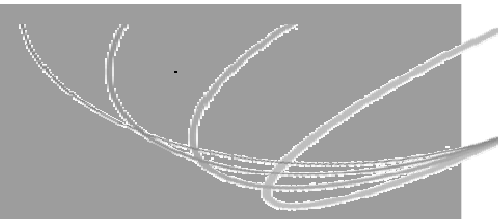
NHS 24

Report to the Board on the 2004/5 Audit

August 2005



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- providing an independent opinion on whether the annual financial statements of public sector bodies have been prepared in accordance with statutory requirements

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Executive summary

• Introduction

In 2004/5 we looked at the key business risks around sustaining health services and information management. We audited the financial statements and we looked at aspects of performance management and governance. This report sets out our key findings.

• Sustainable Health Services

Service delivery model: NHS 24 has experienced problems with its delivery model since its inception. To try and remedy this, the then new Chief Executive introduced a transformation programme in February 2005. This programme was subsequently updated to take on board the interim findings of the Review Group led by Owen Clarke. NHS 24 is clearly committed to making the organisation a success and is setting up four mini-centres to support the existing three contact centres. We are concerned that there was not a thorough option appraisal and a full business case does not exist for the new service delivery model.

Call management: When NHS 24 was set up, the use of call-back was intended to be on an exception basis, but at 31 March 2005 it was used in over 50% of call activity. The length of time taken to return patient calls has also increased significantly. Largely as a result of the increase in the population served, the average time to return a call is currently 49 minutes compared with 8 minutes when the service was set up for the Grampian Region in May 2002.

One of the reasons for this deteriorating performance is the increase in call activity. Calls in the month of March 2005 reached 149,000 compared with 61,000 in March 2004. NHS 24 is taking action to address the situation and call centre technology offers some potential solutions.

Staffing: It has been difficult to recruit nurse advisers to manage peak period and out-of-hours call activity. The service has a shortage of 100 nurse advisors (i.e. 25% of the current establishment) and the new service delivery model seeks to address this by extending the catchment area for recruitment.

• Information Management

Business continuity arrangements and an IT security policy are not yet in place at NHS 24. These are critical weaknesses given the reliance of the service on information technology.

• Financial Statements

We have given an unqualified audit opinion on the financial statements of NHS 24 for 2004/5.

In 2004/5, NHS 24 returned £3.0m of revenue resources to the Scottish Executive Health Department (SEHD). However, the revised revenue resource limit of £46.8m was underspent by more than 10% (£5m). The underspend was mainly due to difficulties in recruiting front line staff.

During the year, NHS 24 also returned £1m of capital resources to the SEHD but spent only half of the revised capital allocation of £1.5m. The underspend was due to slippage on IT projects, and these are planned for completion in 2005.

• Performance Management

Performance monitoring: the Board receives a lot of performance information, but it needs to be updated to take account of service expansion and changes in service delivery.

Partnership Working: agreements and operating protocols for data sharing with partner organisations need to be made more robust.

Use of Management Consultants: Since December 2000, NHS 24 has paid over £15 million for management consultancy services. At the request of the organisation, we have carried out a review of the use of consultancy services and this will be reported shortly, giving recommendations for the future management of these services.

• Corporate Governance

Risk management: needs to be developed to take account of growth and service delivery changes within NHS 24. Corporate and strategic risks need to be more closely aligned to ensure there is a direct link between the two risk areas. Consequently, risk management is not fully embedded throughout the organisation from strategic to local levels.

Changes in leadership: during the year the board membership/executive directorships have changed considerably and the turnover of key posts has been high. This has added to the pressures faced by NHS 24 during this critical period of development.

• Staff Governance

Staff governance arrangements continued to develop during 2004/5. The Board successfully completed the self assessment audit tool and we concluded that a robust process had been followed. Considerable progress was made during the year and good quality information was available to support the process.

• Looking Forward

NHS 24 face significant challenges in 2005/6, including:

- recruiting sufficient nurse advisers;
- implementing the new service delivery model and improving performance, particularly of call management;
- achieving financial balance during a period of service growth;
- implementing the recommendations of the Clarke review;
- addressing the challenges of the Kerr report to be a key player in the provision of unscheduled care; and
- managing public expectations and maintaining public confidence in the service.

We will review these areas and the arrangements put in place by management to address them in the course of the 2005/6 audit.

Audit Scotland
August 2005

Introduction

1.1 This report summarises the outcomes from our 2004/5 audit of NHS 24. The scope of the audit was set out in our Audit Planning Framework, which was submitted to the Healthcare Governance Committee on 3 March 2005. The plan set out our views on key business risks facing NHS 24 and described the work we planned to carry out on financial statements, performance and governance.

1.2 We have issued a range of reports this year, and we briefly touch on some of the issues we raised in this report. Each report set out our findings and recommendations and NHS 24's agreed response. Appendix A of this report sets out the key risks highlighted in this report and the action planned by management to address them.

1.3 This is the fourth year of a five year audit appointment. We would like to take this opportunity to express our appreciation for the assistance and co-operation provided by officers and members of NHS 24 during the course of our audit work.

Business Risks

2.1 In our audit plan, we identified two main areas of risk for NHS 24. We also described longer term planning issues which will impact on NHS 24 and our audit in the future. In this section, we describe the risks and our views on their current status. We also comment on longer term planning issues.

Sustainable Health Services

2.2 In our plan we highlighted risks relating to NHS 24's ability to provide an appropriate, safe, sustainable service in an environment of rapidly changing clinical demands. Major factors combining to increase these risks were:

- the increased demand for the service during out of hours periods, over envisaged levels, which was further impacted by GPs' discontinuation of weekend consultations;
- the continuing difficulties NHS 24 faces in recruiting and retaining sufficient numbers of nurse advisors to cope with peaks of demand for the service; and
- the use of call-back arrangements to manage patient demand.

2.3 A transformation programme for service improvement was established by NHS 24 in February 2005 to address issues of service provision. The programme identified four separate workstreams:

- service design —review of call management to better reflect patients' needs;
- dispersed model —collaboration with NHS boards to provide a more locally integrated service for the public;
- workforce planning —issues affecting recruitment, retention and development of staff; and
- operational implementation —implementation of improvements flowing from the other three workstreams.

2.4 In addition, on 24 February 2005, against a background of increasing public concern and media criticism, the Minister for Health & Community Care announced an independent review of NHS 24 chaired by Owen Clarke CBE. The review team's remit was to report and recommend corrective action in relation to :

- improving responsiveness of NHS 24 to callers and waiting times for service users;
- reducing the use of 'call-back';
- improving services for patients in remote and rural areas;
- providing seamless and effective handover of patients as they move between NHS 24 and its NHS partners; and
- staff and staffing issues.

2.5 An interim report was presented by the review team in June and a final report will be delivered to Ministers by 30 September, 2005. The interim report makes twelve recommendations, five of which require action by SEHD or NHS boards, and acknowledges that progress has already been made by NHS 24 under the recently established transformation programme.

Service Delivery Model

2.6 The original blueprint for NHS 24 stated that three main contact centres should be created to provide a 24 hour health advice and information service to the population of Scotland. The contact centres were to be located in the north, west and east of Scotland with full roll-out of services to take place by December 2004. NHS 24 followed this blueprint but this model did not allow them to meet service demand when the service was fully rolled out across Scotland in December 2004. Again this was impacted by GPs' withdrawal of Saturday surgeries under the new GMS contract.

2.7 As part of the transformation programme the Board has decided to create four "mini-centres". These will be located across Scotland to develop local services and encourage partnership working with other NHS Boards. Since NHS Boards are responsible for providing out of hours care within their own area, it is essential that strong partnership arrangements are formed between boards and NHS 24 to provide an integrated 24 hour service.

2.8 There is a risk that the mini-centres will not achieve the required service improvements. A full option appraisal and business case has not been developed to support the decision to create mini sites and expand service locations across Scotland. Therefore as the mini-centres are developed, it is important that NHS 24 measures the improvements in service delivery as each mini-centre is completed prior to starting future developments. We are aware that NHS 24 recognises this risk but view the need for a rapid implementation of the new model prior to the period of high winter demand, as being of key significance. **(Action Point 1)**

Out of hours impact

2.9 The Board recognises that the level and nature of service to be provided is far more onerous than originally planned, with a large shift in demand to out of hours, especially weekends. Approximately 90% of NHS 24 activity takes place out of hours (compared with 60% anticipated in the original Blueprint). This changed scenario has had an adverse effect on call-back periods and on the number of call abandonments. A new system has been introduced to increase efficiency and effectiveness, and a new capacity management programme is proving to be successful.

2.10 With the service now being provided throughout Scotland, and with new GP contracts in place, the Board took measures to alleviate the strain expected on the service over the festive period. New partnership arrangements were formed with NHS Boards, GPs and pharmacists to assist in meeting the anticipated high demand. However, over the festive period callers experienced problems both in accessing the service, and in the length of time for call-back.

2.11 It is essential that resources are in place during peak activity to manage the demand, namely weekends and holiday periods. There are currently over 300 shift patterns at NHS 24 but they do not provide sufficient cover for peak periods. In fact, there are more staff resources outwith the peak periods. **(Action Point 2)**

Frontline Staff – A Key Challenge

2.12 NHS 24 has been unable to recruit sufficient nurse advisors to cope with service demand. Out of an establishment of 400 nurse advisors, one in four are vacant. These 100 vacancies create a risk that service delivery and clinical safety will be compromised. NHS 24 is trying to address this risk through recruitment campaigns and by creating geographically spread mini centres.

Call Related Issues

2.13 Despite management action taken earlier in the year to cope with the increased demand for the service, and despite the specific measures taken to meet weekend and seasonal peaks, the service has struggled to deal with demand. Call activity increased significantly in-year, due to the full roll-out of the service, with calls in the month of March 2005 reaching 149,000 compared with 61,000 in March 2004. NHS 24 now handles in excess of 30,000 calls per week.

2.14 Call-back activity has also increased with the percentage of calls handled via call-back reaching 52% compared with 2% in March 2004. In addition, the length of time taken to return patient calls has also increased significantly with the average time taken reaching 49 minutes compared with 8 minutes when the service was set up for Grampian Region in May 2002.

2.15 When NHS 24 was originally set up, call-back was to be on an exception basis. However, it is now utilised routinely with more than 50% of calls being managed in this way. The use of call-back has attracted extensive media criticism and contributed to a reduction in public confidence in the service. A call-back group was established in July 2005 to review the risks surrounding the use of call-back. The group is made up of non-executive directors from NHS 24, a nursing and medical director from other Boards, a risk management specialist, and management consultants. A representative from Audit Scotland observes proceedings at the group meetings. The group will report its findings to the Board by the end of August 2005.

2.16 A new system ("model office") has been developed to address and improve the effectiveness of call management processes. This includes efficiencies in talk and wrap up times which have both decreased over the past few months. Another aspect of call management that has been subject to review is the use of algorithms in determining outcomes for patients. Usage of algorithms decreased in the last quarter of the year and targets were not achieved. The decreasing usage of algorithms by staff may reduce call times but this could conflict with the need to comply with clinical care pathways. **(Action point 3)**

Managing Expectations

2.17 Service demand has increased significantly during the development and full roll out phase. NHS 24 have taken steps to manage patient expectations and service demand through various initiatives such as communicating through the media "when should you call NHS 24?" giving advice on when it is appropriate to contact NHS 24. Further action is planned in this area.

Information Management

2.18 On occasions in 2004/5, NHS 24 was subject to service failures because of hardware or telephony problems. NHS 24 lost the ability, in October 2004, to transfer capacity between call centres and callers to the service were unable to obtain a response. Incidents such as these highlight the critical nature of business continuity planning arrangements within NHS 24.

2.19 Satisfactory business continuity arrangements are still being developed at NHS 24. In addition, comprehensive IT security is not yet in place and IT asset registers are still being compiled. Work on developing the three strands of business continuity, information security and physical security of IT equipment has progressed:

- An overall business continuity strategy and supporting detailed business continuity plans are still being developed, although it is acknowledged that robust data recovery and disaster planning systems are already in place.

- A security policy statement was approved by the Board in December, 2004 setting out high level requirements for information security. An information security management system is still under development, to provide the policies procedures and technical systems necessary to safeguard NHS 24's information systems.

- Work on physical verification of IT equipment was expected to be completed by 30 June, 2005. Asset management software is currently being tested, which will enable IT hardware to be identified and logged without the need for physical inspection.

2.20 Procurement of a new strategic frontline application is being investigated because the latest IT Strategy identifies weaknesses in the functionality of the present patient relationship management system. Changes to the current application are needed to allow higher levels of clinical safety, efficiencies in service delivery and potential savings in development, licensing and support costs. As with the replacement of any key system it would be worth reviewing the purchase of the original system to ensure that any lessons can be learned for the acquisition of any replacement. **(Action Point 4)**

2.21 During 2004/5 and in prior years both internal and external audit reports made a number of recommendations in relation to IT issues. Agreed audit action dates have slipped significantly. Non executive directors have expressed concern and challenged the lack of progress in completing audit actions relating to IT. New audit action dates have now been agreed with progress being reported to the Board on a regular basis. IT and telephony issues remain a high risk area for NHS 24. **(Action Point 5)**

Longer Term Planning Issues

The following longer term planning issues will have an impact on NHS 24 in future years:

Shared Support Services

2.22 The national shared support services project covers the transactional elements of finance, procurement, payroll services, internal audit and practitioner services payments. The shared services are to be organised on a 'hub and spoke basis' with two hubs (payroll and finance & procurement functions) and twelve spokes (dealing with ordering, accounts receivable and practitioner payments). The project is expected to contribute recurring savings of £10 million per annum to the Efficient Government Initiative.

2.23 It is not anticipated this will directly impact NHS 24 staff, however, discussions have taken place between NHS 24 staff and the provider of its shared services (National Services Scotland —NSS) about the financial coding structures. This is an area of concern as existing coding structures will need to be revised to manage the specialised services within NHS 24.

David Kerr Report

2.24 The Kerr Report *'Building a better health service fit for the future'* outlines the changes required in the NHS. The report highlights the need to manage unscheduled care and the important role that NHS 24 will play in the delivery of NHSScotland unscheduled care system. Recognition is also given to the need for NHS 24 to develop a more localised approach to contribute to the future of the NHS.

Financial Statements

Our Responsibilities

3.1 We audit the financial statements and give an opinion on:

- whether they give a true and fair view of the financial position of our clients and its expenditure and income for the period in question;
- whether they have been prepared properly in accordance with relevant legislation, applicable accounting standards and other reporting requirements; and
- the regularity of the expenditure and receipts.

3.2 We also review the statement on internal control by:

- considering the adequacy of the process put in place by the Chief Executive as Accountable Officer to obtain assurances on the overall system of internal control; and
- assessing whether disclosures in the statement are consistent with our knowledge of the organisation.

Overall Conclusion

3.3 We have given an unqualified opinion on the financial statements of NHS 24 for 2004/5.

NHS 24's Financial Position

3.4 NHS 24 is required to work within the resource limits and cash requirement set by the Scottish Executive Health Department. NHS 24's performance against these targets is shown below.

Table 1
2004/5 Financial Targets Performance £ million

Financial Target	Target	Actual	Variance
Revenue Resource Limit	£46.788	£41.800	£4.988
Capital Resource Limit	£1.468	£0.759	£0.709
Cash Requirement	£41.505	£41.505	-

3.5 The use of the RRL is not a reliable measure of NHS 24's performance on financial management as it is not fixed for the financial year. Up until as late as February 2005, there were a number of changes to NHS 24's RRL notified by the SEHD which, taken together, reduced the agreed allocation by £3.0m to £46.788m.

3.6 The total underspend against the original revenue budget was approximately £8.0m, resulting principally from delays in recruitment of frontline staff. Staff salaries alone were underspent by £6.3m, and other costs which are dependent on staffing were significantly underspent as a consequence. These underspends were offset by expenditure on new projects, e.g. NHS 24 Online, Model Office and Agenda for Change which were not provided for in the original budget.

3.7 Agreement has been received from SEHD for the £4.988m underspend against the final RRL position to be carried forward into 2005/6. The initial allocation of RRL for 2005/6 is £51.430m, including the agreed carry forward. NHS 24 management has expressed concern at the underlying reduction in baseline recurring costs reflected in the proposed allocation, and is engaged in discussions with SEHD over required levels of funding for the future. As the new service delivery model develops, it is important that financial resources are matched to service growth. **(Action point 6)**

3.8 The original allocation for capital expenditure was £2.468m. Capital expenditure requirements were revised downward by £1m during the year. Actual capital expenditure for the year fell short of this revised CRL by £709k due to slippage in IT projects. This shortfall in expenditure will now be incurred in 2005/6, and will be carried forward as part of the 2005/6 capital budget. As already mentioned, IT is critical to the delivery of NHS 24's services and slippage on this important area should be minimised.

Statement on Internal Control

3.9 The statement on internal control provided by the Accountable Officer reflected the main findings from both external and internal audit work, the independent review ordered by the Minister and NHS Quality Improvement Scotland's Review of healthcare governance. The statement refers to areas of internal control that need to be strengthened or developed further including:

- the integrated risk management strategy is to be developed combining quality, clinical governance and risk management. The risk management policy and procedures will be developed from the integrated strategy during 2005/6;

- the information management and technology security policy and business continuity plans are to be finalised during 2005; and

- the development of key performance indicators in the revised balanced scorecard.

Performance Management

4.1 This year we focussed on three main areas:

- use of management consultants;
- performance management information; and
- systems for information sharing with partner organisations, such as the Scottish Ambulance Service and social services departments within local authorities.

4.2 Accountable officers have a duty to ensure arrangements are in place to secure Best Value. Draft guidance issued in August 2003 provided accountable officers with a framework to develop Best Value, although allowed them discretion to adopt an alternative approach. The guidance has not been implemented by NHS 24 and there has been limited development of an alternative local framework. (**Action point 7)**

Use of Management Consultants

4.3 Since December 2000, NHS 24 has paid in excess of £15m for management consultancy services. These services were mainly used in drafting, developing and delivering the original service design blueprint, and subsequently in ongoing programme and technical support. At the request of management we carried out a review of the procurement and subsequent management of these services and will report our findings shortly, with recommendations for the future management of this area..

4.4 In agreement with NHS 24, we are now extending our review to cover a wider range of contractors.

Performance Management Information

4.5 On a monthly basis the Board receives detailed performance information including call activity, patient talk time, call-back activity and algorithm usage. NHS 24 has recognised that the current performance indicators in the balanced scorecard are in need of update to take account of service expansion and changes in service delivery.

4.6 Also, management information reports presented to the Board on operational performance have contained a number of errors. It is essential that these reports are compiled accurately to ensure decisions taken are based on reliable data. The Board has requested that the information supplied to inform board reports is checked in detail prior to submission.

Information Sharing with Partner Organisations

4.7 Our initial risk assessment discussions with senior management highlighted some specific issues relating to NHS 24's lack of access to critical information held by other agencies. It became clear, on further discussion, that a broader review was justified, which would also consider partner agencies' effective access and use of information held by NHS 24.

4.8 Completion of this work requires linkage with a number of other NHS bodies, and we will report on its results by end September 2005.

Corporate Governance

Introduction

5.1 This section sets out our main findings arising from our review of your governance as it relates to:

- clinical governance;
- corporate governance (including financial aspects); and
- staff governance.

Clinical Governance

5.2 The Clinical Governance Annual Report from Quality Improvement Scotland (QIS) was presented to and approved by the Board on 27 July 2005. QIS noted in their report that NHS 24 has a clinical governance strategy in place, however, there were a number of principles within the strategy that were still to be implemented. QIS also made reference to NHS 24 having separate strategies in place to manage risk, clinical governance and quality. NHS 24 is in the process of aligning these strategies but clinical governance has still to be embedded throughout the service.

5.3 In terms of clinical effectiveness, QIS viewed NHS 24's ability to measure clinical effectiveness electronically for call length and wrap time review as a major strength to the service. QIS also noted the significant challenge to the service was in relation to recruiting and retaining staff to provide a clinically effective service.

Corporate Governance

5.4 Our work on corporate governance focused on systems of internal control; prevention and detection of fraud and irregularity; standards of conduct and NHS 24's financial position. (We have already commented on the financial position at paragraphs 3.4 to 3.8.)

5.5 We relied on the work of Internal Audit to give us assurance in these areas and we also looked at two specific areas of risk (payroll and Agenda for Change) to ascertain what governance arrangements are in place to manage them. We found that governance in these areas was well developed. We will monitor the outcome of Agenda for Change in 2005/6 and the impact it has on NHS 24's financial position.

Committee Structures

5.6 The Healthcare Governance Committee has a combined remit of both audit and clinical governance and meets on a quarterly basis. It has been recognised that the current Committee structure is cumbersome and NHS 24 has now decided to split its roles.

Board membership

5.7 There has been a significant number of changes in Board membership and executive directorships with the departure of the Chairman, Director of Operations and Development, Director of Communications, Director of Human Resources and a non-executive director. A new Chief Executive was appointed in February 2005. An Interim Chairman was appointed in June 2005 and the position will be advertised shortly for permanent appointment. All of

the key executive posts have now been filled with the exception of the Director of Communications which is being covered in the interim by a temporary senior appointment. An additional non-executive director was also appointed during the year.

5.8 The Independent Review interim report highlighted that no-one within SEHD has been assigned a "programme manager" role to act as a facilitator between SEHD, Health Boards and NHS 24 to ensure the complex project was proceeding as planned. It is clearly important that NHS 24 has regular contact with the SEHD to ensure that they are kept informed of service issues and developments to enable them to provide guidance and support to NHS 24.

5.9 In our view, lack of stability in leadership during the year put pressure on the organisation during a critical development period. This was exacerbated by the lack of an SEHD programme manager. Increased stability and support from SEHD will help the Board implement the transformation programme.

Risk management

5.10 The SEHD, in its Accountability Review of NHS 24 in September 2004, noted that the "key building blocks" were in place with regard to risk management, i.e. risk management indicators, risk register, risk management co-ordinator and training in risk recognition.

5.11 In June 2005, NHS Quality Improvement Scotland reported, in its clinical governance review that "Strategic development and operational delegation of risk management… is only partly reflected in organisational frameworks and arrangements for implementation and feedback". QIS found that, while the processes for recognition and assessment of risk were well developed, risk management has to become fully devolved across the organisation, and responsiveness in managing the risks has to be made more robust.

5.12 In our view, the emphasis in NHS 24's risk processes focussed more on the risk to the roll-out timetable rather than to the quality of ultimate service delivery. **(Action point 8)**

Staff Governance

5.13 NHS 24 completed a self assessment audit and a staff survey to assess their effectiveness in staff governance. The self-assessment process was carried out in partnership with significant staff involvement. The resulting action plan was approved by the Partnership Forum and Executive Management Team, and so has agreement and support across the organisation. This work is part of an ongoing NHS Scotland initiative designed to recognise the value and importance of staff in service delivery and generally improve staff relations in the NHS.

5.14 In our view, the revised action plan on staff governance is credible and demonstrates organisational commitment to the achievement of high standards in this area.

Looking Ahead

6.1 NHS 24 faces significant challenges in 2005/6 which include:

- Recruitment of sufficient nurse advisors to cope with peaks of demand for the service will be key to delivering sustainable health care services in 2005/6. Approximately 25 % of the nurse advisor establishment remains vacant. It is hoped, however, that with the creation of mini-centres NHS 24 will be able to recruit additional staff as a result of the greater geographical spread.

- Success of the new service delivery model which includes significant change in current service delivery. There are plans to create four mini-centres to provide more localised services. A full option appraisal and business case was not developed to support this decision and it is therefore important that the success of each centre is measured post implementation.

- Implementing recommendations included in the Interim Review and driving forward the transformation programme.

- Reviewing and improving current call management practices to improve efficiency and effectiveness of service. This will also include assessing the use of call-back arrangements to take account of both clinical safety and cost.

- Addressing the challenges of the Kerr Report to be a key player in the provision of unscheduled care.

- Maintaining public confidence in service provision against recent media criticism and performance failures.

- Achieving financial balance during service growth and development. It is essential that service growth keeps pace with the financial resources available.

These areas, and the controls put in place by management to address the issues, will be subject to audit review during 2005/6.

Action plan

Appendix A

No.	Issue, risk & recommendation	Responsible officer	Response & agreed action	Action date
1	As mini-centres are developed, it is important that NHS 24 is focussed on measuring the improvements in service delivery as each site is completed prior to commencement of future developments. A full business case has not been developed to support the decision to create mini-centres and expand service locations across Scotland. There is a risk that the mini-centres will not achieve the required service improvements.	John MCGuigan, Chief Executive	The feasibility of creating the mini-centres, as recommended in the Independent Review Group's Interim Report from Owen Clarke, is being developed and implemented through the Transformation Programme. That has a number of staff allocated to it and progress is co-ordinated and reviewed on a daily/ weekly basis. Mini-centres will be in areas where staff may be recruited and that will assist access and remote and rural issues to be resolved. It is currently planned to have at least three mini-centres operational by the festive period 2005/06.	30th November 2005 —for festive period
2	Over the festive period callers experienced problems both in accessing the service, and in the length of time for call-back. Service demand is high particularly at weekends and holiday periods. There are currently over 300 shift patterns at NHS 24, it is essential that resources are in place during peak activity to manage the demand. There is currently a risk that staff are not in place during peak periods to meet service demand.	Jim Smith, Director of Operations (with assistance from the Partnership Forum, the Director of HR and the Employee Director)	The revision to shift patterns is a major workstream in the Transformation Programme. A replacement for the existing workforce planning software (Qmax) is in the final stages of procurement. It is important to note that it is not necessarily the numbers of shifts which may cause issues —it is the alignment of the shifts to the call demand profiles which impacts on the ability of the service to respond to the callers' needs.	31st March 2006 - for full revised and reviewed action to have been taken.

No.	Issue, risk & recommendation	Responsible officer	Response & agreed action	Action date
3	A system called "model office" was developed to address and improve the effectiveness of call management processes. This includes efficiencies in talk and wrap up times which have both decreased over the past few months. Another aspect of call management that has been subject to review is the use of algorithms in determining outcomes for patients. Usage of algorithms has decreased in the last quarter of the year with targets set not being achieved. The decreasing usage of algorithms by staff may reduce call times. However compliance with clinical care pathways and requirements is also important in meeting service targets.	Dr Brian Robson, Medical Director	Model Office was a quality improvement programme aimed at improvements in service, both in quality (e.g. referral patterns, algorithm usage) and efficiency (e.g. call times, wrap times, etc.). Regular reporting demonstrated significant gains in both efficiency and effectiveness. Staff are encouraged to maximise possible algorithm usage - evidence from earlier work has noted that usage is associated with shorter and more structured calls. Action being taken through the Transformation Programme will establish new standards for algorithm usage in the re-designed call flows.	31st December 2005
4	Procurement of a new strategic frontline application is being investigated because the latest IT Strategy identified weaknesses in the functionality of the present patient relationship management system. Changes to the current application are needed to allow higher levels of clinical safety, efficiencies in service delivery and potential savings in development, licensing and support costs. A review should be carried out of the procurement of the current system to ensure any lessons can be learned.	Dr Chris Stewart, Director of Development	The potential procurement of an alternative to the current PRM software was discussed and partly investigated during 2005 and early2006. That work is presently "on hold", pending the necessary work required through the Transformation Programme. It is planned to re-activate the proposal in 2006 for potential installation during 2007/08. The use of the current PRM system by NHS 24 from the outset was directed by the SEHD based on the procurement for NHS Direct in England in the late 1990s - NHS 24 has a side contract to the initial one between NHS Direct and CAS Services Ltd (the supplier).	For further consideration during 2006

No.	Issue, risk & recommendation	Responsible officer	Response & agreed action	Action date
5	Satisfactory business continuity arrangements are still being developed at NHS 24. In addition comprehensive IT security is not yet in place, and IT asset registers are still being compiled. Because of NHS 24's reliance on IT systems, these risks should be addressed urgently.	Dr Graham Dixon, Director of IT	The Internal Audit Reports in 2004 recommended work in this area and that is being progressed, with urgency, in line with recent presentations and discussions with the Healthcare Governance Committee and the Board by Dr Dixon.	Plan of work in place across NHS 24 through to 31st Mar. '06
6	Agreement has been received from SEHD for the £4.988m underspend against the final RRL position to be carried forward into 2005/6. The initial allocation of RRL for 2005/6 is £51.430m, including the agreed carry forward. NHS 24 management have expressed concern at the underlying reduction in baseline recurring costs reflected in the proposed allocation, and are engaged in discussions with SEHD over required levels of funding for the future. As the new service delivery model develops and it is important that financial resources are matched to service growth.	Bill Templeton, Director of Corporate Services	Discussions on issues relating to re-establishing the recurring revenue cost baseline for 2006/07 onwards are continuing with the SEHD. Financial projections of the current NHS 24 profile have been completed. Progress on finalisation and further discussions has been delayed due to the consideration required for the longer-term planning of the future shape of the provision of the NHS 24 service and the impacts and consequences of the Reports from the Independent Review Group (Clarke).	31st October 2005 - for agreement on the RRL funding for 2006/07
7	Accountable officers have a duty to ensure arrangements are in place to secure Best Value. Draft guidance issued in August 2003 provided accountable officers with a framework to develop Best Value, although allowed them discretion to adopt an alternative approach. The guidance has not been implemented by NHS 24 and there has been limited development of an alternative local framework.	John McGuigan, Chief Executive	During the build and roll-out phases, NHS 24 tried to ensure the principles of "best value" were observed. The guidance will be reviewed to determine where action can be taken to comply more fully with the recommended approach.	31st March 2006 - progress report

No.	Issue, risk & recommendation	Responsible officer	Response & agreed action	Action date
8	In our view the emphasis in NHS 24's risk processes focussed more on the risk to the roll-out timetable rather than to the quality of ultimate service delivery. Risk management needs to be fully embedded within the organisation at all levels.	John McGuigan, Chief Executive	In building the infrastructure and the relationships with NHS Boards, the focus for NHS 24 was primarily on the roll-out of the service. Risk Management is now managed corporately through the Transformation Programme which will ensure all risks are co-ordinated and reported together. The Risk Management Strategy is being revised, new monitoring software has been installed, discussions have been held in the contact centres and this programme of work, along with the adoption of an integrated strategy for risk, clinical governance and quality, will ensure that the principles of risk management reach all staff.	31st December 2005 — significant tangible progress