Transforming Urgent and Emergency Care and the Vanguard Initiative

Learning from Evaluation of the Southern Cluster

Extended summary

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For more information on this publication, visit www.rand.org/t/RR2062

Published by the RAND Corporation, Santa Monica, Calif., and Cambridge, UK

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Background and context

The urgent and emergency care system in England is facing extreme pressures related to the nature of demand and service use. There are 110 million urgent care same-day appointments each year, of which 85 per cent are urgent GP appointments and the rest accident and emergency (A&E) and minor injury setting attendances.[1] According to a systematic review by Ismail et al. (2013), inappropriate attendances may account for 15–40 per cent of presentations at A&E departments, and prior efforts to reduce this had minimal effects on patients and the health and care system.

In this context, the Urgent and Emergency Care (UEC) vanguards were established in August 2015, as part of the new models of care programme that is considered key to delivering NHS England's Five Year Forward View.[2] Within the wider vision set out in the FYFW, the UEC vanguards reflect the effort to create more appropriate alternatives to the way UEC care has been delivered in the health and care system, and to ensure high quality and more cost-effective care, including reducing inappropriate demand on A&E. The UEC new care models build on key elements for improving UEC identified in 2013 in the Keogh review,[3] and pertaining to: better advice for patients, the public, and health and care professionals to make the most appropriate care choices; more responsive services out of hospitals; access to centres with the right expertise and facilities; better support for self-care; and integration across all urgent and emergency services. The new care models programme is intended to also support other initiatives aiming to transform the way the NHS works, including the clinical commissioning group improvement and assessment framework[4] and the Sustainability and Transformation Partnerships (STPs).

Each UEC vanguard reflects local circumstances, but also some common overarching approaches to transforming urgent and emergency care, such as: implementing a new model of integrated urgent care accessed through NHS 111; investing in improved directories of services and mobile interfaces; facilitating closer working between health and community and social care in discharge support; engaging with a Channel Shift modelling tool to better plan and facilitate service design; and strengthening the data-sharing and IT infrastructure to support service delivery.[5]

As part of the vanguards initiative, local and national stakeholders agreed that all vanguards should include rigorous evaluation to support learning and the spread of good practice. RAND Europe and EY (with additional support from Dr Julian Elston, Researcher in Residence at Plymouth University) were commissioned to evaluate three UEC vanguards (known as the 'Southern Cluster'). These are UEC vanguards coordinated by: the Cambridgeshire and Peterborough Clinical Commisioning Group (CCG) (referred to as the C&P UEC vanguard); the Barking and Dagenham, Havering and Redbridge System Resilience Group (BDHR UEC vanguard); and South Devon and Torbay (SDT UEC vanguard). We were asked to provide extra depth to our analysis of the mental health crisis care pathway element of the Cambridgeshire and Peterborough UEC

1 NHS (2017).

2 NHS (2014).

3 Keogh (2013).

4 https://www.england.nhs.uk/commissioning/ccg-assess/

5 https://www.england.nhs.uk/stps/

vanguard, which provides enhanced support for mental health, and were provided with supplementary resources to do so.

Evaluations aims, design and methods

This evaluation had three core objectives: (i) to evaluate the impacts of the three UEC vanguards; (ii) to examine the processes underpinning delivery and impact, including associated enablers and challenges; and (iii) to examine implications for future practice and policy (including any insights pertaining to scalability and sustainability of the models). From the outset, the local evaluation has aimed to provide learning of relevance for both local and national level decisionmakers.

The evaluation was rooted in a theory-driven framework, which is important for the credibility of the findings (elaborated on in Sections 1.5 and 1.6). We first worked with each site to understand their approach to achieving change and the assumptions about why local stakeholders expected their interventions and processes to have desired impacts. Once we jointly specified the intervention logic, we co-produced evaluation indicators to allow the evolution and performance of the three vanguards to be reflected on, learnt from, and acted on. We implemented the evaluation through a combination of qualitative and quantitative methods including evaluation framework development workshops, key informant interviews, surveys, indicator data dashboards, reflection and learning workshops, and formative interim progress reporting (written and verbal).

Caveats

There are some caveats to consider when interpreting the insights from the evaluation data (Section 1.7 provides further detail). First, we engaged with diverse individuals in each vanguard, but recognise that there are likely to be other individuals and organisations with valuable insights whose views are not presented in the scope of this work. We are reassured that many of the individuals we interviewed seemed aware of the importance of not only their own role for the overall functioning of the vanguard, but also of the roles of other actors and organisations. Second, the combination of interview, survey and quantitative indicator data (where available) has helped enrich the evidence base. However, some challenges to recruiting participants in the evaluation and to accessing data on indicators of interest were experienced, and are reflective of the limitations in the data architecture in the UEC system and of the competing pressures on the time of the individuals we aimed to engage in the evaluation. Thus, some of the perceptions shared during interviews have been challenging to triangulate with associated desired indicator data on UEC activity, for example around unnecessary A&E admissions avoidance. Third, clarity in the lines of responsibility and capacity for engagement with the evaluation varied between sites (and were in some cases accentuated by the lack of designated resources to release individual time for evaluation-related activities). However, all sites shared good will to engage.

Finally, while the key messages from our evaluation largely apply across the three vanguards, there are also site-specific differences (for example relating to local demographic contexts, service pressures, UEC priorities, and pre-existing relational contexts), which have implications for future efforts. Hence, we provide both overarching and site-specific conclusions in Section 5, and recommendations in Section 6. There may also be variation across hospitals within a region that our analysis would not have picked up. Future evaluations could explore these similarities and differences in more depth.

Key insights on progress and impact

The Southern Cluster UEC vanguards have been pursuing ambitious goals to transform the UEC landscape in their regions and provide a more efficient and effective service. Despite a reduction in originally envisaged resources for delivering vanguard activity, progress has been made across core activities (although variably across activities and sites reflecting different strategies and priorities).

At the core of the UEC vanguard model were ambitions to create an Integrated Urgent Care (IUC) clinical hub offering clinical advice in a timely and effective manner, and to support the NHS 111 service to ensure more appropriate referral pathways and patient flow management through better targeted access to care for patients who contact 111. **Clinical hubs with staff supporting NHS 111 service delivery** are now operational across sites, with efforts taking place to further strengthen capacity in terms of the numbers of staff and the diversity of professions supporting the NHS 111 service. At BDHR, for example, the hub is staffed with GPs and community nurses. Interviewees reported reductions in ambulance conveyance and an increase in calls closed as self-care (26 per cent of all calls to NHS 111 at BHDR as of March 2017). At C&P, the hub has access to GP, dentistry, pharmacy and mental health specialists. Just over 22 per cent of calls to NHS 111 are being referred to the clinical hub (with slight month-to-month variation) and the hub is also seen to be strengthening support services to ambulance crews. The First Response Service (FRS) for patients experiencing mental health crises is also fully operational at the C&P vanguard, via Option 2 for callers to NHS 111. The FRS supports triage for both self-referred patients as well as patients referred by carers, health professionals, and adjacent services such as the police. The use of the mental health specific option in NHS 111 has increased substantially (from 100–200 calls per month in September 2016, before the full-scale model was implemented to 1200–1500 per month in early 2017) with reported impacts on freeing up capacity in other parts of the system (in-hours mental health services, out-of-hours GPs) and reducing police deployment. New services were seen to be improving choice and access to care, and data collected by the FRS suggests a 19 per cent reduction in emergency department attendance and a 20 per cent reduction in A&E admissions by mental health patients. At SDT, the NHS 111 service, clinical assessment and out-of-hours GP service have all been brought together under the Clinical Assessment Service (CAS), staffed by GPs, nurses, dental health practitioners, physiotherapists, pharmacists and palliative healthcare professionals. Interviewees have reported impacts on better call management (e.g. maintenance of call handling within 60 seconds despite increase in volume of calls), clearer pathways for patients and providers, and improved access to health and care professionals (including care homes and paramedics), leading to a more patient-centred service. Across the three vanguards, there is need for improved activity an outcome metrics on A&E dispositions and ED attendances that would allow evaluators to make unambiguous assessments of impact on outcome measures such as unnecessary A&E admissions avoidance.

Direct booking capacity from clinical hubs into primary care was also intended to support more efficient patient management and referral, as well as to improve patient experience. Across sites, progress is being made in terms of booking appointments into out-of-hours services, but less so into in-hours primary care. This is due to a range of technological challenges, reservations from in-hours GPs and potential risks to inappropriate use of in-hours

booking capacity to secure a faster appointment to in-hours GPs in non-urgent cases.

Gradual progress with **joint planning and governance** of UEC services between providers is being made between NHS 111 and out-of-hours and between health and social care discharge teams, although to different degrees between sites. Opportunities presented by local systems integration efforts (e.g. STPs) may enable further progress but will require careful consideration of appropriate incentives and accountabilities. For example, at BHDR, interviewees reported that particular progress has been made in bringing together acute, community and social care to improve speed and decisionmaking around patient discharge. At C&P and SDT, joint planning of NHS 111 and out-of hours capacity is also leading to a greater recognition of the interdependencies between primary, acute, community and social care providers, and at C&P also with the police (especially around mental health patients).

Efforts to ensure **seamless data sharing** between UEC providers and an interoperable **IT infrastructure** are progressing slower than originally hoped for, although gradual signs of potential for change are emerging (e.g. through establishing improved information sources such as updated directories of services and mobile interfaces that provide real-time information to support effective patient-triaging; through platforms enabling the sharing of summary care records and special patient notes between some providers).

Other areas of progress relate to **site-specific developments**, in aspects such as: **front door triage** and streaming at A&E at BDHR; **new service options for patients presenting with mental health conditions** via the **First Response Service and associate interventions** (e.g. sanctuaries, drop-in based support for children and young people, online counselling and crisis support) at C&P; efforts to **map mental health pathways** at SDT; and progress with **operational policies and service specifications for minor injuries units** at SDT. Further progress and impact information for each site is presented in Section 2 (for BDHR), Section 3 (for SDT) and Section 4 (for C&P, including mental health crisis response), and discussed across sites in Section 5.

Key learning about enablers and challenges to delivery

A series of factors have influenced vanguard progress to date. The **funding** (despite being significantly reduced in relation to the original proposals from sites) had a catalytic role in pump-priming activities and facilitating pace in transformation efforts, as well as in providing the permission and space to innovate in approaches to improvement. However, some evaluation participants also highlighted the risks to sustaining stakeholder engagement and the commitment that the difference between originally envisaged and ultimately secured resources for implementation can lead to, as an area for particular attention in future policy efforts. This highlights the need for greater upfront dialogue between national and local stakeholders and further clarity on budgets available for supporting new service transformation efforts.

Committed leadership across professions and levels in organisations, and **practical mechanisms to support joint working and interaction** between providers making decisions on UEC and patient pathways (e.g. through protected time for collaboration and engagement, visits, secondments) helped support the vanguard vision, helped establish a shared understanding of individual needs and capacities and shared goals, and nurtured enabling relationships. For example, although progress has been variable between sites, across the board we were told of closer working between providers and CCGs. Going forward, there is scope for further

enhancing collaboration with local STPs and for coordinating activities.

There is also scope for further focus on **patient and public engagement**, despite examples of effective consultation during the design of the vanguards and in awareness raising about new service options on some fronts. For example, although not vanguard-funded, a large-scale public consultation at BDHR, with 10 focus groups and 4,000 survey-respondents, informed vanguard direction; consultations that took place during the development of the SDT Urgent Care Strategy have informed SDT vanguard work and activities; and public awareness campaigns via radio, posters, flyers and meetings were seen to help drive uptake of the First Response Service for mental health service in C&P. There is, however, a need for more attention on soliciting, consolidating and analysing feedback, and communicating resulting actions back to the public and patients. Patient engagement will also require a consistent message and coordinated consultation efforts between different service transformation initiatives taking place locally, to sustain buy-in and prevent engagement fatigue.

Substantial progress has been made in recruiting critical posts, but ensuring a critical mass of diverse health and care professionals supporting NHS 111 and the clinical hub (such as GPs, pharmacists, mental health practitioners, nurses, paramedics, social care staff, dental professionals, senior doctors, and potentially some specialists) remains a challenge, reflective of more general workforce challenges in the wider health system (pertaining to the recruitment pool, skills and career structures). Addressing this will call for further strengthening of relationships and considering new skills for risk-management in patient triage, clinical informatics skills and flexible working arrangements.

Data infrastructure and interoperability challenges will also need to be addressed for longer-term impact at scale, and for ensuring that appropriate evidence on costs, activities and outcomes can be generated and safely shared to inform service strategies and to make more convincing business cases for continuation and potential scaling of high-impact activities. At the moment, and although some progress has been made in terms of linking up NHS 111 and out-of-hours, for example and in relation to shared care records, the IT infrastructure is still fragmented and this limits potential for impact from UEC service transformation efforts. In addition to enhanced data sharing between providers and commissioners, patient access to their data through secure and user-friendly interfaces needs to be achieved, to enable patients to make more informed choices about access to UEC care and about health-seeking behaviours. Given the learning vanguards have gained throughout this phase of their existence (including on data needs and specifications, and on requisite cross-organisation commitments), they may now be better placed to pursue data and IT infrastructure-related goals than prior to the vanguards.

Looking to the future and reflecting on the scalability and sustainability of the vanguard model

The challenges set out by NHS England for the original UEC vanguards focused on breaking down boundaries between physical and mental health to improve access to UEC for people of all ages; developing more integrated care to encourage not only effective treatment and the provision of out-of-hospital care where appropriate, but also prevention and self-care; and changing the way that organisations work together.

In reflection on our findings, the sustainability and scalability of the models being pursued will depend on financial, social and technological

determinants and on their interactions. Section 6.1 in the report offers recommendations for addressing challenges experienced thus far, and for further building on realised successes – both for individual sites (Boxes 6–8) and across them (Box 5). These recommendations have to do with: (i) capacity building and skills enhancement in integrated urgent care hubs; (ii) collaboration, communication and engagement across communities of practice; and (iii) data, evidence and underlying IT infrastructure (as overviewed in the Summary Box).

Summary Box . Overarching recommendations for future capacity building and for advancing the UEC vanguard vision

Capacity building for skills enhancement in IUC hubs

1. Establish new types of incentives, skills (clinical informatics, risk-management) and accountabilities in the health and care workforce through flexible working arrangements, training and mentoring, and performance-based considerations. These should support consistent and standardised care.

Collaboration, communication and engagement across communities of practice

2. Coordinate more closely between local- and national-level UEC transformation efforts and initiatives, balancing local and national direction in decisionmaking and implementation, and ensuring effective management of expectations (given financial uncertainties in the health system landscape).
3. Continue to nurture and further strengthen collaboration between different stakeholders within localities and across professional groups, including with patients and the public. This should build on current efforts to ensure equity in access to improved urgent and emergency care across demographic profiles.
4. Consider how vanguard activities can support an end-to-end UEC pathway to: ensure learning across the pathway; minimise unnecessary duplication of effort; most effectively coordinate resources; and secure a whole that is more than the sum of its parts – this will require a focus on how a package of complementary activities relates to each other and can support impact, scale and sustainability. This will require renewed emphasis on how other interventions in the UEC system interact with and influence the current core focal points of most UEC vanguards in the Southern Cluster, i.e. the clinical hubs supporting NHS 111.

Data, evidence and underlying IT infrastructure

5. Continue to improve the availability of cost and outcome data that is available, so as to facilitate a robust business case for future scalability and sustainability efforts. This includes learning from localities where smaller-scale efforts have succeeded in establishing a robust business case (e.g. such as initial FRS pilots in Cambridgeshire and Peterborough). These efforts should consider the utility of existing system level tools and initiatives linking activity and outcome data (e.g. such as the Reporting Analysis and Intelligence Delivery Results RAIDR tool, and the Channel Shift Model).
6. Reinvigorate efforts to secure resources (financial and relational) for progressing an interoperable data infrastructure, perhaps in collaboration with other local and national initiatives (e.g. efforts of Digital Exemplars, Local Digital Roadmaps and others) and in consideration of appropriate data specifications and standards. However, the approach to establishing and scaling this infrastructure needs careful thought as the determinants of success will extend well beyond technological considerations to include a diversity of social issues (IT skills, concerns over liabilities, behavioural incentives to change practice, patient and public acceptability, and data protection safeguards, as well as the nature of regulation governing IT infrastructure and data use in the health system).
7. Strengthen capacity for evaluation and learning (both in terms of structures to support collection and sharing of data and in terms of human resource capacity and skills to support evaluation endeavors).

Pursuing these areas of further capacity would call for attention to clinical, operational, communications-related, public engagement, leadership-related, funding and incentive related matters. A multipronged approached is essential. For example, structurally delivering integrated care will rely on also driving the right behaviours both amongst health and care professionals (and upskilling them where needed) and patients and the public. Doing so at scale will call for strong systems leadership across health, social care and voluntary care sectors, and alignment with wider local transformation initiatives (e.g. STPs, local A&E delivery boards). Ensuring that new organisational forms and the complexities of achieving integrated cross-working between professions do not obscure the underlying objectives to improve patient outcomes as well as service efficiency will necessitate close engagement with patients and communities, especially in an effort to address both physical and mental health outcomes (and their interdependencies) more effectively.

Before implementing future interventions, it will be important to scope the urgency and the impact of change, and relative implementation difficulty. This includes: considering what the expected impact is on services (at organisational and systems levels) and patients; the implications of change on operations (e.g. planning, management-demands); what challenges will need to be overcome and how (e.g. incentives, time, funding, partnerships); and conducive governance arrangements. In March 2017,

both NHS England and NHS Improvement set out the current areas of focus for Urgent and Emergency Care,[6] many of which are reflected in the key considerations discussed in this evaluation. For example, amongst other things, Next Steps on the NHS Five Year Forward View states that every hospital will need to have: enhanced front door clinical streaming in place by October 2017; improved and more integrated assessment and discharge practices between hospitals, primary and community care; enhanced capacity for specialist mental health care 24/7 in A&E by five-fold; and an increase to 30 per cent of calls to NHS 111 being referred to a clinician by March 2018. These are all areas the vanguards (and their local UEC landscape partners) have been working on and learning lessons in, and have been sharing these experiences and information with national level decisionmakers.

In relation to this, it will be important to reflect on which actions will need to be taken locally and at national levels, and on how local and national stakeholders will collaborate and coordinate in delivery at scale. This will call for further consideration of how Leaders in the vanguards to date and STP Leaders, A&E Delivery Boards, Urgent and Emergency Care Networks, NHS England and NHS Improvement can work together to ensure a single shared and coordinated delivery plan for UEC and A&E improvement, which would also need to have the requisite degree of flexibly and adaptiveness to reflect local priorities and ways of working as part of STP delivery.

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