2 February 2015

Dear Mr Martin

**NHS 24 Future Programme Implementation**

Further to the evidence session on 20 January 2016, please find attached a copy of NHS24’s Lessons Learned Report on issues with the implementation of their new patient contact system (“the Future Programme”). This was discussed at the NHS24 Board meeting on 27 January and subsequently provided to the Scottish Government.

Copies of the report have now been placed in SPICE, in accordance with the First Minister’s statement in Parliament on 19 November 2015. In that statement the First Minister confirmed that Chief Nursing Officer Fiona McQueen has been asked to provide assurance that the appropriate lessons have been learned and that the plans to reintroduce the system are robust.

Yours sincerely,

Andrew Scott
Director of Population Health Improvement
FUTURE PROGRAMME
IMPLEMENTATION OCTOBER 2015 – LESSONS LEARNED

This report sets out the lessons learned following the launch suspension of the Future Programme on patient safety grounds. The NHS 24 Board is asked to consider this report.

Executive Sponsor: Chief Executive
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1. **INTRODUCTION**

1.1 The NHS 24 Board approved the launch of the Future Programme system into service in October 2015. Launching the system at the beginning of the peak winter period was high risk. However, the decision was taken on the basis that the risk could be managed and also would avoid the continuation of significant double running costs. Positive assurance was given by all departments that the system was ready to launch. This was accepted by the Board, provided the basis for the Chief Executive to exercise his delegated authority to bring the Future system into service and had the full support of the joint trade unions.

1.2 The purpose of this report is to set out clearly and accurately the issues which arose that caused the Future Programme system to be withdrawn from service. The aim is to use the extensive information collected to positively ensure that the key lessons learned can now be used to mitigate risk and inform the success of the reintroduction of the system later this year.

1.3 The Chief Executive and the Director of Finance and Performance gave evidence to the Scottish Parliament Public Audit Committee (PAC) on 20 January 2016 in response to the Auditor General Section 22 Report into the Management of an IT Project. This report also reflects some of the key messages presented to PAC in relation to lessons learned as these clearly impacted on the program launch as well.

2. **DIARY OF EVENTS**

2.1 The Future Programme system was launched on 28 October 2015. The system was stable during the quieter in-hours period however, a manual adjustment, shortly after the out of hours period commenced, caused a major database issue and a controlled withdrawal from service was required. A major incident was called and the service reverted to paper recording, then a full rollback to the previous decision support system that evening. This rollback procedure was in line with the agreed contingency plan.

2.2 After a re-planning exercise and confirmation of the route cause of the database failure and its resolution, the Future Programme was relaunched on 3 November 2015. Given the previous disruption to service and in the interests of protecting patient safety, NHS 24 considered it more prudent to relaunch mid-week rather than during the high volume weekend period.

2.3 The system was closely monitored following relaunch and reported as being stable. However, there were a number of areas confirmed where process improvement was required. The Future Programme and Service Delivery teams worked jointly with the system suppliers to remedy these issues. On 5 November 2015, the teams proposed and agreed the required process changes and confirmed the system should stay in service going into the weekend period.

2.4 On Monday 9 November 2015, six days after the Future System was relaunched, the EMT discussed the performance of the unscheduled care service over the weekend period 6-8 November 2015. Service access levels...
had fallen dramatically, staff had struggled to use the system effectively and partner boards had expressed concerns.

2.5 On the evening of Thursday 12 November 2015 the Future Programme system was temporarily taken down as a result of a database failure. The service responded very quickly and reverted to paper then rolled back to the previous decision support system. It was subsequently brought back up overnight.

3. SERVICE PERFORMANCE IMPACT

3.1 The Director of Finance and Performance carried out a review to predict service performance over the weekend commencing 13 November 2015. The prediction was influenced by two key factors "staff competence and confidence in the system" and "system improvement" activity since 8 November 2015.

3.2 Key to the performance of the service is the average time taken to process a call once the call has been answered and is in the system. Any increase in call handling time may affect patient experience and patient safety and will also impact the access service level for people trying to call in which in turn could cause a patient safety incident. The review indicated that the average call handling time experienced across the weekend 6-8 November 2015 had almost doubled, halving productivity.

3.3 The review also confirmed that a significant proportion of the staff had been on their first shift with the new system during the weekend 6-8 November 2015. Whilst that percentage was planned to reduce for the weekend commencing 13 November 2015, it was unclear whether that would facilitate the required improvement in staff competence and confidence in using the system. This was further compounded by the knowledge that staff who had worked on two or more shifts with the new system did not show any marked increase in overall performance.

3.4 Based on the information considered as part of the review, the recommendation from the Director of Finance and Performance was that service performance over the weekend commencing 13 November 2015 was unlikely to materially improve.

4. EXECUTIVE MANAGEMENT TEAM REVIEW

4.1 The Chief Executive following consultation with the EMT took the decision on 13 November 2015 to withdraw the Future Programme from service and roll back to the legacy system. The decision to withdraw ensured the continuing patient safety of the 111 service.

4.2 The decision was underpinned by four key factors:

- a recommendation from the Medical Director that, taking all the known "system" and "process" issues together, the safety of the service could not be guaranteed going into the next weekend and should be withdrawn.
a recommendation by the Director of Finance and Performance that predicted service performance over the coming weekend was unlikely to materially improve.

a review of a series of rapid improvement activities which indicated that even with substantially improved support, any improvement in the shorter term would be insufficient to meet weekend requirements through at least the first half winter period.

a position statement from staff side, which confirmed concerns amongst staff in relation to system performance and operational issues arising.

4.3 The decision to withdraw was correct and permitted the continuation of the current system and processes, thus ensuring the safety of patients during the busiest time of the year for the organisation. The decision has, however, created major organisational, reputational and financial risks for NHS 24 and has now been investigated fully.

5. KEY LEARNING

5.1 Overall, although the technology was stable it is clear that the system as configured was not fully ready for use and that the NHS 24 operational teams were not fully ready to use the system as configured.

Underlying root causes were a failure to comprehensively identify risks around launch, a weak shared understanding at executive level regarding the detailed plan and a lack of independent advice and expertise in call centre IT system replacement and implementation.

5.2 The fact that a number of areas went well must, however, not be lost. For example:

- the system, in some instances, worked well – this is borne out by the system screen recordings where there are positive examples of users navigating the system correctly.

- telephony only services were successful, and indeed, there were many members of staff in scheduled care services, disappointed that they too had to roll back, as they were already seeing the benefits of the new applications.

- operational contingency and business resilience arrangements worked very well and the service was able to rollback to the previous system and maintain patient safety.

- feedback from partners was helpful in the decision making process when the issues with the system became evident.

- those calls which were successfully triaged through the system were safe and dispositions did not change.
• local centre staff coped better with the new application; they had dedicated coaching staff available on most shifts, which led to them feeling well supported and confident after a short period.

5.3 The lessons learned indicate that a number of issues effectively compounded to create the experience of the 10 days of live operation. These issues were particularly acute during the first weekend of service at high volumes. The key learnings have been generated from the reflections and reviews of the Future Programme Team, Service Delivery, Clinical and Workforce teams. Key learnings are:

• The system configuration requires further improvement to allow it to operate effectively in alignment with organisational processes and workflows both internally and with partner Boards.

• There was no contingency for delivering peak volume management which is essential to the safe access of patients and processing of calls within the service and this was not understood prior to implementation.

• Lack of effective cohesion and joint working between the Future Programme and Service Delivery teams at senior level.

• Weaknesses in partner engagement at the planning and testing stages leading to an incorrect assumption that integration with external processes and partners was clear, understood and operationally safe and effective.

• As a result of increasing demand on out of hours' services generally, territorial health boards were under pressure and were not in a position to support the impact of the issues arising from the Future Programme system.

• Weaknesses in the training and familiarisation approach resulting in a lack of operational staff's experience of the system, which significantly reduced staff confidence and may have contributed to increased call handling time.

• There was an inability to build momentum with staff experience and their confidence in using the new system given constraints with the existing rostering approach.

• Whilst some staff had difficulties in understanding and interpreting the triage scripts and guidance notes, others found them helpful, this lack of consistency impacted on the overall operational experience.

• Issues with aspects of the clinical content, resulting in operational processes and workflow not operating effectively.

• End to end user testing did not fully simulate peak call volumes and the complexity of the operational processes required to manage service access and call processing.
• Lack of call centre implementation expertise input at Executive Management Team, Programme and Board level, in particular to inform productivity assumptions and training needs assessment.

• There were a number of incremental asks of the programme team including the need to engage in the commercial and contractual discussions with suppliers which impacted on resourcing at key points in the plan.

• The programme experienced a variety of environmental challenges including the SWAN outage and a fire alarm at Norseman House that required the building to be evacuated during launch.

• It should be noted that given all these problems, staff were under significant pressure throughout and especially over the weekend. Their commitment to our patients, despite their own problems in using the system, was outstanding and ensured public safety through the launch period.

6. CONCLUSIONS & RECOMMENDATIONS

CONCLUSIONS

6.1 The EMT regret that this programme has yet to be successfully delivered and fully accept responsibility for the organisational, financial and reputational risks that have been realised as a consequence. NHS 24 has consistently learned from its mistakes but as an approach, this has been risky and expensive.

6.2 At the PAC evidence session on 20 January 2016, the Chief Executive advised that from the very start NHS 24 greatly underestimated the challenges involved in bringing such a complex programme into service and that a lot of time and resource has been spent over the last 18 months trying to recover that position.

6.3 The challenges have been systemic, in that none of the governance arrangements around the project have successfully mitigated the risk enough to deliver the new system safely, on time and to budget.

6.4 Although there have been many mistakes made, NHS 24 has learned from them. This has taken NHS 24 to a position where the technology now works and that was not the position a year ago.

6.5 The evidence presented to PAC also confirmed a number of other areas where NHS 24 has sought to improve the overall position with the programme over time:

• progress has been made and is continuing to recover the contractual position over the 10-year contract term with both suppliers.
• governance and risk management arrangements are being fully revised both at Board and programme level.
expertise is being used to provide effective commercial management and expertise is currently being sought to support system implementation at launch.

6.6 Also at PAC the Chief Executive advised that the experience of NHS 24 brings learning for the wider NHSS and the wider public sector in Scotland.

RECOMMENDATIONS

6.7 Taking all of the evidence within this report, the next implementation of the Future Programme must be underpinned by the following key learning points:

- The NHS 24 Board should look for assurance from external call centre implementation expertise as well as the Executive Management Team.

- The Executive Management Team should secure effective call centre implementation support from both Capgemini and other independent sources to support the Future Programme.

- The Executive Management Team to be restructured to facilitate more effective joined up and clearer responsibilities for launch.

- Staff and partners to be included in end-to-end testing and to be seen as being as important a customer group as patients throughout the programme.

- Pre-launch testing to be comprehensively executed end-to-end using the 2015 go-live learning which engaged 30,000 patients.

- More comprehensive training and engagement and fit for purpose quality assurance to be put in place to confirm staff effectiveness and confidence prior to launch.

- Revised workforce plan to assume reduced launch productivity, as a starting point, a reduction of 50% for three months should be used as a working assumption. This will be subject to continuous review and external expert advice.

- Findings from root and branch review of workstreams by Non-Executive Directors to be incorporated.

- Launch into a quiet period to minimise ramp up costs and maximise the ability to manage operational issues, at this point the working assumption is June 2016 but this is subject to review of the Implementation Plan.