Redesign Urgent Care
Unscheduled Care Programme

Report from the Short Life Working Group: Review of Paediatric Pathway to Flow Navigation Centres

May 2021

Scottish Government
Riaghaltas na h-Alba
gov.scot

1. Purpose

To consider the optimal pathways of urgent care for individuals aged under 12 years by:

- **considering the evidence** of an optimal pathway of care for paediatrics' urgent care assessment and the safety of this in Flow Navigation Centre context
- advising on the **minimum specification** required and assessing the readiness of the pathways, across NHS 24 and nationally, against this to include paediatrics in referrals to Flow Navigation Centres
- **reviewing data** relating to paediatrics needs, capacity and demand to inform next steps and readiness

2. Background

The Redesign of Urgent Care (RUC) programme seeks to promote significant transformational change in how optimal urgent care can be delivered for the people of Scotland. The RUC included establishing flow navigation centres (FNCs) in each board. Callers to NHS 24 who require emergency department (ED) attendance receive a call back from a Senior Decision Maker (SDM) based in the FNC within four hours, except for life threatening or major trauma presentations where (as currently) an ambulance will be called or the caller directed immediately to ED. All emergency, life threatening or trauma presentations should continue to proceed directly to ED without calling NHS 24.

The FNC was tested in a "pathfinder" carried out in NHS Ayrshire & Arran between 3 and 23 November 2020 helping inform national rollout on 1 December 2020.

The NHS A&A pathfinder included all ages and in this period - 87 under 12 year olds were referred to the FNC, accounting for 17% all FNC referrals. Feedback from staff and from parents was very positive, with parents appreciating the opportunity to speak to a clinician as early as possible. An additional benefit was that the appointment system allowed families to make arrangements for other siblings rather than expose them to a hospital setting unnecessarily.

At the time of the rollout concerns were expressed around the inclusion in the system of infants and children. The majority view at that time was that it was not safe to include unwell <12 year olds (<12s) in the new system at the very outset. Therefore patients <12 years were not included in the rollout to the FNC pathway. Currently NHS 24's outcome is to direct to ED all calls for <12s that could have been eligible for the RUC stream. As pre 1st December, NHS 24 continue to refer <12s to non-ED points of care, e.g. the GP Out of Hours service.

This Short Life Working Group (SLWG) was established to support a pathway review and develop an optimal pathway of care for <12s. The Group reports to the Scottish Government and Strategic Advisory Group on findings and recommendations on when and how to include <12s in referrals to the Flow Navigation Centres. The SLWG is multidisciplinary (see Annexe 1 for group membership) and met four times between 15th December 2020 and 14th January 2021. The SLWG considered

relevant data, the benefits and risks of including <12s in the FNC, discussed issues arising and made recommendations.

3. Data

Data from A&A pathfinder - 3 to 23 Nov 2020

There were 87 <12s referred to the FNC in the NHS Ayrshire & Arran pathfinder November 2020. The median time for the FNC SDM to call the parent/carer was nine minutes. Of these 87, 28 were given an appointment to attend ED, 31 to MIU and 28 given self-care advice.

		< 12s	**12 & Over**	**Total**
1	Total UC calls to NHS 24	225	1059	1284
2	Number of patients sent direct to ED by NHS 24	47	207	254
3	Number of patients sent direct to MIU by NHS 24	4	4	8
4	Number of patients sent on to FNC by NHS 24	87	424	511
5	Number of patients appointed to ED by FNC	28	115	143
6	Number of patients appointed to MIU by FNC	31	193	224
7	Number of patients closed by FNC	28	116	144

NB Figures in above table exclude 999 calls

NHS 24 outcomes for <12s olds across Scotland in November 2020

Comparing NHS 24 outcomes for <12s in NHS A&A pathfinder against the remainder of Scotland during November 2020, the proportions of immediate ED outcomes were 10% and 17% respectively and referrals to out of hours were 27% and 34%. Other outcomes were similar when data from NHS A&A and all other boards were compared.

<12s Contact Records November 2020					
Final Endpoint	**NHS A&A Number**	**NHS A&A %**	**All Other Boards**	**All Other Boards %**	**Result**
ED / MIU	70	9.5	1,174	17.4	**1,244**
Contact GP Practice	35	4.7	319	4.7	**354**
Contact Midwife		0.0	4	0.1	**4**
Contact Optician		0.0	4	0.1	**4**
Dental	39	5.3	406	6.0	**445**
Flow Navigation Centre - MIU 4hrs Flow Hub to arrange	19		0		**19**
Flow Navigation Centre - Speak to Clinician 4hrs	105		0		**105**
GP Telephone Advice	77	10.4	689	10.2	**766**
Home Visit	1	0.1	1	0.0	**2**
Other Professional		0.0	19	0.3	**19**
Pharmacy	22	3.0	272	4.0	**294**
Self-Care	162	21.9	1,373	20.4	**1,535**
GP Out Of Hours	199	26.9	2,291	34.0	**2,490**
Overall Result	**729**	81.8	**6,552**	97.2	**7,281225**

NB Figures in above table exclude 999 calls

Considerations given to the collected data

- The data for November shows that 17% of <12s were managed in NHS A&A via the FNC, which is roughly the same as the % of under 12s seen in ED/MIU and urgent care centre in other boards.
- As to be expected, there is consistency between NHS A&A and other boards on % advised to dial 999, contact GP, dentist, GP telephone advice, pharmacy or self-care.
- The % <12s presenting to ED and referred to GP Out Of Hours was lower in NHS A&A compared to the rest of Scotland
- To note, NHS A&A pathfinder ran over a short period of time (3 to 23 November) and the Board was not under the same level of pressure that is currently being experienced across all Boards due to COVID-19, alongside winter pressures. This is reflected in the relatively low level of cases routed via the Flow Navigation Centre.
- Attendances to ED services in NHS Scotland saw a large drop in March 2020 due to the social distancing measures put in place to respond to COVID-19. In April attendances were at the lowest levels ever recorded.
- Based on monthly published information there was a 27.6% decrease in attendances at core Emergency Department sites in November 2020 (86,193 attendances) compared to November 2019(119,054 attendances).

- NHS 24 data suggests that under 12s account for 10-13% of all 111 demand, however, they account for 25-30% of referrals direct to ED for this pathway and that has been consistent since launch, so there are significant benefits for patients and the system by including FNC as an additional pathway.

Further data from Public Health Scotland on referral/outcome for under <12s attending ED can be found at Annex 3.

Estimate of activity across Scotland

The Chair felt it was helpful to estimate what the numerical impact of including <12s in the FNC would have on an individual board. Based on discussions and examination of the data there are two assumptions for the paediatrics pathway:

1. The current percentage of referrals to ED by NHS 24 would be the same percentage referred instead to FNC, but what would differ is the time of presentation to ED. Important to remember that the small number of NHS 24 calls (emergency or life-threatening situations) would still go direct to ED+/- ambulance

2. Extrapolating the A&A FNC outcomes shows that 32% of referrals were appointed to ED, 35% to MIU and 32% closed. The experience in 12 year olds and older in the FNC is that the proportion being directed to the different end points has changed from the November pathfinder. This means the proportions assumed in this model are also likely to change, should the FNCs include <12s.

    - For the busiest month in 2019 (May) –**14,110** ED presentations of which **1368** came through NHS 24 – this would mean **478** would be directed to MIU, **438** would avoid having to come to ED or MIU at all and **438** would still come to ED, but at an arranged time. For the quietest month in 2019 (Feb) – **11,103** of which **1003** came through NHS 24 – the respective numbers would be **350, 320** and **320**.

    - If this was translated to NHS Grampian (~10% of the population) on a *pro rata* basis this would be equivalent to 3-5 children a day receiving different care. If the public started to call NHS 24 more commonly then this number would obviously rise.

NB in 2019 NHS 24 only took calls during Out Of Hours and from December 2020 NHS 24 receive calls at all hours. This means that the numbers are likely to be an underestimate of any activity in the FNC, should <12s be included.

4. Discussion within SLWG

The potential risks to the individual against the potential benefits to the whole population were identified and discussed by the SLWG in depth to inform recommendations.

Benefits

- FNC system is regulated by allocating appointment time if appropriate or avoiding it altogether; this is Realistic medicine (getting the right treatment in the right place, by the right person, at the right time)
- Appointment system means ED/MIU will be less busy should the patient be advised to attend; reduced exposure to infection (increased due to COVID 19) from other ED attendees in unregulated environment with poor ventilation
- Potentially shorter time to assessment by Senior Decision Maker
- Pathway would capture minor injuries and direct children to MIU, relieving pressure on ED.
- Parents/carers save on time and transport costs, and having to make childcare arrangements for siblings
- Under 2s potentially not automatically taken to ED by SAS unless necessary to do so
- Moving from reactive to proactive unscheduled care

Risks and Mitigations

1. Senior Decision Maker (SDM)
There was considerable discussion on this issue.

- The Group acknowledged that additional provision to boards had been made to provide SDM time for working in the FNC. The group also acknowledged that there was an inevitable delay between funds being available and staff starting to work in the FNC. The expectation is that the RUC will in time reduce footfall in ED and thus free up more time for SDM to work in FNC.
- Ensuring consistency between boards: Not all boards who have an FNC may have a SDM with confidence and competence in remote telephone/video assessment of <12s.
- Regional working: Might regional networks (e.g. East, North and West) of paediatric staff (e.g. on call middle grade staff) provide support to the SDM in FNC. If so, considerations could be then given to the implication for paediatric services and governance.
- Island boards: The group noted that NHS Highland provides the FNC for NHS Orkney, Shetland and Western Isles.
- A set of standards to be applied across all Boards was established as part of the rollout of the RUC programme. De-Minimis Document (Annex 5)
- The group reviewed the De-Minimis document and recommend the following addition to mitigate risks:

Outcome: Senior decision maker to be available for each health board and needs to be competent to give remote assessment to children under 12; may be supported by input from a paediatrician if required.

The group also discussed how the de-minimis document could include a “home first” statement for all ages, i.e. wherever possible keep the patient at home.

2. Age

The experience of the group was that triaging of children by phone/video may be challenging.

The group discussed the current age cut-offs

- Upper age cut-off. Discussion around whether the current ceiling of <12 was appropriate, or could be made higher. Current NHS 24 decision making is different for <12s compared to older patients so change would involve some redesign. Most presentations to NHS 24 of individuals aged 12-16 would be more similar to “Adult” than “Paediatric” presentations.
  The group agreed there was insufficient justification to change the age ceiling for inclusion in FNC.
- Lower age cut off. Serious Events investigated by NHS 24 occur most commonly in the <5 year age group and especially the < 2 year olds. The group considered whether children aged 5-12 or 2-12 could be included in theFNC whilst younger children are directed by NHS 24 to ED and not FNC. This will not reduce serious events continuing to occur in young children. NHS 24 processes for under 18 month olds, which are separate to those for older individuals, are currently in place.

3. Time to assessment

Rapid deterioration of young children may occur during the wait for call back (up to 4 hrs) from FNC SDM. It is possible to 'highlight' <12s on the Adastra system therefore enabling boards to identify referrals of <12s and review as a priority. It should be noted that NHS 24 currently advises all callers that if they deteriorate or are worried they should call back.

4. Workforce and System Capacity

The group acknowledged that all current workforce resources are stretched due to the COVID 19 surge and particular consideration should be given to assessing whether FNCs have capacity in the current environment to accommodate <12s.
In more general workforce terms, MIUs would need to have sufficient capacity to see cases of <12s referred from FNC and should consider any additional training needs for the nurses staffing the MIU.

If <12s were introduced within the current pandemic surge there could be negative consequences on the whole system. Conversely, as unscheduled paediatric activity is currently low there may be a case for including <12s within FNC provision if the boards can confirm there is adequate FNC staffing available.

Clinicians in NHS A&A were contacted to ask about their experience after <12s stopped going through the FNC in December 2020. However, due to the current surge in activity – system pressure due to COVID 19 – it was not possible to make a meaningful assessment of this and the group had to rely on the evaluation of the pathfinder. The SLWG agreed that if <12s were included in the FNC this should continue to be independent of COVID pathways.

Public expectations of ED

Data shows that 90% of ED attendances for under 12s (Annex 3) are self-presentations and 10% come through NHS 24. If more parents/carers of <12s call NHS 24 instead of self-presenting to ED then this may increase overall activity in some areas of unscheduled care (e.g. MIU, GP out of hours) although self-care advice may reduce ED presentations. In the group's opinion, parents/carers who are worried abouttheir young child and have contacted NHS 24 may not wait at home for a call back from FNC, they will likely go to ED.

The national media campaign for Right Care, Right Place launched with a mail drop in January and will incrementally increase reach and coverage across digital media, press, radio and TV. None of the campaigns mention any age exclusion specifically however at the NHS 24 clinical triage stage, all children <12s are referred directly to ED, excluding them from the FNC.

Scotland-wide comparisons

The Royal Hospital for Sick Children, Edinburgh undertook a trial looking at GP triaging of attendances. Wishaw General Hospital and the Edinburgh Royal Infirmary have had (adult) versions of flow navigation for at least 5 years in the in-hours period.

Incremental roll out

It is not possible to undertake a further pathfinder for this cohort of presentation due to the need for geocaching the specific area for NHS 24 to provide a safe and effective service. This means NHS24 are unable to separate out different board callers. If a decision is made to include <12s in FNC then all FNCs must go live on a nationalbasis at the same time to allow safe transfer from NHS 24.

5. Discussion with stakeholders not represented in the SLWG

The group made attempts to involve parents and carers in this report. One parent kindly gave their time but no more were able to contribute.

Paediatric trainees
Feedback from discussions with this group made two key points:

- Overall supportive of the FNC concept
- Recognised potential to prevent admissions which might wait unnecessarily or be avoided

6. Survey

Given the range of opinion within the group, after the final meeting, members were invited to complete a survey (Annex 4). There were six questions and 12 of the 14 group members responded.

The first three questions explored the group member's sense for if and when it would be appropriate to include <12s in the FNC.

- 10 respondents agreed ("definitely yes") that the FNC should include <12s under the correct conditions, 3 agreed that FNC should include <12s at the end of January and 8 agreed that the FNC should include <12s once the COVID surge has passed.

The 4th question asked "Do you think that the risks of harm would be reduced by including only children aged two years old and older in the FNC?"

- Of the 11 respondents 6 answered definitely yes and 5 possibly yes.

The 5th question asked SLWG members to rank the disadvantages/risks of the FNC identified in earlier discussions.

- Provision (or lack of) of a robust SDM was ranked the greatest risk.

The final question asked SLWG members to rank the advantages/benefits of the FNC identified in earlier discussions.

- There was no consensus on the greatest advantage/benefit, and the following were equally rated:
    - shorter time to access senior decision maker
    - ability to direct to MIU and away from ED
    - this is realistic medicine; a move from reactive to proactive care.
- The respondents rated the potential to reduce the number of <2 year olds conveyed to ED by ambulance as having the least benefit.

7. Key Considerations

- If a proportion of children who would normally self-present to ED go through this new pathway, when safe to do so, there is an opportunity to reduce the impact of paediatric attendances at ED by both NHS 24 provided self-care and referral to the RUC flows locally.
- The facility is still there to send the unwell <12s either direct to ED or in 999 ambulances, and will continue to be used by NHS 24 as appropriate.
- Robust public and child protection processes and mechanisms are and will remain in place to ensure children attend ED.
- If the recommendation is to include <12s then all boards would simultaneously go through the readiness assessment process prior to Go Live as per the original rollout.
- Should this be rolled out to all <12s or consider applying a lower age limit of 18 months before rolling out to all ages? For example many minor injury units follow strict protocols and generally will not see children under two. All under 2s currently require a face to face response from SAS and are conveyed to ED
- This is a new system still in development and is untested at volume. The NHS Ayrshire & Arran pilot managed the RUC calls in conjunction with GP OOH and COVID-19 calls and so a proportionally senior and well-resourced workforce was available. The concerns are about the system, not individual clinical decisions that are made, and the way it will perform under stress. The potential impact on children pertains to the impact of a possible delay for an

unwell child, where the parents would otherwise have attended ED.

8. Summary of findings

- There is absence of evidence to inform what constitutes an “optimal pathway” for <12s.
- There is limited data from a pilot in NHS A&A which found the FNC was acceptable to parents/carers and staff and was not associated with any adverse outcomes
- The SLWG was able to examine key considerations and make recommendations on the specification below
- A simple model based on data provided to the SLWG was able to indicate an estimate of possible additional FNC activity if <12 year olds were included in FNC pathways

9. Conclusions

9.1 Minimum specification for each board to meet before <12s are included:

- Senior decision maker to be available for each health board and needs to be competent to give remote assessment to children <12; may be supported by input from a paediatrician if required.
- Consideration should be given to establishing child health support for the FNC SDM. This support could come from within board or be provided on a regional basis.
- Shorter guaranteed call back from the FNC. The current guarantee is within four hours but two hours may be more acceptable to parents/carers.
- Consideration of a minimum age limit, e.g. 18 months, below which NHS 24 calls continue to direct all referrals to ED and not FNC

9.2 Recommendations

The majority of the group agree:

- <12s should not be included while the system is still working on the de minimis specification
- Under the current COVID19 surge of the pandemic the pathway should not be introduced to include <12s due to increased staffing pressures at FNCs and additional demand on NHS 24
- After the current COVID 19 surge passes, the pathway should be introduced to include <12s once the de minimis specification has been passed by all boards
- All boards will be required to confirm a readiness assessment based on the above specification providing safe and effective care
- The pathway will roll out nationally

Annex 1 - Membership and meetings

Steve Turner	CHAIR, Consultant Paediatrician, NHS Grampian Honorary Professor, University of Aberdeen
Kirsty Brightwell	Medical Director, RO and GP, NHS Shetland
David Bywater	Lead Consultant Paramedic, SAS
Dave Caesar	Interim Deputy Chief Medical Officer, Scottish Government
Vicki Campbell	Ayrshire & Arran FNC Lead, Head of Primary and Urgent Care Services
Nicola Dawson	Head of Integrated Service Delivery, NHS 24
Eddie Doyle	Senior Medical Adviser, Paediatrics, Scottish Government
Carol Goodman	RUC Programme Director, Scottish Government
Linda Harper	Associate Nurse Director, NHS Grampian
Scott Hendry	Consultant in Paediatric Emergency Medicine, Royal Hospital for Children, Glasgow
Chris McKenna	Medical Director and Responsible Officer NHS Fife
Steph Phillips	Director of Service Delivery, NHS 24
Laura Ryan	Executive Medical Director, NHS 24
John Thomson	Consultant in Emergency Medicine, Divisional Clinical Director, Division of Unscheduled Care, Senior Responsible Officer, RUC, NHSG Chair of Scottish Board & Vice President (Scotland) at Royal College of Emergency Medicine
Sian Tucker	CD LUCS, Chair National OOHs Group Scotland, Scottish Government Advisor OOHs and Urgent care
Chris Williams	GP, Grantown-on-Spey. Clinical lead for IT, RCGP Scotland Joint Chair (elect)

Meetings

Tuesday 15.12.2020
Wednesday 23.12.2020
Wednesday 06.01.2021
Thursday 14.01.2021

Annex 2 – Terms of Reference

Purpose of the Group

The National Redesign of Urgent Care launched on 1st December 2020 following a Pathfinder at NHS A&A to consider the national impact on patient and staff experience and outcome. An evaluation of this pathfinder site and the national readiness of all boards was undertaken to inform the national roll out and launch date. There was agreement to launch the de Minimis specification to offer the public a single communication message with local variability of services provided at local level in response to their local population needs and demand.

Scottish Association of Medical Directors (SAMD) and Scottish Executive Nurse Directors (SEND) advised Board Chief Executives and the Redesign Urgent Care Strategic Advisory Group that their recommendation was to delay the inclusion of paediatrics in the new pathway as part of the de minimis and allow the process to fully embedded and remove any early delays, waits and bottlenecks across the urgent care system which could negatively impact on this more vulnerable cohort of attendances.

Helen Maitland, National Director of Unscheduled Care, has commissioned a SLWG on paediatrics to give a broader clinical view of these options.

The group will look to agree an optimal pathways of care for Paediatrics – under 12s, and assess the readiness of the system to include this cohort in the referral criteria to the Flow Navigation Centres that will be capable of delivering safe and effective care.

Background

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

To inform this decision the Chief Executive of NHS Scotland commissioned a review of the implementation of the NHS Ayrshire & Arran Pathfinder site prior to national roll out of the programme to all territorial NHS Boards throughout Scotland. During this review there have been a number of discussions about optimal children's (paediatric) urgent care pathways and whether the RUC model should include paediatrics in the de minimis specification.

The NHS A&A pathfinder programme has included both adults and children and to date, in its earliest stages, no adverse impacts have emerged; rather, positive public/parent experiences have been reported. These early findings are encouraging but are limited.

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

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

A delay in access to a Clinician via NHS 24 /111, while a new system embeds, has been raised as a safety risk for paediatrics and a decision was taken to offer a single national messaging for all adults and children however any contact from those under 12 who requires a face to face contact will be directly referred to ED / MIU within the hour and will not be referred to the Flow Navigation Centre.

The age range of under 12s was agreed to align to the national age range for COVID pathways and current algorithms in place at NHS 24.

Role and Remit of the Group

To consider the optimal pathways of urgent care for Paediatrics – under 12s
This will be achieved by:

- considering the evidence of an optimal pathways of care for paediatrics urgent care assessment and the safety of this in Flow Navigation Centre context

- advising on the minimum specification required and assessing the readiness of the pathways, across NHS 24 and nationally against this to include paediatrics in referrals to Flow Navigation Centres

- reviewing data relating to paediatrics needs, capacity and demand to inform next steps and readiness, e.g. data from the pathfinder in A&A

Governance

This SLWG will report its findings to the National Director and the Strategic Advisory Group (SAG). This will inform advice to the Chief Executive NHS Scotland, Health and Social Care Management Board (HSCMB) and ultimately the Cabinet Secretary for Health and Sport to inform decisions and next steps.

Meetings

Frequency: Weekly

Outputs - The group will consider options and make recommendation for next steps.

Annex 3 - data on <12s attending ED by presentation

Number of <12s self-presenting by month

Month	Place of residence	Admission to same hospital	Transfer	Other specified destination	Unknown
Jan-19	10,018	1,151	274	1	192
Feb-19	10,100	1,025	224	4	174
Mar-19	11,691	1,199	240	0	209
Apr-19	11,650	1,173	253	0	192
May-19	12,742	1,210	225	3	181
Jun-19	12,593	1,074	242	2	222
Jul-19	10,873	955	196	1	150
Aug-19	11,306	1,029	230	2	132
Sep-19	12,275	1,292	238	1	221
Oct-19	10,808	1,365	218	2	178
Nov-19	11,613	1,594	305	0	271
Dec-19	10,489	1,494	377	2	228
Jan-20	9,468	1,108	266	4	126
Feb-20	9,450	967	218	0	149
Mar-20	7,535	902	168	0	106
Apr-20	4,531	440	58	0	55
May-20	6,125	591	94	4	66
Jun-20	7,124	652	97	0	89
Jul-20	7,898	738	114	2	125
Aug-20	9,418	856	146	0	132
Sep-20	9,706	941	164	2	100
Oct-20	7,973	890	154	2	73
Nov-20	7,508	886	119	0	59
Dec-20	6,214	739	98	3	67

Source: Management Information, Public Health Scotland

Number of <12s referred to ED by NHS 24

Month	Place of residence	Admission to same hospital	Transfer	Other specified destination	Unknown
Jan-19	1,165	216	50	0	30
Feb-19	1,003	187	19	0	23
Mar-19	1,279	182	19	0	27
Apr-19	1,231	198	25	0	24
May-19	1,368	204	25	0	23
Jun-19	1,258	166	16	0	23
Jul-19	1,224	145	19	0	17
Aug-19	1,139	159	16	0	21
Sep-19	1,228	214	24	0	25
Oct-19	1,179	206	28	0	13
Nov-19	1,389	324	52	0	34
Dec-19	1,527	327	93	0	44
Jan-20	1,167	226	59	0	21
Feb-20	1,139	180	58	0	19
Mar-20	622	110	26	0	7
Apr-20	614	82	10	0	8
May-20	808	94	18	0	11
Jun-20	976	117	38	0	3
Jul-20	926	104	28	0	11
Aug-20	1,108	151	34	0	10
Sep-20	989	114	46	0	8
Oct-20	797	152	55	0	8
Nov-20	770	148	43	0	2
Dec-20	1,337	170	32	0	13

Source: Management Information, Public Health Scotland

Annex 4 – SLWG members' survey results

Figure 1. Bar chart showing the responses to the first three questions

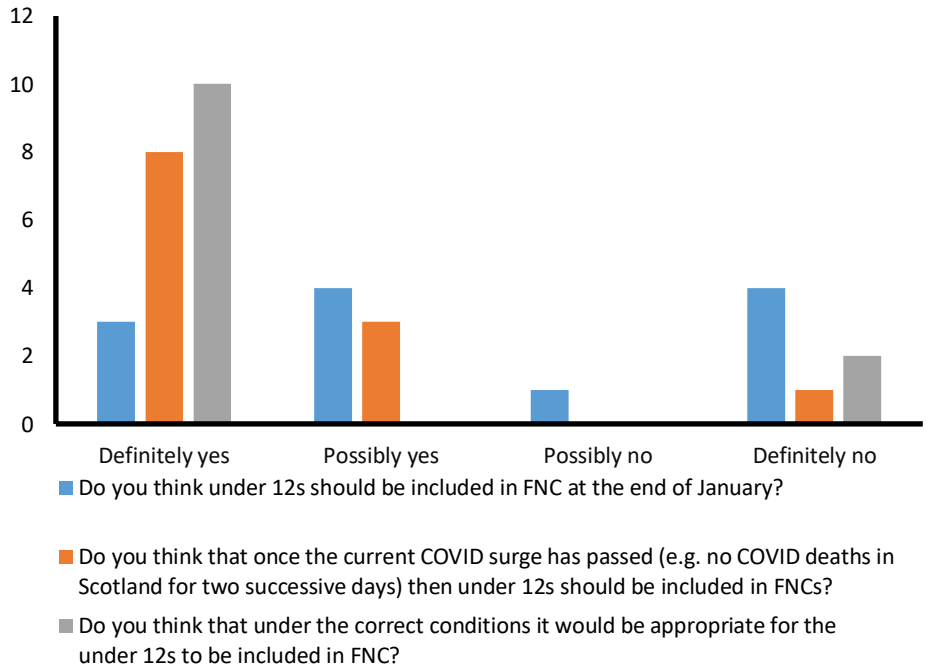
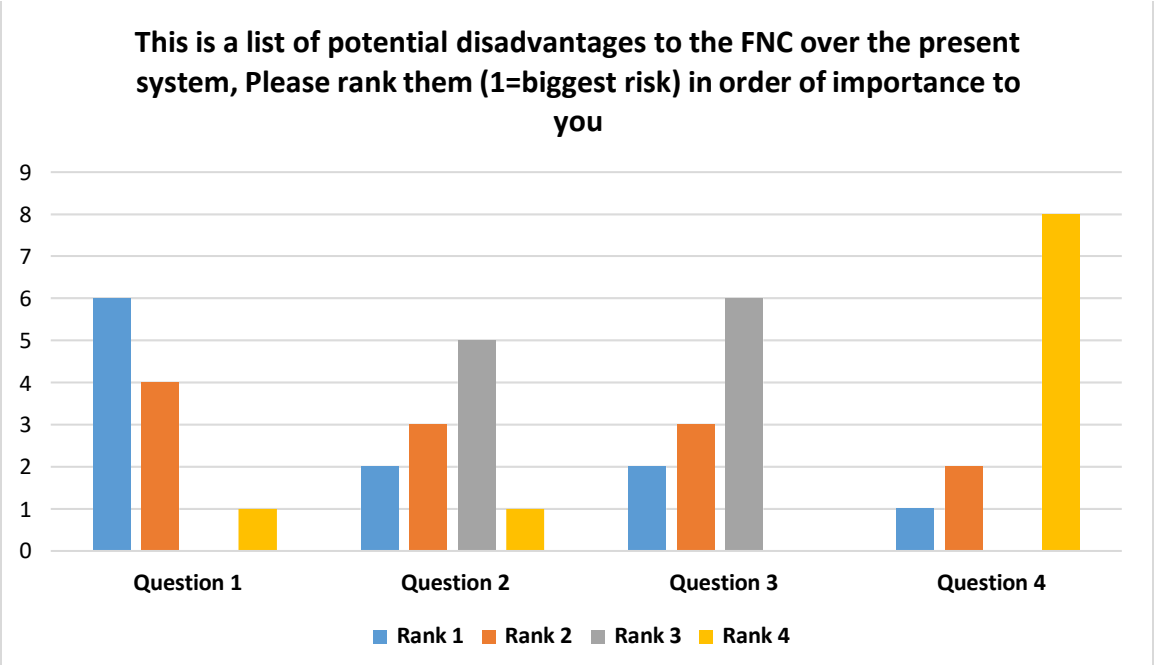


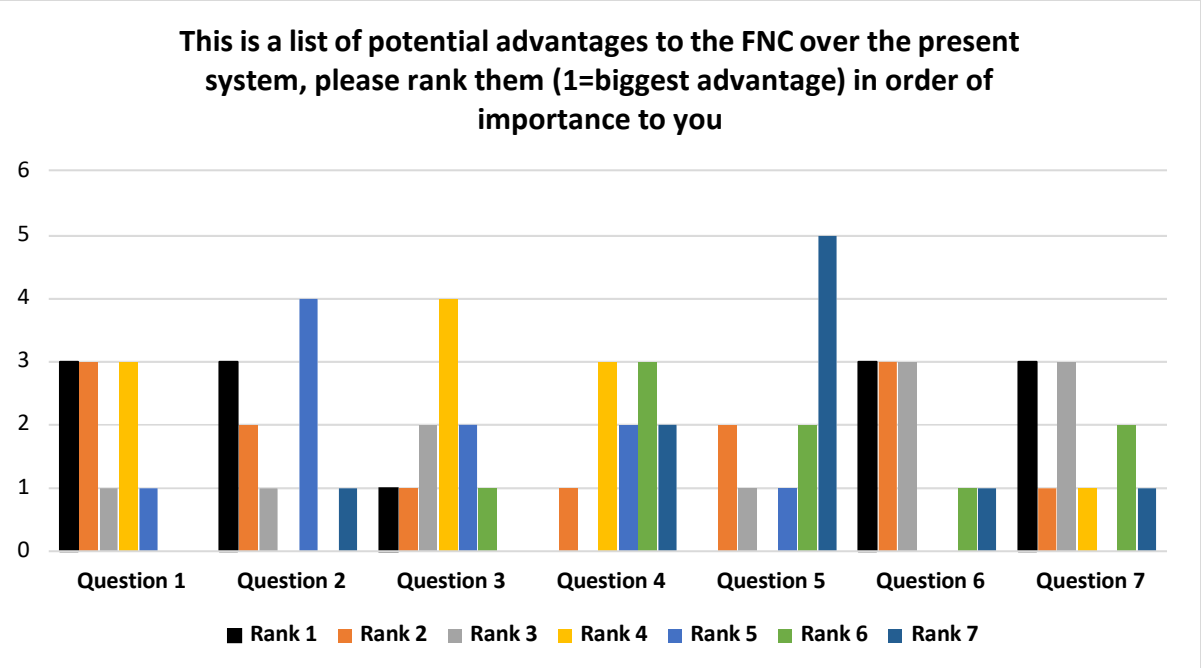
Figure two. Bar chart showing the responses to question five



Question 1	**Staffing resource – can each board currently offer the requirement of FNC for adequately – trained senior decision maker?**
Question 2	**Triage of children by phone/video is challenging**

Question 3	**Rapid deterioration of young children**
Question 4	**Compliance in relation to safeguarding of children**

Figure three. Bar chart showing the responses to question six.



Question 1	**Shorter time to access Senior Decision Maker**
Question 2	**Facility to capture minor injuries and direct children to MIU and away from ED**
Question 3	**Reduce exposure to infection from other ED attendees**
Question 4	**Reduce transport cost to families**
Question 5	**Reduce potential number of under 2s at ED (currently all ambulance call-outs required to take under 2s to ED do so)**
Question 6	**Realistic medicine (right treatment, place, person, time)**
Question 7	**Move from reactive to proactive care**

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

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

ISBN: 978-1-80004-978-9 (web only)

Published by The Scottish Government, May 2021

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS873326 (05/21)