening access to place-based urgent health and care provision. This includes promoting self-care, self-management support, where appropriate, and anticipatory care, initially focusing on pressure points in the urgent care service
b) Ensure ongoing wide engagement with local service users and providers, to take a whole system focus for the RUC Programme as it evolves, including OOH services, Primary Care- including General Practice, Community Pharmacy ((NHS Pharmacy First Scotland[16]), Mental Health, Social Care and non-statutory services.

6. Broader collaborations

a) Develop/explore closer working, collaboration and partnerships across NHS Boards, where appropriate, as a way of improving synergies and efficiency of services - including best use of collective resources
b) Take into account additional recommendations in the earlier report: '*Pulling together: transforming urgent care for the people of Scotland' (2015)*[17]

7. Flow Navigation Centres

Current performance characteristics for FNCs suggest activity/care episodes would need to increase demonstrably to reduce overall A&E services total attendances. This must be measured against the total impact of the RUC-FNC-A&E services

[16] https://www.nhsinform.scot/campaigns/nhs-pharmacy-first-scotland
[17] https://digital.nls.uk/pubs/scotgov/2015/9781785448782.pdf

pathway to ensure no unintended consequences and recognise system constraints, particularly workforce and system design.
The National RUC Programme to lead work on:

a) Better understanding and promoting optimal models for FNCs, recognising the differences in scale and geographical issues, including remote and rural
b) Promoting the most appropriate and effective modality for assessment and consultation, whether in-person or remotely. This includes improving the capability and confidence in appropriate use of digital technology, mitigating any digital exclusion risks
c) Review the RUC workforce model, developing greater use of multidisciplinary teams and skills including: Medical, Nursing, Pharmacy, Allied Health Professional (AHP), Paramedic, Social Care and support staff.

NHS Boards should:

d) Ensure flow navigation adds value to the patient journey as part of the development of local place-based and where appropriate regional care provision (see also Recommendation 6)
e) As for the National RUC Programme - develop, maintain and support a resilient workforce model, incorporating optimal multidisciplinary skills, teams and leadership
f) Optimise scheduled care, increasing the focus beyond A&E services with extended access to community and outpatient provision

8. Data and Digital infrastructure

The National RUC Programme should:

a) Accelerate access to the clinical portal and the single shared care record
b) Digital team to work more closely with local Board digital teams to extend professional to professional communications, including Near Me
c) Improve data quality, including completeness and consistency
d) Resolve existing data challenges, including standardised coding and reporting at NHS Board level across the patient pathway, which limits the ability to analyse and monitor changes effectively.

The following should be addressed:

A&E services
- Improve consistency of coding of “new planned” attendances i.e. referrals from FNC.
- Improve diagnostic coding to provide insight into the case-mix of attending patients.
- Obtain more granular data on individual MIU, rather than aggregate returns.

FNC activity
- Improve consistency and completeness of disposition/outcome recording (recorded in A&E services and ADASTRA datasets).

Primary Care – General Practice In-Hours data

- Provide patient level GP IH data to enable linkage across pathways.
- Provide aggregate data for high-level assessment of patient flow in urgent and emergency patient pathways.

Urgent Paediatric care

- Ensure ongoing data analysis and evaluation of RUC paediatric pathways and outcomes, to agreed timelines.

Urgent Mental Health care

- Mental Health RUC pathways to be evaluated in line with future RUC implementation.

9. Equality and diversity

a) NHS Boards should ensure equality and diversity data is collected and monitored in line with statutory requirements and as outlined in Recommendation 8 above
b) Boards must undertake equality and other impact assessments as necessary to ensure they can mitigate against any unintended negative impacts for people who may use the newly redesigned urgent care service, reflective of their local and regional demographics. These should go beyond the protected characteristics and include socio-economic factors such as digital exclusion. Further Information can be found in the Care services - planning with people: guidance[18]

10. Public messaging

a) The RUC Programme must ensure that communications meet the needs of people with protected characteristics, including socioeconomic factors such as digital exclusion (see Recommendation 9)
b) NHS Boards need to nuance and align local messages with the national media campaign, securing best use of all urgent care assets and resources
c) Increasing patient/public activity via NHS 24 111 call activity is unlikely to improve the patient journey and experience alone, unless:
    - The importance of the urgent care role of Primary Care is emphasised (see Recommendation 5)
    - Disposition pathways are reviewed and optimised for patient benefit including FNCs (see Recommendation 4)
    - NHS 24 call response times improve across the week (see Recommendation 3)

11. Local improvement

NHS Boards should provide dedicated improvement and change management support to enable a culture of improvement learning that:

a) Actively involves patients, public, care providers and staff

[18] https://www.gov.scot/publications/planning-people/

b) Works across pathways and systems
c) Engages Quality Improvement Teams and Fellows as local champions for change
d) Optimises use of available public health skills and assets to support RUC development (see Recommendation 4)

12. National support and improvement

The RUC Programme should build on current support to:

a) Ensure improvements in the RUC pathway are informed by best practice and the application of improvement and systems learning
b) Undertake a rapid and time-limited re-assessment of the current RUC pathway, based on the recommendations, including patient need and evidence, to define and develop the next phase priorities of the RUC Programme.
c) Recognise ongoing robust data accrual and analysis are essential, including establishing clear improvement goals which can be measured timeously (see Recommendation 8) and should seek to ensure this is in place
d) Extend improvement learning to multiagency, multi-professional teams through collaborative style regional and national learning exchanges when there is capacity in the system for fuller engagement of front-line teams (see Recommendations 5 and 7)
e) Co-ordinate synergistic activity with partner organisations to enable local organisational development, change management and build the capability and capacity for improvement learning

This report will be considered by the RUC Strategic Advisory Group and the Scottish Government to determine how the recommendations will be incorporated to the RUC Programme plan.

7. Acknowledgements

We are particularly grateful to members of the RUC Evaluation Advisory Group (see Appendix C). We are indebted to colleagues who participated in the staff focus groups, Dahrlene Tough, staff in NHS Greater Glasgow and Clyde, and NHS 24 for their work in the review of the patient pathway; to Healthcare Improvement Scotland (HIS) - Community Engagement team, who produced the Gathering Views Report.

With thanks also to Public Health Scotland (PHS) for their support in developing the management information and Dr Milka Marinova for the in-depth data analysis provided. We are greatly indebted to Dr Nicki McNaney for her sterling work throughout this report and particularly in relation to Focus Group organisation and findings. Finally, we wish to express our sincere appreciation of our SG support colleagues: Jill Pender, Jessica Milne, and to Elizabeth Lorimer, Marese O'Reilly and Amanda Trolland, NHS National Services Scotland (NSS).

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November 2021

8. Glossary

A&E	Accident & Emergency
A&E services	Accident & Emergency services (ED & MIU)
AHP	Allied Health Professional
CfSD	Centre for Sustainable Delivery
EAG	Evaluation Advisory Group
ED	Emergency Department
EQIA	Equality Impact Assessment
FNC	Flow Navigation Centre
GP	General Practice
HIS	Healthcare Improvement Scotland
IH	In Hours
IM&T	Information Management & Technology
LGBT+	Lesbian, Gay, Bisexual and Transgender/Transsexual People
MIU	Minor Injuries Unit
NES	National Education Scotland
NHS GG&C	NHS Greater Glasgow & Clyde
NSS	National Services Scotland
OOH	Out of Hours
PC	Primary Care
PHS	Public Health Scotland
RUC	Redesign Urgent Care
SAG	Strategic Advisory Group
SAS	Scottish Ambulance Service
SIMD	Scottish Index of Multiple Deprivation
SCDM	Senior Clinical Decision Maker
SPC	Statistical Process Control

9. References

NHS Ayrshire & Arran RUC Pathfinder	https://www.gov.scot/publications/nhs-ayrshire-arran-redesign-urgent-care-pathway-finder-programme-rapid-external-review/
Danish Model	The Danish prehospital emergency healthcare system and research possibilities – Nov 2019
RUC First Staging Report	https://www.gov.scot/publications/nhs-scotland-redesign-urgent-care-first-national-staging-review-report-1-december-2020-31-march-2021/
The Redesign of Urgent Care Gathering Views Report, Healthcare Improvement Scotland	https://www.hisengage.scot/informing-policy/gathering-views/redesign-of-urgent-care
Care Opinion	https://www.careopinion.org.uk/
Review of the COVID-19 data compared with historical data to support future service design and understanding of the unscheduled care pathway for NHS Scotland", December 2020	https://www.nhsgoldenjubilee.co.uk
Making Data Count, 2018	https://www.england.nhs.uk/publication/making-data-count/
NHS Pharmacy First Scotland	https://www.nss.nhs.scot/pharmacy-services/pharmacy-services/nhs-pharmacy-first-scotland-pfs/
Pulling together: transforming urgent care for the people of Scotland' (2015)	https://digital.nls.uk/pubs/scotgov/2015/9781785448782.pdf
Care services - planning with people: guidance	https://www.gov.scot/publications/planning-people/

Appendix A - Membership RUC Strategic Advisory Group

Membership as at 21st October 2021

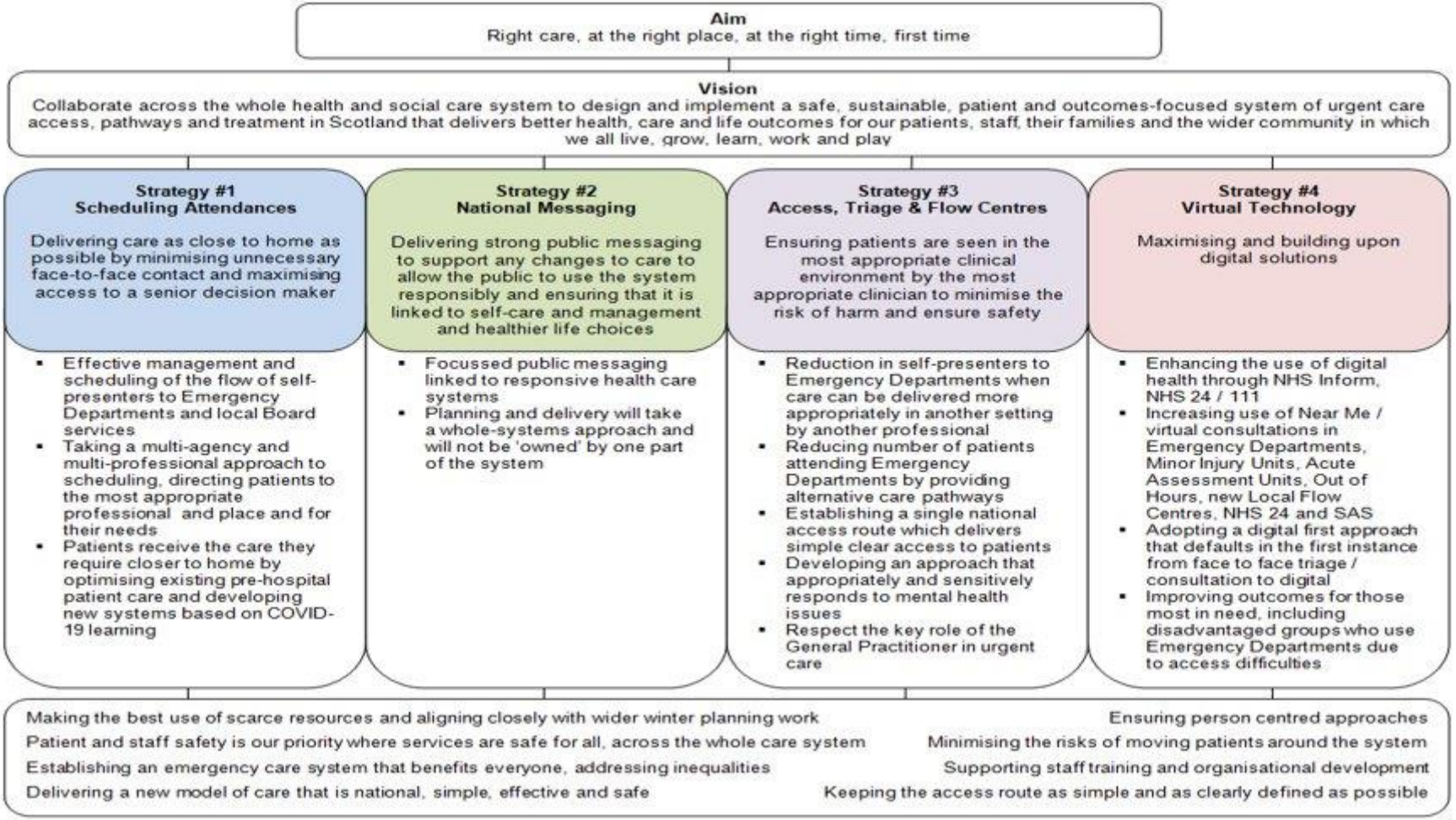
Name	Role	Responsibilities
Calum Campbell, Chief Executive, NHS Lothian	**Co-chair**	• Co-chair Strategic Advisory Group • Link into the Chief Executives Group • Represent their constituent organisations • Provide strategic leadership and guidance to the RUC
Jim Miller, Chief Executive, NHS 24	**Co-chair**	
Helen Maitland, Director, Unscheduled Care, Scottish Government	Senior Responsible Owner (SRO)	• Delegated responsibility on behalf of the Cabinet Secretary to authorise/ approve any decisions the group endorse • Accountable for the delivery of the programme and associated project delivery. • Report progress to the Ministers on behalf of the programme. • Provide strong leadership, overall guidance and direction to the programme, workstreams and projects ensuring they remain viable within any specified constraints. • Makes decisions on the best solution to blockers in delivery of the programme • Champions the vision of the programme
Carol Goodman, RUC Programme Director, Unscheduled Care, Scottish Government	Programme Director	• Delegated responsibility for the co-ordination and delivery of the programme and its constituent workstreams • Oversees and directs the preparation of key programme documents • Secures resources and expertise as required for the programme • Leads, co-ordinates and fosters teamwork across the programme • Resolves or mitigates problems/issues/risks as they arise • Report on progress and escalates areas of risk or concern to the SAG • Establishes and maintains a mechanism to ensure regular • dialogue with all those involved in the programme to promote problem solving, team working and risk sharing

James Ward, Medical Director, Scottish Ambulance Service William Edwards, Director of eHealth, NHS Greater Glasgow & Clyde	Digital Solutions Workstream Lead	• Support the Programme Director to deliver programme as defined and on time • Provide updates to the SAG on achievements and challenges along with progress. • Represent their constituent Organisations • Highlight risks and issues that may hinder progress along with any mitigating actions taken/ to be taken • Ensure those impact by the change are informed • Work to ensure preparedness and highlight gaps • Ensure dependencies are clear with links to other workstreams
Dave Bywater, Lead Consultant Paramedic, Scottish Ambulance Service Scott Davidson, Deputy Medical Director for Acute, NHS Greater Glasgow & Clyde	Scottish Ambulance Service Joint Lead	
Alastair Cook, Principal Medical Officer, Mental Health Division, Scottish Government Gavin Gray, Deputy Director, Mental Health Division, Scottish Government	Mental Health Workstream Lead	
John Freestone, Clinical Lead, Primary Care	Primary Care Workstream Lead	
Jan Beattie, AHP Advisor, Scottish Government Laura Stuart-Neil, AHP Lead, NHS 24	Musculoskeletal Workstream Lead	
Stephen McBurney, Associate Director of Pharmacy, NHS Lothian	Community Pharmacy Workstream Lead	
Professor Derek Bell, Clinical Advisor, Scottish Government	Data & Monitoring Workstream Lead	
Stephanie Phillips, Director, Service Delivery, NHS 24	FNC Workstream Lead (NHS 24 111)	
Hazel Archer, Head of Programme – Near Me, Scottish Government	Near Me Workstream Lead	

Suzy Aspley Director of Comms, NHS 24	National Communications Workstream Lead	
Heather Campbell, Deputy Director of Primary Care	Primary Care Representative	• Represents the Primary Care Directorate
Grant Archibald, Chief Executive, NHS Tayside	Representative North Region NHS Boards	• Represents North Region NHS Boards • Member of Chief Executives group • Strategic leadership and board level support
Craig Cunningham, Head of Commissioning and Performance South Lanarkshire Health & Social Care Partnership	Primary Care / IJB Chief Officers Representative	• Primary Care / IJB Chief Officers
Laura Ryan, Medical Director, NHS 24	Clinical Representative	• Provides clinical advice and guidance
Frances Dodds, Executive Director of Care Quality and Professional Development at Scottish Ambulance Service Professor Angela Wallace, Nurse Director, NHS Forth Valley	SEND Representative	• Represents SEND • Provides clinical advice and guidance
Jane Grant, Chief Executive, NHS Greater Glasgow and Clyde	Representative West Region NHS Boards	• Represent West Region NHS Boards • Member of Chief Executives group • Strategic leadership and board level support
Kerry Neylon, NHS GG&C OOH GP Lead	National PC Leads Network Representative	• Represents National PC Leads Network • Provides clinical advice and guidance
John Thomson, Vice President RCEM Scotland	RCEM Representative	• Represents RCEM • Provides clinical advice and guidance
Nicola Gordon, Policy Manager, Executive Support Team	Board Chief Executive policy support	• Support to the Chief Executive Group
TBC	CO Group Representative	• Represents Chief Officers Group • Provides advice and guidance

Sir Lewis Ritchie, Clinical Advisor	Clinical Advisor	• Offers Clinical advice and guidance
Sian Tucker, Senior Medical Officer, PC, SG, (National OOH Leads)	OOH Representative	• Provides advice and guidance • Represents OOH
TBC, Chair, RGCP Scotland	RGCP Chair	• Provides advice and guidance • Represents RGCP
Prof Alan Paterson, Strathclyde University Lay representative,	Academy of Royal Colleges representative	• Provides advice and guidance
Tracey Gillies, Medical Director NHS Lothian, Chair of SMD	SAMD representative	• Represents SAMD • Provides advice and guidance
Dr Jennifer Armstrong, Medical Director, NHS Greater Glasgow & Clyde	Clinical Representative NHS GGC	• Provides advice and guidance

Appendix B - Overview of RUC Phase 1



Appendix C - Membership of the RUC Evaluation Advisory Group

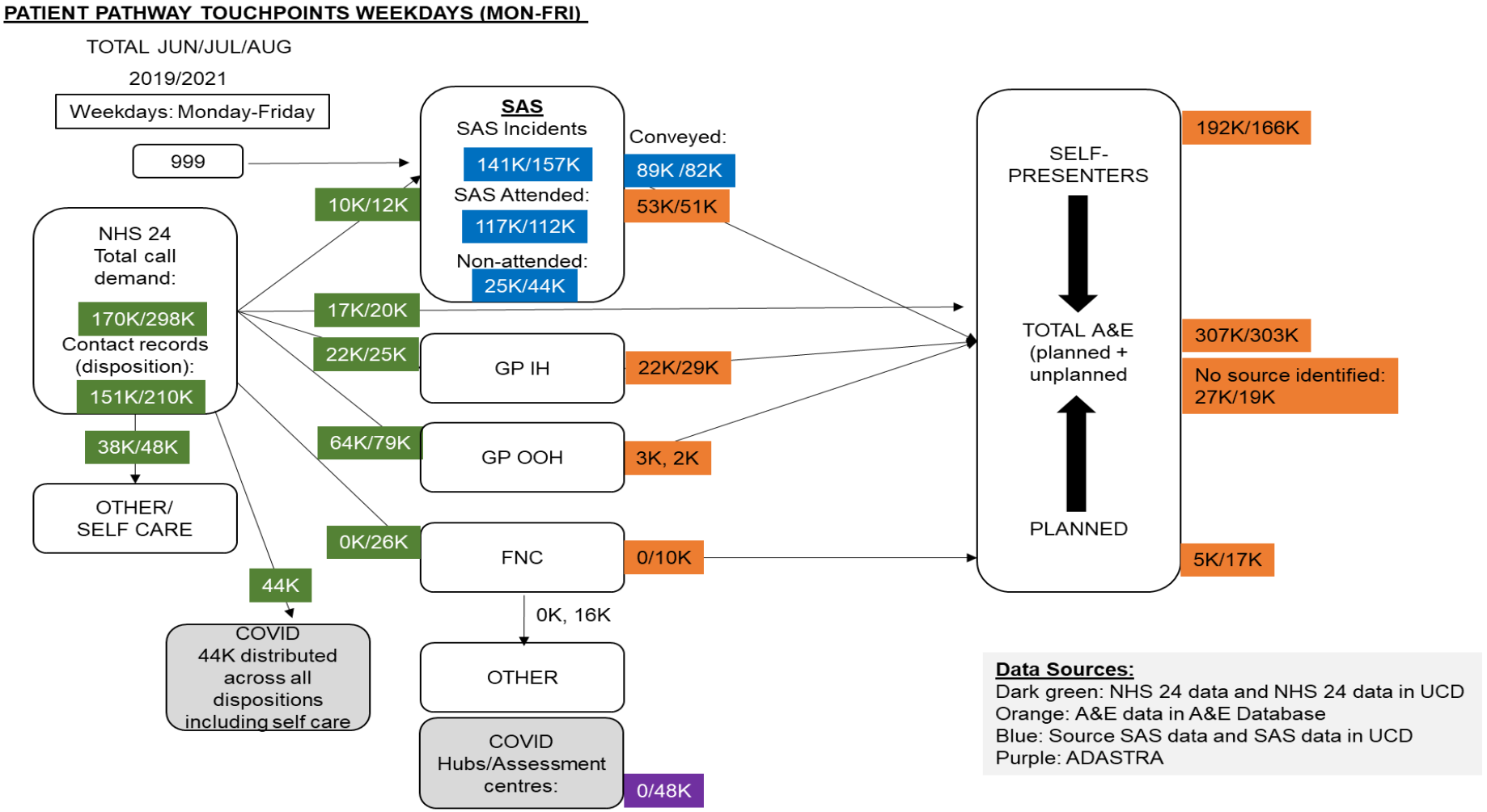
RUC Evaluation Advisory Group Membership as at October 2021

Name / Job Title / Organisation
Professor Derek Bell, Clinical Lead, Scottish Government (Co-chair) Joint Senior Responsible Owner (SRO)
Sir Lewis Ritchie, Professional Advisor, Scottish Government (Co-chair) Joint SRO
Heather Campbell, Interim Deputy Director, Primary Care Directorate, Scottish Government
Neil Craig, Principal Public Health Advisor, Public Health Scotland
Jane Davies, Head of Engagement Programmes, NHS Healthcare Improvement Scotland
Ron Cook, Associate Medical Director, NHS 24
Jim Ward, Medical Director, Scottish Ambulance Service
Lorien Cameron-Ross, Clinical Director (Out of Hours), NHS Highland GP (in hours)
John Thomson, Consultant in Emergency Medicine NHS Grampian and Vice President (Scotland) RCEM
Kerri Neylon, Deputy Medical Director for Primary Care, NHS GG&C
Professor Alan Paterson, Lay Representative, Strathclyde University
Carol Goodman, Programme Director, Redesign of Urgent Care, Scottish Government
Helen Maitland, National Director for Unscheduled Care, Scottish Government
Fiona MacDonald, Social Researcher Scottish Government
Jessica Milne, Unscheduled Care Policy Team Leader, Scottish Government
Jill Pender, Policy Manager, Unscheduled Care, Scottish Government
Elizabeth Lorimer, Programme Support Officer
Marese O'Reilly, Programme Manager, Unscheduled Care

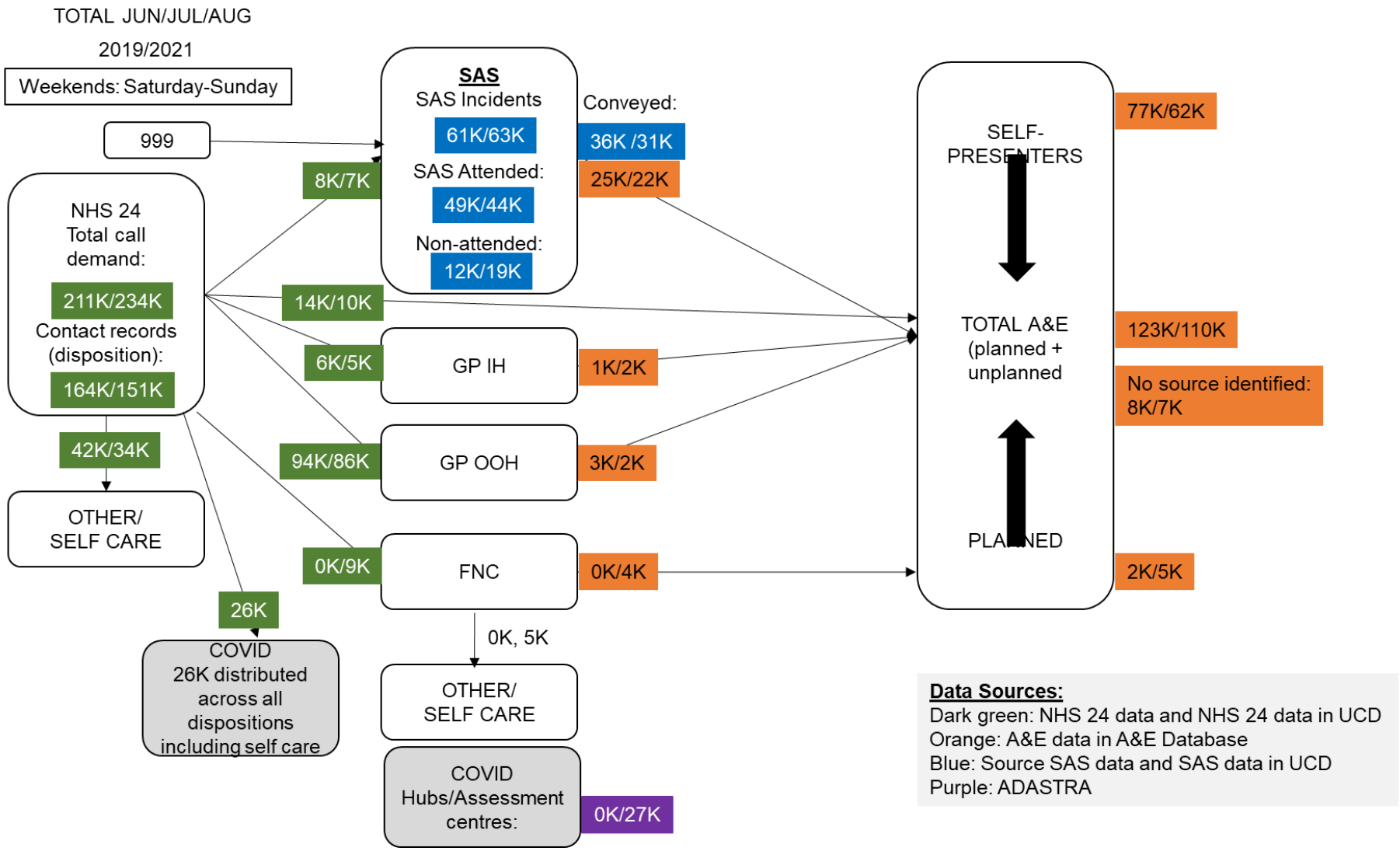
Appendix D - Membership Workstream 1 Data and Monitoring Group

Professor Derek Bell (Chair)	Clinical Advisor, Scottish Government
Eleanor Anderson	Consultant in Public Health Medicine, Public Health Scotland
Katy Barclay	Head of Business Intelligence and Data Protection, Scottish Ambulance Service
Nicola Dawson	Clinical Services Manager, NHS 24
Michael Fox	Improvement Advisor, Scottish Government
Carol Goodman	Programme Director, Scottish Government
Katherine McGregor	Principle Information Analyst, Public Health Scotland
Emma McNair	Information Consultant, Public Health Scotland
Milla Marinova	Clinical Fellow, Imperial College
Sir Lewis Ritchie	Clinical Advisor
Peter Stonebridge	Medical Director, NHS Tayside
Amanda Trolland	Programme Manager, Scottish Government
Kelly Walker	Project Support, Scottish Government
Robert Williams	Deputy Director – Business Intelligence, Scottish Government

Appendix E - Data findings for touchpoint comparison between Jun-Aug 2019 to Jun-Aug 2021 Mon-Fri and Sat-Sun



PATIENT PATHWAY TOUCHPOINTS WEEKENDS



Appendix F - Scotland Data Table August 2021.

This table uses percentages for illustrative purposes. In interpreting these charts, it is important to consider the actual volume of activity as this more accurately reflects the demand that the individual services required to manage.

Data to 29 August 2021	Data	Prediction of RUCP	Current v August 2019	SPC recent trend last 3 months
NHS 24 Contacts	Mon-Fri: ALL contacts	↑	↑ 42%	Stable for 3 months.
	Mon-Fri: In Hours contacts	↑	↑ 458% (1172 v 210)	Stable for 3 months.
	Sat-Sun contacts	↔	↓ 3%	Stable for 3 months.
NHS 24 111 direct referrals to A&E	Mon-Fri	↔	↑ 36%	Stable for 3 months.
	Sat-Sun	↔	↓ 28%	Stable for 3 months.
NHS 24 111 referrals to SAS 999	Mon-Fri	↔	↑ 29%	Pattern stable. Minor increase Aug.
	Sat-Sun	↔	↓ 6%	Pattern stable. Decrease June.
NHS 24 111 to Self Care	Mon-Fri	? ↑	↓ 8%	Stable for 3 months.
	Sat-Sun	? ↔	↑ 7%	Pattern stable. Minor decrease July.
GP OOH (non-COVID only not including COVID Hubs)	Mon-Fri	? ↑	↓ 4%*	Stable for 3 months.*
	Sat-Sun	↔	↓ 7%*	Stable for 3 months.*
COVID Hubs & Assessment Centres	Mon-Fri	↑	N/A	System variable. Approx. 500 per day.
	Sat-Sun	↑	N/A	Stable for 3 months. Approx. 800 per day.
SAS	SAS All incidents	↔	↑ 7%	Pattern stable. Minor decrease July.
	Attended	↔	↓ 7%	Pattern stable. Minor decrease July.
	Conveyed	↔	↓ 8%	Pattern stable. Minor decrease June.
	Non-attended	↔	↑ 80%	Stable for 3 months.
	Turnaround times	?	↑ 37%	Steadily increasing. 35m May, now 41m.
FNC	All contacts	↑	~ 3-4% of all ED attends	Pattern stable last 2 months.
A&E (coding of FNC activity improving)	A&E ALL Planned + Unplanned	↑	↓ 3%	Stable for 3 months.
	A&E ALL Unplanned Attendances	↓	↓ 9%	Pattern stable. Minor decrease Aug
	Self presenters ALL	↓	↓ 17%	Pattern stable. Decrease Aug
	4-hour emergency access standard	?	↓ 13%	Decreasing since February.
Emergency Admissions	Mon-Fri	↔	Comparison in progress	Pattern stable. Minor decrease July
	Sat-Sun	↔	Comparison in progress	Stable for 3 months.

<u>Scotland Summary Data compared to Predicted impact of RUC and historical data</u>

- Buffer of 5% included for arrow comparison
- Stable means within control limits.

*If COVID activity is added to GP OOH activity, this results in an increase compared to historical values, most marked at weekends.

Appendix G - Individual Health Board summary data

BOARD DATA: COMPARATOR OF CURRENT DATA VS August 2019 and GO-LIVE CHANGE

Tables shows high level overview of daily activity data for individual boards. See slides 13 onwards for SPC charts. Arrows (increase, decrease or activity stable). Where current data is within 5% of August data, we have assumed activity is stable, except for ED performance which is already calculated as a % and is shown.

RUC Data Report to 29 August 2021

	RUCP Prediction	Lothian		Glasgow & Clyde		Lanarkshire		Tayside		Grampian	
		Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019
NHS 24 Mon-Fri: ALL contacts	↑	↑	↑	↑	↑	↑	↑	↑	↔	↑	↑
NHS 24 Mon-Fri: In Hours contacts	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
NHS 24 Sat-Sun contacts	↔	↔	↔	↔	↔	↔	↔	↔	↓	↔	↔
GP OOH (non-COVID): Mon-Fri	?↑	↓	↓	↔	↓	↔	↑	↔	↑	↔	↔
GP OOH (non-COVID): Sat-Sun	↔	↔	↔	↔	↓	↔	↑	↔	↔	↔	↔
COVID Hubs & Assessment Centres	↑	↔	N/A	↔	N/A	↔	N/A	↔	N/A	↑	N/A
SAS Attended Incidents	↔	↓	↓	↔	↓	↔	↓	↔	↓	↑	↔
SAS Conveyed	↔	↓	↓	↓	↓	↔	↓	↓	↓	↔	↓
A&E unplanned attendances	↓	↓	↓	↓	↓	↑	↔	↓	↔	↓	↓
Self presenters ALL	↓	↓	↔	↓	↓	↔	↓	↓	↔	↓	↓
4-hour emergency access standard	?	↔	↓15%	↑6%	↓10%	↓3%	↓18%	↓3%	↓2%	↓5%	↓10%
Emergency Admissions Mon-Fri	↔	↔	N/A	↓	N/A	↔	N/A	↔	N/A	↔	N/A
Emergency Admissions S-Sun	↔	↔	N/A	↔	N/A	↔	N/A	↔	N/A	↔	N/A

BOARD DATA: COMPARATOR OF CURRENT DATA VS August 2019 and GO-LIVE CHANGE

Tables shows high level overview of daily activity data for individual boards. See slides 13 onwards for SPC charts. Arrows (increase, decrease or activity stable). Where current data is within 5% of August data, we have assumed activity is stable, except for ED performance which is already calculated as a % and is shown.

RUC Data Report to 29 August 2021

	RUCP Prediction	A&A		Fife		Forth Valley		Dumfries & Galloway		Borders	
		Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019
NHS 24 Mon-Fri: ALL contacts	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
NHS 24 Mon-Fri: In Hours contacts	↑	↔	↑	↑	↑	↑	↑	↑	↑	↑	↑
NHS 24 Sat-Sun contacts	↔	↓	↓	↓	↔	↔	↑	↔	↓	↔	↓
GP OOH (non-COVID): Mon-Fri	?↑	↔	↑	↑	↑	↔	↑	↑	↑	↔	↑
GP OOH (non-COVID): Sat-Sun	↔	↔	↑	↑	↔	↔	↑	↔	↑	↔	↑
COVID Hubs & Assessment Centres	↑	↔	N/A	↔	N/A	↔	N/A	↑	N/A	↑	N/A
SAS Attended Incidents	↔	↔	↓	↔	↔	↑	↔	↑	↔	↔	↔
SAS Conveyed	↔	↓	↓	↑	↔	↔	↓	↑	↑	↔	↑
A&E unplanned attendances	↓	↓	↓	↔	↓	↓	↓	↓	↓	↓	↓
Self presenters ALL	↓	↓	↓	↓	↓	↓	↓	↓	↔	↓	↓
4-hour emergency access standard	?	↔	↓9%	↔	↓12%	↔	↓21%	↓7%	↓9%	↑1%	↓25%
Emergency Admissions Mon-Fri	↔	↔	N/A	↔	N/A	↓	N/A	↔	N/A	↔	N/A
Emergency Admissions S-Sun	↔	↔	N/A	↔	N/A	↔	N/A	↔	N/A	↔	N/A

BOARD DATA: COMPARATOR OF CURRENT DATA VS August 2019 and GO-LIVE CHANGE

Tables shows high level overview of daily activity data for individual boards. See slides 13 onwards for SPC charts. Arrows (increase, decrease or activity stable). Where current data is within 5% of August data, we have assumed activity is stable, except for ED performance which is already calculated as a % and is shown.

	RUCP Prediction	Highlands		Western Isles		Orkney		Shetland	
		Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019	Step change at Go-Live during Dec 2020?	Current V August 2019
NHS 24 Mon-Fri: ALL contacts	↑	↑	↑	↑	↔	↔	↓	↑	↑
NHS 24 Mon-Fri: In Hours contacts	↑	↑	↑	↔	↑	↔	↔	↑	↑
NHS 24 Sat-Sun contacts	↔	↓	↓	↔	↑	↔	↔	↔	↔
GP OOH (non-COVID): Mon-Fri	?↑	↔	↑	↔	↔	↔	↑	↔	↓
GP OOH (non-COVID): Sat-Sun	↔	↔	↔	↔	↓	↑	↔	↔	↓
COVID Hubs & Assessment Centres	↑	↔	N/A	↔	N/A	↓	N/A	↔	N/A
SAS Attended Incidents	↔	↔	↑	↑	↑	↔	↓	↔	↑
SAS Conveyed	↔	↔	↔	↑	↓	↔	↔	↔	↑
A&E unplanned attendances	↓	↓	↓	↓	↓	↓	↔	↔	↓
Self presenters ALL	↓	↔	↓	↔	↓	↓	↓	↓	↓
4-hour emergency access standard	?	↔	↓5%	↔	↓1%	↔	↑1%	↔	↓1%
Emergency Admissions Mon-Fri	↔	↔	N/A	↔	N/A	↔	N/A	↔	N/A
Emergency Admissions S-Sun	↔	↔	N/A	↔	N/A	↔	N/A	↔	N/A

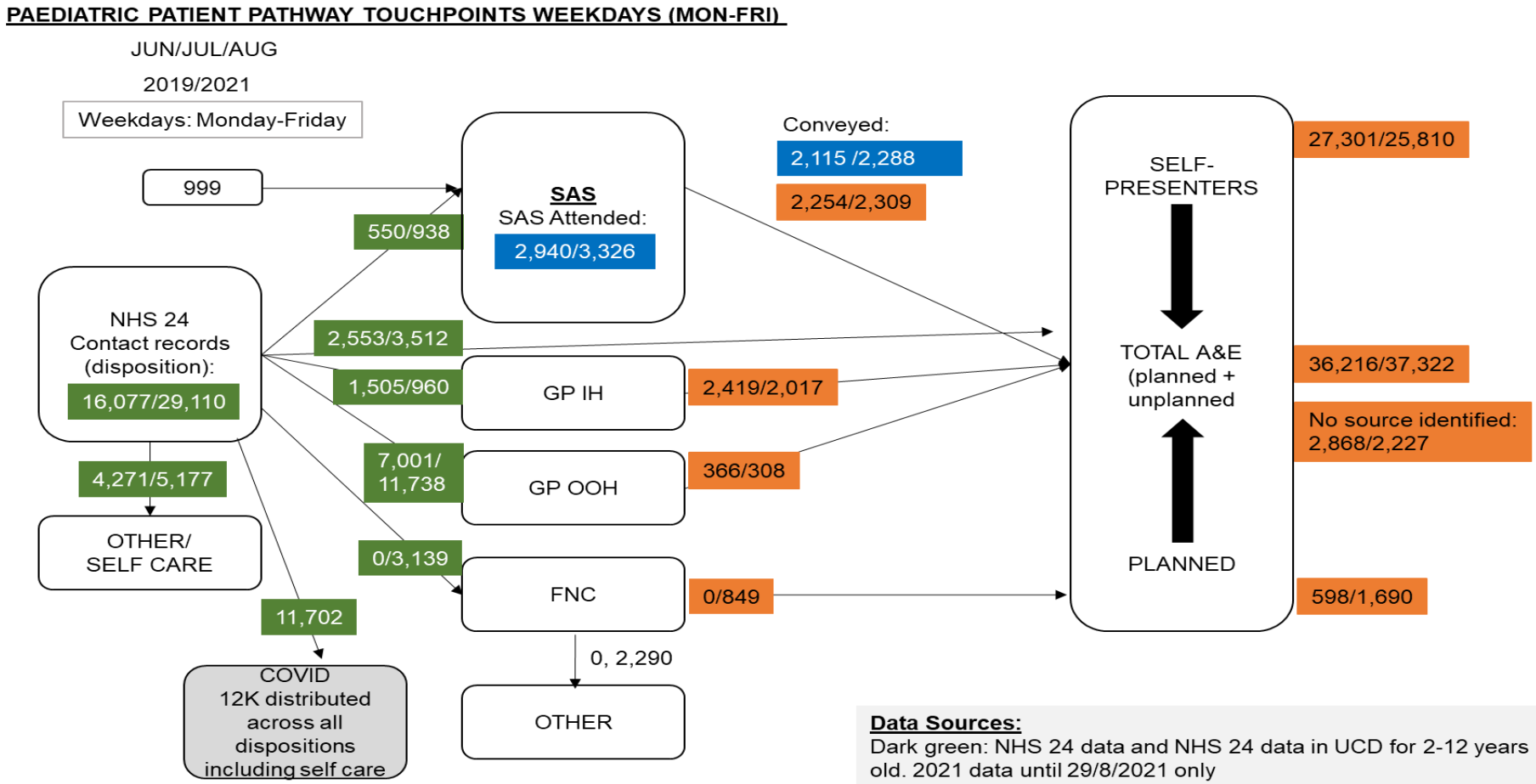
RUC Data Report to 29 August 2021

Appendix H - NHS 24 111 Time to Answer (TTA) & Call Abandonment Rates

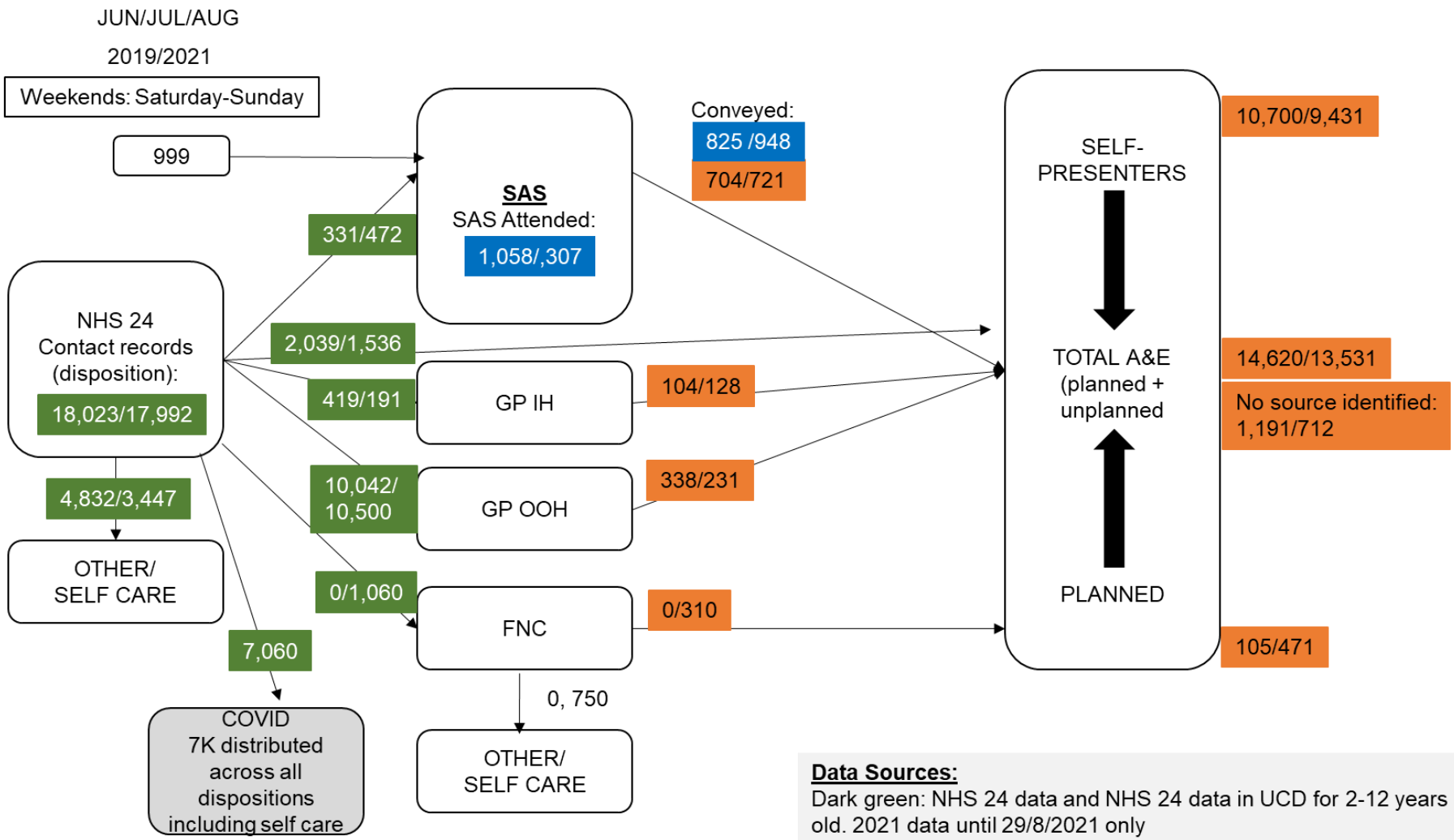
	Monday-Friday In-hours							Monday-Friday OOH						
	Median TTA (secs)	mins	90th%tile TTA (secs)	mins	Average Call Demand		Average Abandoned after threshold	Median TTA (secs)	mins	90th%tile TTA (secs)	mins	Average Call Demand		Average Abandoned after threshold
Jan-20	6	0	73	1	268	4%	12	6	0	217	4	2,898	8%	240
Feb-20	6	0	261	4	380	7%	27	6	0	281	5	2,318	4%	94
Mar-20	2,576	43	7,499	125	2,732	65%	1,781	750	13	3,021	50	3,472	38%	1,313
Apr-20	6	0	2,062	34	1,603	16%	251	6	0	775	13	2,196	5%	112
May-20	6	0	9	0	876	1%	6	6	0	312	5	2,118	3%	74
Jun-20	6	0	9	0	620	0%	3	6	0	495	8	2,121	5%	98
Jul-20	6	0	12	0	705	5%	34	9	0	653	11	2,054	6%	122
Aug-20	6	0	2,276	38	1,537	22%	334	150	3	1,491	25	2,349	14%	320
Sep-20	6	0	1,308	22	1,387	11%	157	60	1	1,376	23	2,142	12%	253
Oct-20	6	0	231	4	1,136	5%	60	160	3	1,324	22	2,132	13%	281
Jan-21	6	0	954	16	1,675	9%	159	192	3	1,498	25	2,942	21%	629
Feb-21	6	0	1,310	22	1,393	12%	164	153	3	1,062	18	2,143	14%	293
Mar-21	105	2	1,544	26	1,393	14%	196	550	9	1,698	28	2,216	19%	423
Apr-21	7	0	1,326	22	1,258	10%	125	500	8	2,069	34	2,984	20%	603
May-21	6	0	592	10	1,481	7%	107	425	7	1,414	24	2,507	16%	404
Jun-21	323	5	1,330	22	1,736	16%	284	823	14	2,306	38	2,814	24%	678
Jul-21	263	4	1,894	32	1,820	19%	341	943	16	2,079	35	2,763	24%	676
Aug-21	126	2	1,249	21	1,708	14%	245	861	14	2,399	40	2,721	25%	686

Saturday							Sunday						
Median TTA (secs)	mins	90th%tile TTA (secs)	mins	Average Call Demand		Average Abandoned after threshold	Median TTA (secs)	mins	90th%tile TTA (secs)	mins	Average Call Demand		Average Abandoned after threshold
175	3	1,065	18	7,889	15%	1,152	51	1	822	14	7,399	11%	807
214	4	918	15	7,717	15%	1,121	196	3	733	12	7,420	12%	867
2,126	35	6,394	107	11,022	50%	5,535	1,086	18	4,149	69	9,926	42%	4,157
1,132	19	3,320	55	7,368	21%	1,561	268	4	1,587	26	6,813	12%	800
399	7	1,710	29	7,403	13%	944	89	1	801	13	6,710	7%	485
677	11	1,681	28	7,261	14%	1,048	82	1	686	11	6,542	6%	406
393	7	1,579	26	6,867	13%	876	150	3	981	16	6,391	9%	562
547	9	2,166	36	7,398	16%	1,181	313	5	1,954	33	7,176	14%	1,029
540	9	1,733	29	7,139	14%	1,006	427	7	1,415	24	6,938	12%	849
827	14	2,495	42	7,106	18%	1,248	448	7	1,714	29	6,861	14%	937
1,753	29	4,037	67	7,986	26%	2,092	960	16	3,548	59	7,230	22%	1,600
1,498	25	3,952	66	7,412	27%	2,011	721	12	2,063	34	6,666	17%	1,158
1,628	27	2,756	46	7,666	24%	1,808	971	16	2,191	37	6,680	19%	1,266
664	11	1,491	25	8,035	15%	1,212	413	7	1,258	21	7,590	12%	879
800	13	1,756	29	8,188	17%	1,357	718	12	1,756	29	7,969	16%	1,258
1,479	25	3,016	50	8,855	26%	2,313	1,196	20	2,618	44	8,395	24%	2,048
1,891	32	3,420	57	8,974	31%	2,786	1,691	28	2,966	49	8,640	29%	2,524
1,891	32	3,420	57	8,848	31%	2,758	1,586	26	3,237	54	8,556	29%	2,523

Appendix I - Data findings for Paediatric touchpoint comparison between June-August 2019 to June-August 2021 for Monday-Friday and Saturday-Sunday

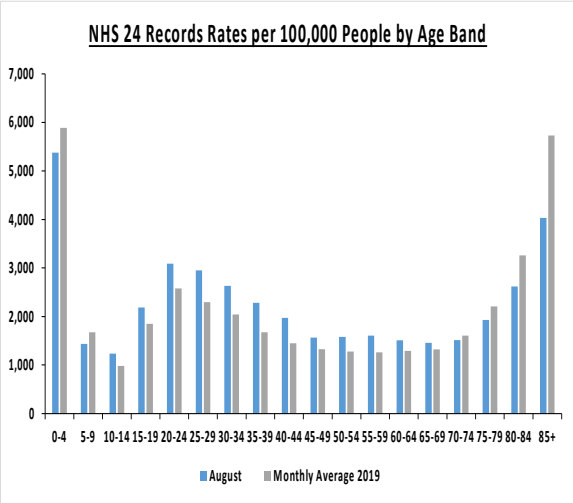


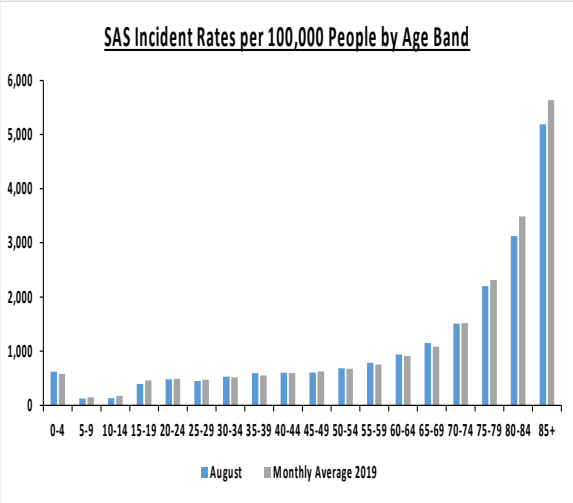
PAEDIATRIC PATIENT PATHWAY TOUCHPOINTS WEEKENDS

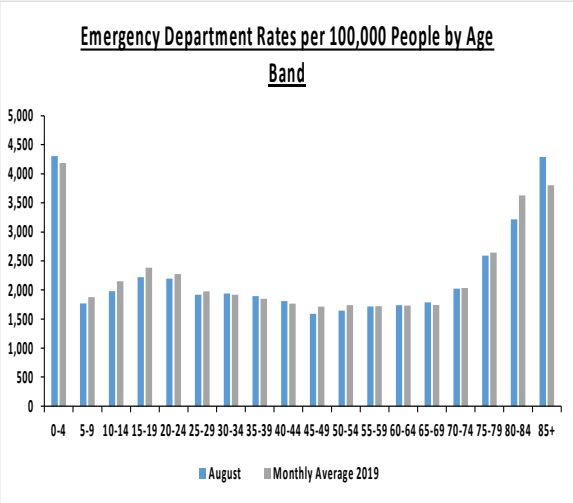


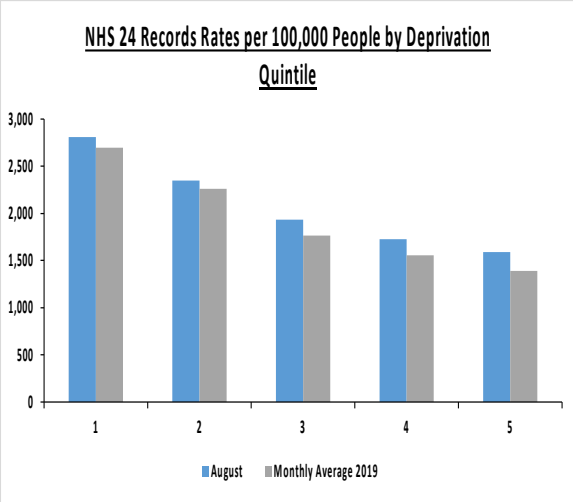
Data Sources:
Dark green: NHS 24 data and NHS 24 data in UCD for 2-12 years old. 2021 data until 29/8/2021 only
Orange: A&E data in A&E Database (18months – 12 years old)
Blue: Source SAS data and SAS data in UCD (18months – 12 years old)

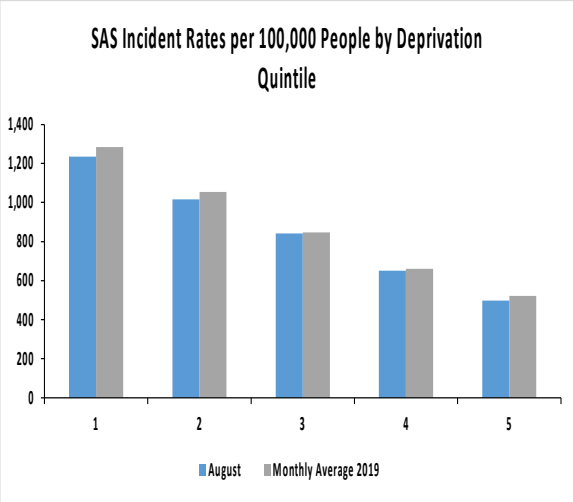
Appendix J - Age deprivation index and ethnicity

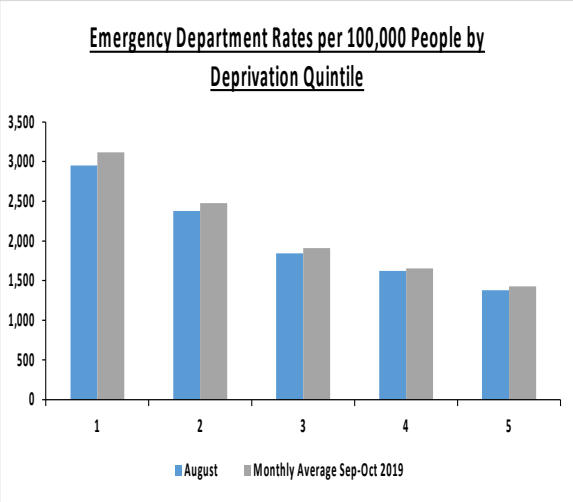












Appendix K - RUC Equity in Access Report

Assessing the impact of the redesign of urgent care (RUC) on equity in access – Contribution to second staging report (September 2021)

Introduction Approach/Methodology

Analysis was performed by PHS to look at whether and how the use of urgent care changed over time following the soft launch of RUC, and whether this differed between populations defined in terms of age, sex and level of deprivation in the area in which they lived. The number of groups used in the analyses were as follows:

- Scottish Index of Multiple Deprivation (SIMD) – Five groups (quintiles)
- Age – Three groups (Under 18, Age 18-64 and Age 65+)
- Gender – Two groups (male and female)

These analyses were undertaken separately for four different urgent care access pathways (A&E self-presentations, A&E attendances, OOH contacts and NHS 24 calls) and for the latter three pathways combined (total contacts). Trends of average numbers per week for the different pathways (with 95% lower and upper confidence intervals) were explored for the following time periods:

- Period 1: pre-COVID-19 to start of COVID-19 (1st January 2017 to 15th March 2020)
- Period 2: start of COVID-19 to soft launch of the RUC (16th March 2020 to 29th November 2020)
- Period 3: soft launch of the RUC to end of the dataset (30th November 2020 to 18th July 2021).

The analyses compared Period 1 to Period 2 and Period 1 to Period 3. Additional analyses were performed to track whether there is evidence of a worsening trend in the outcomes of NHS 24 calls (call termination by the caller before triage is possible). Trends of average numbers per month were explored for the following time periods:

- Period 1: pre-COVID-19 to start of COVID-19 (January 2017 to February 2020)
- Period 2: start of COVID-19 to soft launch of the RUC (March 2020 to November 2020).
- Period 3: soft launch of the RUC to end of the dataset (December 2020 to June 2021).

The analyses also compared Period 1 to Period 2 and Period 1 to Period 3.

High level findings

- Average numbers of contacts fell between Period 1 and Period 2 for all equality groups across all the separate urgent care pathways and all the pathways combined; average numbers of monthly call terminations increased over the same period for most equality groups.
- Average numbers of contacts fell between Period 1 and Period 3 for most equality groups across most of the separate urgent care pathways and the pathways combined; average numbers of NHS 24 calls and call terminations increased over the same period for most equality groups.
- There was no evidence of differences in A&E self-presentations, A&E attendances or total contacts between levels of deprivation. There was evidence of a SIMD gradient for OOH contacts, NHS 24 calls (higher percentage drop for levels of use in the most deprived areas) and NHS 24 call terminations (higher number of terminations for more deprived areas).
- There was no evidence of a gender gradient except with NHS 24 calls (higher percentage increase for males).
- There was evidence of an age gradient for all separate pathways and combined pathways (higher percentage drop for under 18s) and for NHS 24 call terminations (higher number of terminations for the 18-64 age group).

Recommendations/future

These exploratory analyses can be summarised in Table 1. These analyses suggest, for OOH and NHS 24 pathways, a worsening of inequalities in access for the more deprived areas and, for all separate and combined pathways, a worsening of inequalities in access for the under 18 age group. These are worthy of further exploration through further analysis or triangulation. It will be worth replicating these analyses and comparing trends to an additional time period (one that commences from start of the national communication campaign (summer 2021) to the end of the period under consideration) once more data becomes available to see if these inequalities are consistent.

NHS 24 call terminations are defined as calls made to the helpline which were terminated by the caller before they reached triage. Termination findings should be interpreted with caution as they make up only around 0.2% of all NHS 24 calls.

As these are initial exploratory analyses only they are relatively narrow in scope: they do not consider pre-existing inequity in access, do not try directly attributing any observed change to the redesign process and do not consider unmet care needs. As such, these analyses do not seek to give a definitive answer to the question of whether any changes in access have been the direct result of the redesign process or whether they represent an improvement or worsening in equity of access to urgent care following redesign. Rather, they seek to offer initial insights into potential inequalities in access to urgent care between population groups and whether these have changed following redesign.

Table 1 – Summary of RUC equity initial exploratory analyses

Pathway	Gradient by Group		Change in gradient by group	
A&E (self-presentations)	Deprivation	Yes	Deprivation	No
	Gender	No	Gender	No
	Age	Yes	Age	Yes
A&E (all attendances)	Deprivation	Yes	Deprivation	No
	Gender	No	Gender	No
	Age	Yes	Age	Yes
OOH	Deprivation	Yes	Deprivation	Yes
	Gender	Yes	Gender	No
	Age	Yes	Age	Yes
NHS 24	Deprivation	Yes	Deprivation	Yes
	Gender	Yes	Gender	Yes
	Age	Yes	Age	Yes
All	Deprivation	Yes	Deprivation	No
	Gender	No	Gender	No
	Age	Yes	Age	Yes

It may be worth exploring the feasibility of tracking the appropriateness of (non-emergency) self-presentations in A&E and/or incidences of harm (such as suicide attempts) that could have been prevented by access to urgent care and if such incidences are more likely among certain equality groups.

Appendix L - Recommendations Gathering Views

Recommendations

This section of the report sets out recommendations based on what participants have told us during the Gathering Views exercise. These recommendations are not ranked in order.
Access to transport and travel

People's ability to access the care and treatment they need through the redesigned urgent care service may be limited if they need to travel to a treatment centre. However, this is not a new issue for people and should have been considered by those delivering services.
Transport and travel to services will remain an issue when delivering health and care services and this underpins the need for good engagement and involvement of people and communities in the design and delivery of services.

With the redesign of urgent care services consideration should be given to additional travel that may be required to access any treatment centres which is more than people would have had to travel if using A&E.

Recommendation NHS Boards to:

- engage and involve people and communities in the design and delivery of redesigned urgent care services to ensure that they mitigate against creating further inequalities to accessing services, and
- consider additional cost and access issues for who may need to travel further to treatment centres, particularly people living in remote and rural areas and develop plans for mitigating against these issues.

Data sharing between organisations

Some people who participated highlighted the need for their personal data to be shared across services to reduce the need for staff to ask the same questions. Many people spoke about their reluctance to use this service. Some people who had experience of using the service highlighted their frustration that outcomes did not fulfil their expectations.

Recommendation

Scottish Government, in partnership with all health and care services to:

- promote data sharing between organisations and services to ensure people receive positive and clear outcomes from accessing the redesign of urgent care pathway through 111.

Define urgent and emergency health care services

It is clear from the findings that people have a limited understanding of the definition of urgent and emergency care, which resulted in confusion around when to access the new service for accessing urgent care.

Recommendation

NHS Boards and Scottish Government to look at how to:

- clarify definitions of urgent and emergency care, and
- liaise with relevant national organisations and community groups, to provide targeted information to support people to understand when to access urgent care, including next steps in the pathway.

Describe the pathway for accessing urgent care through the 111 service

People raised some concerns that derived from them feeling they did not have a full understanding of the pathway and whether this new urgent care service would replace existing services.

People also said they experienced difficulty understanding the automated service and felt the options did not cover their specific need.
Recommendation

NHS 24 and NHS Boards to ensure that people have:

- clarity regarding where they are in their care pathway
- a clear explanation about the next steps in their treatment
- an understanding of the call handler role in terms of knowledge base, and
- an awareness of the timescales involved.

NHS 24, NHS Boards and Scottish Government to:

- explore ways in which the automated processes can be improved, including the offering of translation services.

Equality and Diversity

People said they were not confident their needs would be understood and accommodated when using the urgent care service. In particular, people who participated highlighted the need for translators and for call handlers to explain things slowly and clearly.
Recommendation

NHS Boards and Scottish Government should:

- further explore and understand the process from the perspective of specific protected characteristic groups.
- inform clear guidance on the process in line with NHSScotland Interpreting, Communication Support and Translation National Policy, and

- consider developing guidance with the support of the participants from the Gathering Views exercise.

Public Health Scotland and Scottish Government should:

- monitor potential inequalities in usage of the 111 service to consider whether new or existing barriers should be addressed.

NHS 24 and NHS Boards to:

- offer quick access to interpretation and translation services to those who require this support.

Provide support to people receiving care when accessing urgent care through the 111 service

Many people told us that carer support, both paid and unpaid status, would help them access the urgent care pathway in its entirety. Almost half of those who completed an equality monitoring form termed themselves as an unpaid carer. Although the actual number of unpaid carers living in Scotland is not known, recent polling suggests that number could have since grown to over a million during COVID-19, representing approximately a fifth of the population of Scotland.

People also told us they would find it supportive if they were asked if they required specialist support in the initial call and this support was provided throughout their consultation.
Recommendation

NHS Boards, NHS 24 and Scottish Government to consider:

- the need for people to have carer support with them, if required, throughout the redesign of urgent care pathway, and
- detail prompt questions within the relevant guidance/initial assessment that allows the need for support for the caller to be identified and provided.

Promote person-centred care

Many people reported the positive difference it makes to them when healthcare professionals connect with a compassionate approach.
Recommendation

Scottish Government, in partnership with NHS Boards and NHS 24 to:

- work together to ensure the principles of person-centred care are embedded throughout the urgent care service, for example, consider further training and staff induction opportunities.

Reduce barriers in accessing technology

People told us about barriers they may have in accessing the new service for urgent care as they have no/limited access to broadband services or the knowledge and understanding to use the devices required.

Recommendation Scottish Government to:

- identify ways through the Connecting Scotland initiative to remove challenges about using technology to allow people to access urgent care through 111.

Appendix M - Summary report of progress by Health Boards with the recommendations of the First National Staging Report

Update on Redesign of Urgent Care Programme
NHS Board Chief Executives Private Session - 31st August 2021 (Summary)

3.0 Redesign of Urgent Care

The Redesign of Urgent Care programme has focussed on developing the FNCs across all mainland boards in Scotland to ensure patients appropriately access the right pathway of care for their urgent care needs. As this is a redesign and transformation programme it is expected that the model and the pathways will continually evolve as we learn from the data and patient and staff experience.

As part of the continual improvement approach the Programme Director has visited every FNC and ED department on the mainland seeking to understand the impact and the challenges of delivery from the staff at the frontline. There is a general consensus from the teams, that the FNC model is the right direction of travel for urgent care and has potential to reduce self-presentations to ED.

There have however been several confounding factors which have impacted upon and had the potential to derail the FNC model and the overall RUC work.

- There has been a dramatic change in the pattern of health seeking behaviour by the public which is impacting across the system

- The requirement for boards to staff multiple additional areas/ services along with staff having to isolate etc. has impacted on the available staffing resource to fully staff the FNC in some boards.

- Due to perceived barriers in accessing the healthcare provider they wish to see, patients are contacting NHS 24 111 or are self-presenting to our ED departments which has the potential for them to be 'bounced' around the system with multiple clinical handoffs.

- Without exception every ED has described the challenge of managing the current level of self-presentations which, in their view, a high proportion could have been more appropriately managed within a primary care setting. It is very difficult in the current circumstances for ED teams to initiate redirection of attendees who would be more appropriately managed in primary care when they are being advised by the patient they have been unable to access primary care

- NHS 24 111 are receiving calls from patients who are advising they have been unable to access an appointment at their GP practice, when the nurse advisor disposition is 'advised to contact their GP practice' there is a significant level of discontent expressed. Initially there was a level of patients defaulting inappropriately into the FNC work flow, however through the

feedback system, this was quickly addressed internally by NHS 24 leadership team.

- Current lack of consistent electronic data from board FNCs makes it difficult to contrast and compare across the FNCs and therefore shape the model to maximise its potential. Work continues with all boards and the PHS team to progress this.

- There is an urgent imperative for national public communications focussed on primary care to inform the public that GP practices are open, and explain the options of telephone or face to face appointments.

The above factors have had an impact on the progress of the new urgent care pathway however it is imperative that we remain fully committed to the progress of this model which has the potential to impact significantly by ensuring patients receive the right care by the right person as quickly as possible and thereby help relieve pressure on our ED departments and potentially beyond into the wider system.

4.0 RUC Evaluation

The first internal SG staging review of the RUC, undertaken by Sir Lewis Ritchie and Professor Derek Bell, was published in June. This was based on the learning and data available to date, including from NHS Boards. This was shared with NHS Boards and will inform the Second Staging Report.

The Second Staging Report is due for completion by 30th Sept, covering the period April to September and will offer recommendation for further redesign based on a range of data sources and interactions. The plan is to present the work, as far as possible, in line with the patient journey.

The data sources are:

- Implementation updates from NHS Boards, including progress against recommendations from the First Staging Report
- Stakeholder and staff experience – 12 focus groups being held during August and early September 2021
- Patient experience; Patient focus group (HIS), NHS Board data and HIS Gathering Views Report
- Equity review (PHS) focused on hard to reach groups
- Patient pathway review work being piloted in GG&C
- Public messaging
- Management information derived from PHS data source

9 of the planned 12 focus groups have been held to date with over 100 stakeholders including representatives from all territorial boards, NHS 24 and SAS, including front line staff, operational and programme leads and senior leaders/execs. Focus groups for exec leads and PC are scheduled for Tuesday 31st August.

Analysis of the feedback from the groups has been commenced however the findings require to be validated. The focus group for the professional bodies is scheduled for 10th September.

Initial findings will be considered over the next week to understand what further work/deep dives may be needed.

The Evaluation Advisory Group has a key role in the initial validation of findings and we plan to present the draft findings to this group on by the end of September.
A further external evaluation will be commissioned in the Autumn which will augment the two Staging Reports by focussing on a specific set of research questions with final report out by end March 2022.

The research is required to understand the impact on staff experience; patient and public experience; cost benefits and to better understand the whole system response and what additional data is required. In preparation, Chief Executives have been asked to ensure work is underway locally to assess patient and staff experience and ensure appropriate processes are in place which will allow the external team to develop a cost benefit analysis.

The second stage evaluation report on the RUC programme will help inform the model as we continue to move forward ensuring we are delivering a service that is fit for the future and results in better outcomes of care and experience for our patients and our staff.

5.0 Flow Navigation Centre (FNC) Model – current

The FNC model launched across all mainland boards on the 1st December 2020 based on the 'de minimus' requirements (appendix 1) with boards progressing towards the additional requirements detailed by 31st March 2021.
In essence these requirements can be described in 4 core elements:

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

Each FNC has been visited on two occasions by the Programme Director since launch to support teams and encourage progress towards the agreed model, based on the 4 core elements above with the latest visits having taken place over August and into early September 2021.

The picture across Scotland is not unexpectedly one of variation in the delivery of the model. It is clear that the FNC model has evolved to meet local circumstances such as location of FNC; utilisation of pre-existing facilities; levels of demand; staffing resource and ability to recruit locally.

Table 1 describes the variation in the models of FNC being delivered across all boards as of 31st August 2021 based on the 4 core components. There are many reasons for the variation however the overriding factor is availability of staffing resource.

Whilst at this stage it is not possible to conclude if there is a 'best' model for delivery, the second stage evaluation will inform the position, alongside with further analysis of the data will help determine the next iteration of the model.

The key headlines are: -

- all boards have an FNC in place that can receive calls from NHS 24 over the 24/7 period, staffed 24/7 with call handlers.
- Grampian and Tayside have the only FNCs which are ED consultant led 24/7
- Across other boards SCDMs are predominately ANPs in hours with access to ED or GP support if require
- Scheduling is predominately used for Minor injuries
- Activity in the out of hours' period in 7 of the 10 FNCs continues to be managed by ANP/GP/ED consultant with the remaining boards defaulting to call handling and directing into ED

Table 1 – Summary of FNC model across Scotland

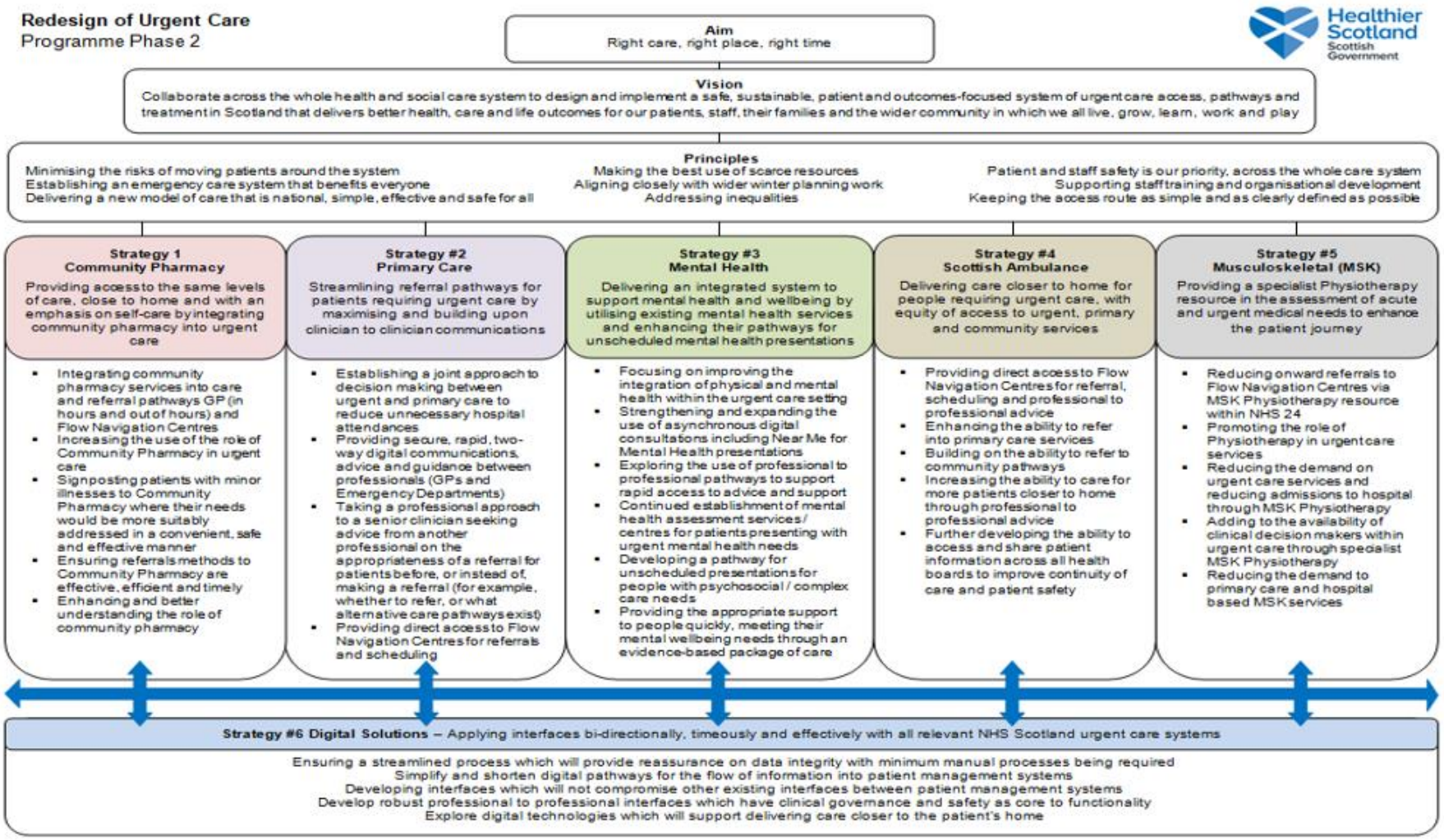
FNC Core Model signed off 31st March 2021	FNC 24/7	SCDM available for FNC 24/7 (may be virtual)	Using Near Me for virtual consultations	Scheduled appointments to ED/ MIU
NHS Ayrshire & Arran	Y	24/7 Urgent Care clinicians (ANP/GP)	Low/variable	Minor injuries and ED
NHS Borders	Y	24/7 ANP, GP / OOH ED consultant	Low/variable	Minor injuries only
NHS Dumfries & Galloway	Y	No clinician in FNC ED consultant virtual only	No	Scheduling into ED
NHS Fife	Y	24/7 ANP OOH by GP or ED	Increasing / variable	Minor injuries only
NHS Forth Valley	Y	0800-2000 ANP OOH by ED consultant	High	Minor injuries / limited scheduling to ED
NHS Grampian	Y	24/7 0800- 0000 ED OOH by ED consultant	Good/ variable	Minor injuries and ED
NHS Greater Glasgow & Clyde	Y	1000 -2200 ANP, GP, ED OOH by ED consultant	Good / Increasing	Minor injuries and ED (in OOH)
NHS Highland & Islands	Y	0800- 0000 GP, REP's EP's OOH by GP	Very Low	Inverness MIU only at present
NHS Lanarkshire	Y	0815 – 2015 Band 5 – 7 RN's Medical clinical shifts offered 1200 -1600 or 1600 - 2000 OOH by ED consultant	Very low	Minor injuries only
NHS Lothian	Y	24/7 clinical nurse advisor 0800-0000 GP (also covers COVID) OOH ED consultant	Good / Minor injury only	Minor injuries / limited scheduling to ED
NHS Tayside	Y	24/7 0800 -2200 / OOH ED consultant	Low/variable	Minor injuries and ED

Healthier Scotland
Scottish Government

Appendix 1

Flow Navigation Centres – Minimum Requirements v2.00		
Minimum Requirements 1st December 2020	**Minimum Requirements by 31st March 2021**	**Desirable Requirements**
• Staffed by multidisciplinary team with senior clinical decision maker available 24/7 (may be virtual). • Technically able to receive electronic transfer of patient details from NHS 24 & acknowledge receipt of the referral. • Administrative/Call Handling support 24/7. • Ability to carry out telephone consultations (training and equipment). • Ability to carry out video consultation (training and equipment). • Ability to accept referrals from primary care. • Standardised referral process from HCP including patient observations. • National guidance on timeframes for call back to patients/clinicians. • Ability to provide a range of professional to professional advice and onward referral where required. • Ability to capture consultation electronically in patient record following on from that sent from NHS 24 and close if ending in self-care. • Visibility of appointment times/slots for ED/MIU. • Technically able to book appointments for patients and advise them. • Technically able to transfer patient record to receiving department / clinic. • Technically able to send patient record to primary care by 0800 next working day. • Process for managing calls if the standard for call back is not met. • Process for patient's/clinicians to call back to update or if their condition changes. • Technically able to capture process measures data within unscheduled care linked data. • Same outcome for patient regardless of how they access care.	• Staffed by whole system multidisciplinary team with senior clinical decision maker available 24/7 (may be virtual). • Ability to accept referrals from primary care services, Scottish Ambulance Service and other community healthcare professionals. • Ability to provide an extended range of professional to professional advice and onward referral where required. • Directory of services with availability of primary care services, community services and secondary care. • Visibility of appointment times / slots for ED/MIU/AAU/SDEC or Ambulatory Care. • Technically able to pass requests for transport to the appropriate provider (HB provider/SAS),	• Ability to record telephone consultations.

Appendix N - Overview of RUC Phase 2



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The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80201-337-5 (web only)

Published by The Scottish Government, December 2021

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS934426 (12/21)