

Comparing performance of urgent care providers across England

Is the drive to improve outcomes and the quality of integrated urgent care being compromised by poor data quality?

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A. Foreword

This review started with a deceptively simple question. Does one type of lead urgent care provider – ambulance, other NHS, not-for-profit, or commercial – perform better than others in delivering integrated urgent care (IUC) services. But when piecing together, reviewing and analysing the different publicly available data sets, it became like peeling away the layers of an onion, as each answer pointed to further questions. At the heart of it lie two concerns. First, that the data underpinning the national IUC key performance indicators (KPIs) is deeply flawed. Or in the words of one analyst, this is the ‘open secret’ that everyone knows about but chooses to avoid. Second, that too many commissioners have lost sight of the vision of “*functionally integrated 24/7 urgent care access, clinical advice and treatment service*” that incorporates “*NHS 111 and out-of-hours (OOH) services.*”

Four years ago, we were involved, in different roles, in developing a new set of KPIs, replacing long-standing national quality requirements. They attempted a step change in measuring the performance of integrated urgent care services (IUC), in particular, how far services were making progress in delivering the new vision for IUC. As is often the case, high aspirations collided with the reality of service delivery. Most KPIs measured activity rather than quality of care, let alone patient outcomes. And, crucially, for almost every contract the failure to integrate systems, failure to oversee the overall patient flow or report on the whole pathway means that any direct comparison is impossible. All of this is further compounded by inconsistencies in coding and stark differences in where the boundary is drawn for some of the metrics within a supposedly integrated service. In practice, these shortcomings mean that there is little or no evidence, based on the publicly available datasets that any progress has been made towards genuinely integrated urgent and emergency care and it is clear from conversations with many within the sector that, for most contracts, progress has not been made in crucial areas. As we move towards Integrated Care Systems (ICS) we have never been more in need of a transparent and reliable system for monitoring progress towards IUC; and yet remain in denial about poor data quality and the flaws in our national metrics, based on the publicly available data sets.

But it is not just the published data and the KPIs. In speaking with commissioners and providers we found far too many that still operated in ways that were very similar to the way that they did before IUC was launched – effectively with a ‘111’ element answering calls and undertaking some clinical assessment and an ‘OOH’ element that also carried out some clinical assessment and saw patients face to face at an IUC treatment centre or in the patient’s home. Although cases are passed from one organisation or IT system to another there is less functionally integrated management of the resources between the two parts than was envisaged, there is little management reporting of the whole of the IUC journey and there are unnecessary delays because of the number of steps involved, each with its own queue. This results in a service that is less effective than it could be in getting the patient to the right place for treatment, that makes less effective use of the resources available within the system than it could do and that can delay patient care to such an extent that clinical risk begins to rise.

Despite this, there is still room for optimism. In speaking to a large number of experts and leaders across the urgent care system, we have found impressive candour in addressing the problems and creativity in crafting solutions. We present concrete proposals for establishing a way of consistently recording data and comparing performance, so that everyone – providers, commissioners, national regulators and the general public – can begin to understand who does what well and how others can learn from this, driving up the quality of patient care and confidence in the NHS to meet urgent needs. Key to achieving this is that commissioners must ensure that providers share the data “required to performance manage and inform the ongoing

development of the IUC service”¹. At present too little is shared to report accurately against some KPIs and, for others, what is shared is inaccurate.

The pandemic of 2020 has demonstrated just how effective remote assessment and treatment can be – but even before this policy makers and commissioners were beginning to recognise the importance of the clinical assessment service (CAS). For it to be most effective it needs to operate as one unit that is focused on ensuring that the advice given remotely (by phone, online, video, message, email etc.) is timely, appropriate, does not involve too many steps and excels at reducing the pressure on the rest of the NHS system by, when it is appropriate, completing cases with adequate time to provide the necessary guidance, explanation and reassurance to the patient or carer. The definition of an integrated service is one that operates “as a whole”. This does not preclude an IUC from being delivered by more than one organisation – but, if the service is to be efficient, effective and safe, it is crucially important that the CAS works as one. Whilst the pandemic has reinforced what we already knew, that clinicians can work effectively from remote locations, this makes the challenge of integration so that the CAS works as one even greater.

We know from past mistakes that it is not enough to develop good ideas. While the principles underpinning the 2016/17 KPIs set out a positive direction of travel, much has been lost in translation and the vision appears, five years on, to be little or no closer to being implemented. We found very few services that might be described as integrated and none where the reported data confirmed that they were.

It is also vital that there is a broad consensus for change. So far, participants in this review agree with the diagnosis, and many have already contributed to potential solutions. We hope that policy makers will pick up on our proposals and explore how they can establish a nationally driven system for genuinely comparing performance, quality and outcome at a national level, while continuing to incentivise local creativity and flexibility. Our proposals for piloting a new approach are outlined on page 17 – if you would like your local IUC system to take part, please get in touch.

¹ This requirement is part of the specification published in 2017.

B. Overview

This independent review was carried out from October 2020 to February 2021 by the Primary Care Foundation, with initial support from the Practice Plus Group who asked the deceptively simple question referred to earlier about whether one provider type performs better than another. The answer to that question is covered more thoroughly in Appendix 2. That review laid bare just how unreliable and potentially misleading the present data collected to report on IUC is and, within the Primary Care Foundation, we chose to prepare a separate report on this analysis.

For both pieces of work we reviewed nationally available data sets, shared initial findings in a discussion paper with colleagues across the urgent care sector and with national organisations, held two 90-minute video sessions with 30 people and follow up 1:1 phone calls with data experts and leaders who wanted to explore the issues in greater detail. The ideas and outputs from our analysis, corrected and improved by discussion and debate, are presented in this report. We are grateful for everyone's time and patience; although in the end, the responsibility for the analysis and the recommendations is ours alone. We have included some of the outputs from this work, including notes from the video sessions and papers prepared to support this work as appendices. We have been careful to ensure that while we describe the ideas generated with colleagues across the sector, always checked for accuracy, we do not identify who said what.

Why is consistent monitoring of performance important?

Monitoring the performance of NHS contracts matters. It is important for commissioners to be able to understand how their local contracts are performing and crucially how their performance compares with others. All of us as tax payers and NHS patients have a right to be able to understand whether our money is being used effectively. There is good evidence that accurately monitoring performance and presenting direct and reliable comparisons across services, is a powerful tool for driving up the quality of services. Local systems can then explore why they are performing so much better or worse than others, allowing them to make improvements or share their good practice more widely. But, even more important is that key measures focus attention on elements that matter for patient safety. Calls that are not answered, cases that wait many hours before reaching a telephone outcome and consultations where patients feel that things were not explained fully, all point to areas of clinical risk.

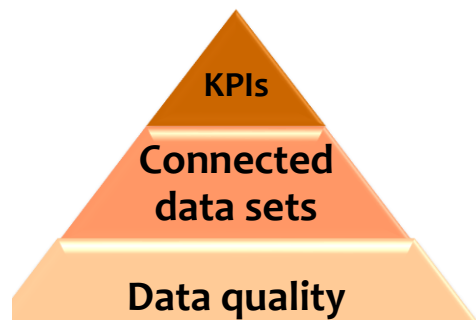
Our approach to this work

There are four overlapping stages to this review (see diagram below), beginning with a detailed study of the current data before exploring how some of the current shortcomings might be overcome and drive practical solutions. Throughout this process, by feeding back ideas and encouraging challenge and debate, we have sought to help build a wider consensus for change.



A hierarchy of issues that need to be addressed

There is a hierarchy in addressing these problems. It is tempting to start by focusing on the high-level metrics for measuring performance, or key performance indicators (KPIs). But without tackling the systemic issues with data quality and the difficulties in joining up the different data sets, any top-level metrics will remain irrelevant or meaningless. Developing more elegant KPIs supported by flawed data will not solve anything. This conundrum lies at the heart of the 'open secret'.



And, though we have drawn the pyramid narrowing to the top, in terms of value the picture is inverted. Once you have good quality data, joining it up adds more value – but the real value comes from the metrics (not just the KPIs) that can be derived from it and the ability to drill down into the detail to shape improvement activity. It is this opportunity to get better that is being missed.

It is vitally important to allow localities to shape their operational practices to suit the locality and, with the introduction of integrated care systems, the emphasis on place-based care will be stronger. To take a simple example, in a rural area it may be appropriate to have many more treatment centres for a given population than would be necessary in an urban or city setting – and it makes sense to utilise these clinicians as part of the clinical assessment service (CAS) to undertake phone or video assessment that those in the city service would have no time to do. The Adastra system is widely used in the sector and this allows local flexibility and configuration. This is good and appropriate provided (and only provided) that this is done in a way that ensures that key data is still collected. If, as a result of the way that the system is configured, it becomes impossible to identify whether a contact was face to face or remote (phone or video) then, arguably, the clinical record is not complete and, certainly, data becomes impossible to collate and compare.

C. Our findings

There are widespread systemic data quality issues

- For national metrics to have value, all providers must collect data and report on the same basis. The quality of data recorded by providers is inconsistent and varies from month to month, and some of the published data does not add up when it should. There are also big gaps in data, to the point where some of the reporting on KPIs is not credible.
- There are inconsistencies between Minimum Data Sets (MDS) and Aggregated Data Sets (ADC) data – even for simple data like number of calls triaged.
- Services are reporting on very different parts of an IUC service – and these differences mean that data is difficult to compare. We could find no service that reports on the entirety of the “integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call-handling and former GP out-of-hours services” that the specification for an IUC describes.
- Providers count calls and start clocks for telephony at different points, so results are not comparable.
- The definitions exclude some cases from the figures so that it is more difficult to understand how the whole system is operating. Officially cases that begin online, are passed to the 111 service from the ambulance service or that come in direct to the CAS rather than through 111 using the ‘star’ lines, are excluded from all of the metrics that follow triage. Yet they are an important part of the case mix. There needs to be consistency in how they are included to support like for like comparison.
- It remains difficult to compare performance across provider organisations as data is measured in different ways across contracts. Those efforts that have been made to standardise the collection and reporting of data have failed to ensure consistency. Even some of the basic checks (for example, that data is complete or that figures add up) have not been carried out or the data is published without regard to the errors.
- Our analysis showed too many results that are just not credible. This includes 100% of calls being answered in 60 seconds; average call-back times that are impossible given the numbers of calls over ten minutes; dispositions that when totalled range from >180% to <30% of calls triaged; and an average time to answer calls that are faster than the reaction time of a racing driver.

Commissioners have failed to ensure different data sets are joined to measure the impact of integrated urgent care

- Different providers across urgent and emergency care use different information systems or different instances of the same system that are not joined up. Because the whole pathway is not covered, reporting is partial too, increasing the problems with data quality.
- The specification is clear that it is the responsibility of commissioners to ensure that data is shared and available to inform the ongoing development of the IUC service. Were such data to be available then there would be far fewer issues with the publicly available data and reported KPIs. The problems with them are largely because no commissioner has yet ensured that the data that is reported includes the whole of the IUC activity.
- Indicators should measure and assess how well urgent care providers work across organisational boundaries. The original vision for integrated urgent care anticipated providers completing and closing cases, benefitting the wider health care system. To date, the current KPIs and information collected falls well short of showing whether the system meets this ambition.

- Where performance comparison between IUC systems is possible, there appears to be far more variation within provider types (Ambulance Trusts, NHS Trusts, commercial or not-for-profit) than between them. There is NO evidence that one provider type is better than another.
- While many commissioners and providers know about RAIDR, a tool paid for by NHS England that joins data from the IUC with that from Emergency Departments, they appear to have little confidence in this tool and limited understanding of what it offers. Until they gain access to the detail, it is difficult for them to understand enough to decide how they might increase the number of patients being directed to the right service, first time.
- The specification and associated guidance do not attempt to define a consistent scope for urgent care services, so it is not possible to make direct cost comparisons. There is also no data collected centrally about the cost. Attempts to compare costs by looking at contract costs or by sending questionnaires to commissioners have failed to provide much useful data.

There appears to be far more variation within provider types than between them

- Commercial and not for profit providers appear to use more clinicians, particularly non-Pathways clinicians (though there are caveats about this finding).
- There is relatively little difference between provider types compared with the variation at contract level in performance in answering the phone, in patient feedback from surveys and there seem also to be little difference in ED and ambulance disposition by provider type with the slight differences changing depending on the data source used.
- But for most of the metrics it was very difficult to make any comparison because of the lack of comparability of the data.

That the vision of an IUC seems to have been forgotten or compromised

- The 2017 vision of a clinical assessment service (CAS), which was at the heart of the vision for IUC services completing all, or virtually all, of the assessment and treatment that could be provided by phone has not been realised and the associated KPIs have failed to drive the intended change. The vision seems to have been forgotten – or has possibly been shelved as just too hard to do.
- The ambition to offer “consult and complete” in which, except at peak times, patients would receive all the advice and reassurance necessary over the phone on their initial call to the service was never realistic. But to finish the assessment with relatively few cases requiring more than one ring back by a clinician is achievable. We appreciate that as the skill mix is widened the demand for particular skills will be small enough that it is impractical for them to be part of the core CAS, except perhaps at busy times. But even when there are a limited range of skills available, the trick that most providers still have to learn, is to train health advisers how to judge which clinician is most likely to be able to complete the case.
- In most services significant numbers of patients receive telephone advice from a number of clinicians, often from different organisations. Each stage involves an additional queue and delay so that time to the final telephone outcome can be several hours. We are concerned that, too often, commissioners and clinical leads are blind to the clinical risk associated with these delays.
- Part of the vision of an IUC was that services would learn to make effective use of the resources available to them. The data shows that health advisers are very seldom completing cases as self-care, despite the fact that NHS Pathways was designed to allow this. Some providers still believe it to be a condition of the Pathways licence that clinicians call patients

to confirm the self-care advice, even though there was a specific objective and KPI to move away from doing this in every case (with suitable risk management and clinical oversight during the change).

- Our analysis suggests that IUC services have a long way to go before they can claim they are successfully directing patients to the right service. What RAIDR does show is that IUC services frequently report one outcome but patients follow a different path. We maintain that if a recommendation is ignored then little or no value has been added by the service, certainly in the eyes of the patient.
- These findings lead us to the conclusion that, despite claims to provide a virtual CAS, there is no evidence from the published data that most providers are operating in a more integrated way than before. Even where we have found a provider that collates the data for the whole pathway and examines, for example, the number of contacts and the time taken to telephone outcome, the published data does not reflect this.
- If a service is to operate in a truly integrated way those involved need to be very conscious that each of the following factors make it more difficult to deliver a fully 'joined up' CAS at the heart of an IUC service:
 - The use of more than one system, or more than one instance of the same system within a 'virtual CAS' so that it is more difficult to recognise and minimise the number of separate contacts with different clinicians.
 - A CAS that does not co-locate health advisers, clinical advisers and a significant number of non-Pathway clinicians such as GPs – there was strong evidence from the pilots doing this led to important learning for both clinical and health advisers and improved outcomes.
 - Clinical advisers and non-pathway clinicians belonging to different organisations – with this factor being even more difficult if there are separate operational reporting lines or supervisory structures that make it more difficult to reallocate clinical resource to different queues and between face to face and remote consultations as things change.
 - Any difficulty in collating data into the day to day and longer-term management reports, metrics, dashboards and KPIs. Indeed, if this is the case there is an argument that the service is not integrated.

This is emphatically **not** to suggest that it is impossible to involve more than one organisation in delivering an IUC or that the totality of the CAS has to be co-located with the health advisers. There are great strengths from involving local clinicians and this can often be easiest if they belong to a local organisation and there are often good operational reasons for wanting a proportion of the clinicians to operate from a base where they can contribute to the CAS, but also see patients face to face. But it is to say that when any of the factors above exist great care is needed to develop an approach to managing the service to ensure it operates as one with the various parts linked and co-ordinated. This is, after all, a pretty good definition of what integrated means.

Current KPIs - and new KPIs scheduled to be introduced in April 2021 – mostly fail to measure the quality of patient care

- New 'Key Performance Indicators' (KPIs) were introduced in 2018 together with guidance and instructions for collating the data². For the reasons outlined above they do not provide a sound basis for comparing performance.

The KPIs and instructions for the ADC data collection are available on the IUC landing page at:
<https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/>

- Some of the current KPIs measure activity and are far from key indicators. The measures focus too little on the clinical care provided and the effectiveness of the service in reducing and managing the pressure on the urgent care system (as well as the wider NHS). Two examples of this are the metrics that report on the number of cases with an ED or Ambulance disposition that are revalidated (both of which remain in the new KPIs). This is simply a count of cases, gives no indication of the clinical value added and gives no credit to the service that trains health advisers to ask probing questions thereby reducing the number of cases to be validated and the chances of them being redirected. Within Appendix One we propose an alternative.
- The new KPIs also retain the most problematic metric – KPI 15, or KPI 4 in the new set – recording the proportion of cases receiving clinical input. This is estimated in very different ways, so that the results are inconsistent, the reported trends misleading and, even if reported accurately, the metric tell us nothing about the value added by these clinicians.
- The new KPIs also water down some standards. It is proposed to change the target level for call answering from 95% answered in 60 seconds to an average call answering time of 20 seconds. Historically those that achieved 95% typically answered calls in an average of ten seconds. The public is told that 111 is the number to ring “if you have an urgent medical problem and you’re not sure what to do”. Calculations using the Erlang formula to compare the staffing levels required indicate that the 95% answered in 60 seconds is equivalent to the normal commercial standard for call answering (80% answered in 20 seconds). To move to a standard that is lower than normal commercial requirements seems to be surprising for such a service. Providers will argue that answering the phone within the standard requires the right number of trained health advisers – and that the market price does not support this. We have sympathy with this view but, rather than lower the standard, we feel commissioners should fund the service to meet it.
- And some new KPIs also impose requirements that will be difficult to meet. The requirement to phone back 95% (or even 99% for the most urgent) with the new KPI 5 seems most unlikely to be achievable.
- The new KPIs also take away the focus on the time to telephone outcome (the definitive phone assessment). This is important particularly because of the clinical risk in a long tail to the end of telephone (or video) assessment. The existing measure of the average time to telephone outcome failed to do this too, but we propose that it be changed to focus on those cases that take many hours before the telephone outcome is reached.
- But the fundamental problem remains. Until commissioners insist, as the specification requires, that data is joined up to support not just accurate reporting but also to performance manage and inform the ongoing development of the IUC service, changing the KPIs will not resolve the issue that the data collated provides little useful information.
- There are difficult issues that need to be tackled if the NHS wants to be able to make meaningful comparisons about patient experience, safety, effectiveness and cost of different urgent care services and their ability to work with others across the health and care system.

There are opportunities for developing more meaningful outcome measures

A large number of constructive and helpful suggestions were made during our meetings with managers and leaders from the sector including that:

- The KPIs should, so far as is practical, focus more on outcomes than process. This is, of course, easy to say or to agree with, but it is much more difficult to devise such indicators. Nevertheless, as part of those discussions and in follow-up calls we have tried to take up the challenge.

- It might be helpful to reorganise current KPIs against the framework used by CQC (are they safe, effective, caring, responsive, well-led). When we did this, it highlighted that most current and proposed KPIs focus on responsiveness and count activity. But it also highlighted the opportunity to include a wider range of metrics.
- The KPIs must focus on the whole of the patient pathway – there was a feeling that the present metrics focus exclusively on the 111 ‘front end’ rather than the clinical value added later in the process. This may be more of a reflection on the fact that data is not collated for the whole pathway rather than being a problem with the KPI itself.
- Genuinely comparable information assembled as a benchmark would offer real value in highlighting where services might be improved. Such a comparison would also be able to highlight the clinical value that good providers deliver in reducing the pressure elsewhere on the system.
- If KPIs are to be valuable, we should be clear what purpose they are intended to serve. There is a big difference between the conversation that takes place when they are used to highlight areas where improvement may be possible so services and people work together to investigate the detail from metrics that are used for contract management where the conversation can be simply about whether it is ‘green’.

As part of these meetings and, in discussions that followed, we have developed an alternative set of indicators that are described in more detail in Appendix One. In developing them they were shaped by the following:

- The IUC KPIs can never provide definitive detail for performance or contractual management. But they can, if chosen well, provide a bundle of indicators that allow one to compare the operation of IUC systems ‘in the round’ and identify possible areas that might be improved. Investigation to look at the detail, typically by categorising the cases and following a sample of those through the entirety of the care pathway, will still be necessary to inform the detailed changes required.
- If KPIs are to focus on what matters, we need more metrics that focus attention on patient safety, effectiveness, whether services are caring and if they are well-led. But if the bundle is to be manageable there should not be too many – which implies removing or merging some of the existing KPIs.
- In choosing KPIs we should consider what data is required and how it will be collected. Unless we are sure that the data is available or can reasonably be collected, the KPI is not viable.
- Our proposals are a starting point. Although we have consulted and sought feedback, others may have suggestions and improvements that they can offer. A wide engagement that includes IUC providers, commissioners and that engages with the emerging ICS leaders is important to getting them right and garnering support for the changes. This does not need to take long, but it is essential.

And a final reminder, none of this is useful or possible unless the underpinning issues with data quality and the failure to join information from different systems/providers within the IUC (and beyond to other parts of the urgent care system) are addressed. For more detail on all of these issues, please go Appendix One.

D. Recommendations

Our recommendations are focussed on particular parts of the healthcare system – service providers, local commissioners or national policy makers – but to be effective, it will need a whole package of changes to be implemented together. As we move towards integrated care systems, supporting integrated urgent care, it will be no surprise that piecemeal measures will not be enough. We sincerely hope that with the move towards integrated care systems the environment will be more supportive of the changes. But we are under no illusions about the difficulty. Genuine improvements require the health system to work in partnership, not passing the buck to others – and it is hard work!

It feels counter-intuitive, in summarising our recommendations, to separate them out when we are looking for those within the system to work in an integrated way and this also means that some items are repeated. But we feel it is helpful to identify who should take the lead on each of the actions.

Commissioners and providers together

- The scope for each IUC contract should be defined agreed and published as contextual information alongside the KPIs. Three elements need to be described – there is a minimum ‘core’ part for each and some additional services or features that may form part of one IUC, but not another. We have described this in more detail in Appendix One and our proposals provide what, we hope, is a flying start that can be developed as part of the NHS England work on the specification (which should define the core and give some insight into the detail in which additional elements might be described with some examples).
- The scope should also make clear the mix of cases that feed into the IUC. Apart from calls to 111 from patients and carers we would expect it also to include online cases that are passed into the system for call-back by a clinician, the calls from health professionals that come into the CAS and 999 calls if they are also assessed as part of the same CAS.
- This contextual information is vital to interpreting the data that is collated about the IUC and it provides a sound basis for cross-checking that each of the data elements that is submitted includes data from the entire IUC.

IUC Service Providers

- Commit to share the necessary data to allow the full data set for the entirety of the IUC to be collated. This should be at patient case level, be suitably anonymised and made available to both providers and commissioners. It should contain all of the data needed to calculate or validate the various metrics (National KPIs, locally agreed measures, those required for management information and those for performance improvement). This dataset should allow ‘drill-down’ to case level so as to support analysis, investigation and improvement. And it should also allow (with suitable safeguards) specific case identification so that, when it is required, the details of the algorithm used, of the full patient journey, of the voice recording etc. can be obtained.
- Review data quality based on the scope for the IUC to ensure that all of the relevant data is available and reported in line with the KPIs and metrics defined both Nationally and locally.
- Review the way that the system is configured and used by clinicians to ensure that all of the relevant data is consistently and accurately reported. We are aware that the flexibility that is available within the Adastra system to allow clinicians and staff to work in particular ways can make it difficult for any standard report to accurately calculate the data for the MDS, ADC

and KPIs. Equally with other systems we have seen that clinicians can sometimes find several different ways to manage a case, again making reporting difficult or potentially unreliable. We understand that NHS E has commissioned Adastra to build a standard reporting suite – but each provider will need to check that their system is configured and used in such a way for this to work – and if that is not practical, to develop their own reporting suite or approach to provide the relevant data.

- Work with others to support the development of the new KPIs and data reporting system as outlined towards the end of the more detailed paper on the KPIs (see Appendix One). Commit to report the types of metrics and KPIs outlined in this report to commissioners and publicly, even before any change in the National data collection.
- Support pilots to develop the data extract that will underpin the KPIs and metrics. The goal is to ensure that this data is fed automatically without requiring intervention, correction or validation.
- Actively support a national benchmark that will highlight local good practice and focus attention of areas that need to be improved.

Commissioners of Urgent Care

- Consider, in the light of this report, how integrated their service really is. Explore with providers what opportunities there are within the existing contracts to further join the different elements together in the interests of patient experience, safety, effective use of resources and improved reporting on the totality of the service and urgent care system. Work with providers to achieve this.
- Where necessary, insist on accurate and full reporting on the totality of the service, not just for the National metrics and KPIs, but also for local measures and that data required to performance manage and inform the ongoing development of the IUC Service is shared as required contractually as part of the specification.
- When commissioning new IUC services (or extending existing contracts) ensure that the specification details the scope to be included in each of the core elements as well as any additional services and ensure that bids are submitted to provide the cost of each part.
- Whilst commissioning the service ensure that the chosen provider(s) are offering a genuinely integrated and complete service - look particularly at the CAS to see how this will operate as one at the heart of the IUC system.
- Promote or act as a catalyst to ensure that data across the urgent care system is joined and then made available (suitably anonymised) to provide comprehensive information to commissioners and providers about how patients move through the urgent care system in sufficient detail to support service improvement. Ensure that this will allow drill-down to the case level detail for each of the key metrics and performance indicators.
- Support an extended pilot project across local IUC health systems to develop a standardised approach for establishing a common data extract and agreeing how it will be implemented in a genuinely consistent way, as the basis for open, transparent and reliable monitoring of performance across England.
- Take part in a national programme of support for local urgent care systems, incentivising and enabling good data quality and the ability to connect up different data sets.
- Make active use of new improved performance information to drive up the performance of the local urgent care system.

National Policy Makers

- Either extend the current review of integrated urgent care KPIs to ensure that there is time to reflect on the findings of this report and the additional proposals for new KPIs that offer increasing insights into the quality of patient care rather than levels of activity or make clear that alongside the new specification it is planned to introduce a fuller more rounded set of metrics and KPIs that will replace the proposed new set.
- Ensure that there is a widespread consensus supporting new proposals for national metrics by developing a 'national conversation' that builds on the findings of this review.
- Work with NECS, who manage RAIDR, to support improvements in this national tool for integrating data sets from GP out-of-hours services and A&E. For more details, see paper prepared for NHS England at Appendix 5.
- Use this understanding to contribute to the new high-level national metric for emergency and urgent care.
- Make resources available for a national pilot project across local IUC health systems to develop a standardised approach for establishing a common data extract and agreeing how it will be implemented in a genuinely consistent way, as the basis for open, transparent and reliable monitoring of performance across England. The Primary Care Foundation and Methods Analytics have a clear view of how this might be put in place and would be happy to work with a small number of services to deliver this.
- Support a national programme of support for local urgent care systems, incentivising and enabling good data quality and the ability to connect up different data sets.
- Consider commissioning a national benchmark for integrated urgent care, to ensure that genuine comparisons can be made across all local urgent care systems.

E. Proposal for Next Steps: data quality benchmark & performance improvement in IUC

We are keen for this review to act as a catalyst for change.

There are serious problems with the quality, collection and use of data that constrains data led improvement in urgent and emergency care.

The new national metrics are flawed as the data required to underpin them is inconsistent. We have identified discrepancies both within and between organisations that makes current data collections inadequate for meaningful use.

We propose four interconnected initiatives that would help improve data quality and enable performance to be compared using appropriate metrics:

- Establishing a consistent approach for recording and collecting data from across the urgent care system.
- Agreeing a new updated set of KPIs that measure the quality and outcome of care rather than just measures of activity.
- Create a public benchmarking service
- Embrace IUCDS – the Integrated Urgent Care Data Service initiative – and ensure that lessons learnt are fed into the central team and made available to all commissioners and providers

The first of these will provide the basis for the Integrated Urgent Care Service to be data led, transforming the ability of the provider to ensure that the service is truly effective and operates cost effectively. With confidence in the quality of data, meaningful measures and metrics can be created and monitored both at a single provider level permitting ongoing data driven improvement and monitoring, but also allowing the service to demonstrate its effectiveness in benefits to the system as a whole. Our third initiative then brings this together into a benchmarking solution enabling commissioners and providers to recognise where they stand compared with others and promoting the sharing of best practice and provider and regional improvement activities. The final element is to ensure that the learning from the pilot is widely spread. But there are benefits too to the IUC service. Just to take one example it will allow the service to really understand how to reduce the number of ring backs between the '111' and 'OOH' service thereby both improving patient experience and saving money.

Note that the benchmarking solution, in our view, should be publicly accessible. It may be, in the initial phases, useful to anonymise organisations other than for appropriate logged in users. Transparency of outcomes is a potent motivator to improve.

All of these initiatives require support from a wide range of partners across urgent care, including providers, commissioners, organisations that manage the information systems, national policy makers and regulators. Our conversations so far suggest that there is the appetite and goodwill to work collectively in this way. The current policy drive towards Integrated Care Systems makes this more important than ever. This broad support is necessary due to the current fragmentation of providers along the pathway, the technical systems they use and inconsistent models of care.

The Primary Care Foundation has a long track record of developing practical solutions for reviewing and comparing performance, including the GP Out-of-Hours Benchmark commissioned by the Department of Health in 2007 and then purchased by two thirds of commissioners across

England and, more recently, diagnostic audit tools such as the Potentially Avoidable Appointment Audit (PAAA) commissioned by NHS England.

We have developed a strong partnership and working relationship with Method Analytics, as data experts. Method Analytics also have recognised expertise in pseudonymising and joining a wide range of NHS datasets to create integrated metrics, supporting benchmarking and detailed analysis.

A pilot, or Proof of Concept, across IUC systems

We would like to establish a proof of concept (PoC) with (say) five local integrated urgent care systems. Working as a team, including partners across the urgent care system supported by independent experts. The PoC would consist of two phases, an initial discovery and then a proof of the concept solution. The benchmark would create, over time, a mutually supportive framework for consistently comparing performance & driving improvements in quality and patient care (see diagram). Importantly it will assist those participating (and others through the lessons learned) get ahead in lining up their data for the IUCDS. They will also, of course, enjoy the benefits from the analysis of the data and lessons earlier.

The Primary Care Foundation and Methods Analytics have a clear view of how this can be put in place and we propose to work with a small number of services to develop the proof of concept.

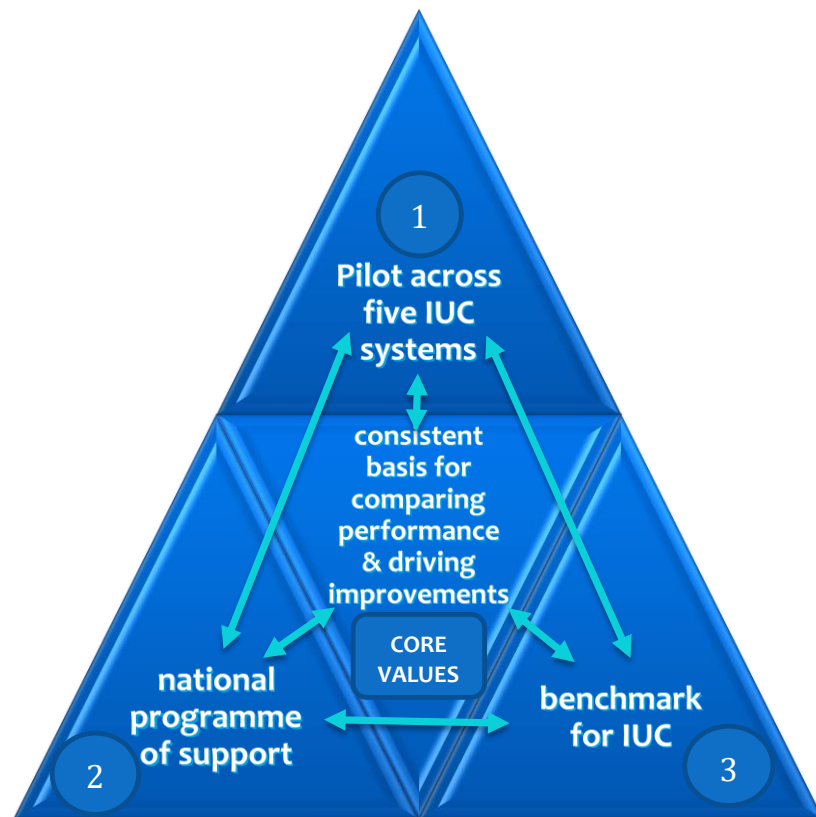
The key components of the PoC approach will include working alongside local providers and commissioners to:

- Develop and put in place a standard for IUC data elements
- Design and test out the new process for consistent creation and validation of data.
- Develop a standard minimum data set, based on pseudonymised linked data, for providers and commissioners to really understand how their system works.
- Bring together the data sets across the five PoC sites to validate the standard data elements and minimum data sets are comparable in the real world data.
- Work across all five sites to develop and agree a new set of metrics that inform improvement.
- Prepare a report for each site on outcome against the new metrics. We would expect this report to provide a full range of incisive recommendations to improve the service and to deliver a mix of benefits to both providers and commissioners
- Prepare a summary report looking at variation across the five sites.
- Run a session across the five sites, with partners across the local IUC system, to review data quality, make sense of the variation and assess the strengths and weakness of the new metrics.
- Prepare a summary report reviewing the learning across the five sites with implications for rolling out the learning and developing more widely, supporting the IUCDS, high level National comparison and a more detailed benchmark.

The PoC would provide evidence for establishing a national programme of support for local urgent care systems, incentivising and enabling good data quality and the ability to collate and link different data sets. It will also demonstrate how to extend this pilot work Nationally and into a wider benchmark for integrated urgent care, to ensure that genuine comparisons can be made across all local urgent care systems.

We estimate the PoC will take six months to complete, assuming sufficient engagement with and access to relevant staff. It would then be possible to design and develop a broader programme

of national support, rolling out the findings from the proof of concept and, in turn, developing a common framework for a national benchmark.



What are the benefits of being a pilot site

There is always pressure and too much work to do ... but we envisage a number of important benefits for the local Integrated Urgent Care system.

- ❖ Immediate opportunities to improve the service and to reduce costs. Two examples illustrate some of the opportunities:
 - Effort is expended in ringing patients unnecessarily. Too many patients speak to a health adviser, a clinical adviser and non-Pathways clinician and some of these will also speak to an OOH clinician. Identifying where this happens most frequently and how the service can best 'short circuit' the process will not only improve patient care it will also save money.
 - RAIDR data consistently shows that nearly as many patients that are NOT expected to go to A&E attend A&E shortly after a 111 contact as those that are recommended to attend A&E PLUS those for whom an Ambulance is despatched. Understanding what is happening and improving the process (for example by providing greater reassurance and explanation) may well provide a route to significantly lower the pressure on A&E services (and reduce costs).
- ❖ The process will ensure you have the best possible data quality and can make genuine comparisons with other sites across the Country.

- ❖ The lack of accuracy and transparency has been an open secret across urgent care services. Failure over many years to tackle these systemic issues demoralises staff and erodes confidence in national metrics.
- ❖ Address the frustration that however hard you work on improving data quality progress remains slow and limited.
- ❖ Currently, services have been required to tackle perceived problems based on flawed metrics. Once you have tackled these issues, you will be able to focus your energy and attention on the relevant issues that drive improvement.
- ❖ At some point, this may become an issue of concern to national and local media and has the potential to erode trust in the NHS. Taking active steps to address this issue mitigates against this risk.
- ❖ Being able to make genuine comparisons about how your services perform compared to others, initially across pilot sites and, in time, across the Country, offers the opportunity for significant improvements, potentially reducing workload and pressure on services and improving patient care.
- ❖ In future, you will be able to identify your strengths and weaknesses, sharing best practice where you are leaders, and learning from others where your service is behind the curve.

To summarise, not only is it the right thing to do for patients and for the NHS, by tackling the problem you will release benefits to providers, commissioners and the wider NHS and you will be demonstrably amongst the first services to properly and accurately report on the operation of the totality of the IUC service including both the '111' and 'OOH' elements as spelt out in the specification.

The cost of running a pilot site

We have explored the work involved in this pilot with our data experts, Methods Analytics, and we estimate that work for each pilot site, or across one IUC system, is likely to be in the region of £85,000. This figure will vary depending on:

- The number of provider organisations involved across the pilot area. Data will need to be collated from each service at patient contact level and joined to allow the overall flow across the system to be understood and reported on – so this is a major driver of cost.
- To a lesser extent the level of granularity at which the data is to be analysed is also important as it will drive reporting costs. Is it to be by commissioner, by the new ICS areas, by CCG, by PCN or practice?
- The extent to which extracting and validating data has already been tackled (for example because much of it is already routinely assembled in a data warehouse) or can easily be adapted to give a flying start.
- There are options, too, for commissioners and/or providers to take on different aspects of the data preparation rather than leaving us to drive the programme of work.
- The cost is also dependant on the extent to which the various organisations across the system are whole-heartedly in support of the initiative. We will be wary of taking on a pilot if it looks as if too many partners have been pressured into taking part, rather than being enthusiastic participants.

So, the cost of the pilot will depend on the scope of the pilot, the numbers of organisations and separate IT systems involved as well as the willingness of those involved to contribute and make things happen. We would need to discuss this in greater detail, to carefully scope what is to be included within the pilot and before providing a fuller proposal and justification supported by a final cost.

Potential sources of funding

Currently, PCF have chosen to carry out much of the work on this review unfunded as part of our remit as a Foundation. But we have now reached the point where to take this further forward additional resources will need to be found. It may be that funding could be shared in a number of ways. This could include:

- Financial contribution from partners across the local IUC network, particularly local commissioners
- National funding from NHS England and NHS Improvement - although to date, while NHSE&I have been supportive, they see their main investment as in the development on IUCDS through NHS Digital. NHSD are keen to work alongside the pilots and build on the learning to develop a better national framework for the future, which may take some time. But an approach from all the pilot sites together on the basis that local improvements would inform national improvement, might be well received, particularly as data quality is seen as a priority for 2021/22 and it will be an important initiative to support the introduction of Integrated Care Systems.
- One-off funding available for innovation in health care.
- Further financial support from the Primary Care Foundation as we will provide our time and expertise at a reduced rate.

To take this forward

To explore this opportunity further, please email us info@primarycarefoundation.co.uk or call Henry Clay on 07775 696360 or Rick Stern on 07709 746771.

F. Appendix One: Proposed changes to the KPIs

The original vision

It is salutary to remind oneself of the way that the IUC was expected to operate by quoting an early part of the specification for an IUC (published in 2017 and still the current specification):

The IUC Service must be designed around the patient's expectations that:

- *Their problem is dealt with on the initial call, including receiving a consultation from a clinician where appropriate;*
- *The assessment will be quick and not involve unnecessary questions;*
- *In an emergency an ambulance will be dispatched without delay;*
- *Their call will be warm transferred to a clinician where clinically appropriate (even if that resource is not co-located);*
- *When a call back is necessary during periods of peak demand any call back is within safe timescales;*
- *For the majority of Patients, their call is completed on the telephone (the "consult and complete" model)*
- *The IUC service has accurate up-to-date information regarding the 'locations of care' and pharmacies in their locality including but not limited to knowing opening times and services offered;*
- *The service has accurate and up-to-date information regarding local capacity, including new GP extended access offer, and to make appointments;*
- *Any prescription required will be sent directly to a convenient pharmacy where appropriate; and*
- *If further care or advice is required they will be referred automatically (electronically) where possible, or signposted to another service including those outside the scope of IUC.*

We accept, of course, that elements of this vision are not realisable with the current model and we accept too that other things have changed or developed since 2017, but it still seems useful to remind ourselves of the above points (and other elements of the vision) as we explore the KPIs. We begin each section with a reminder of those of the design criteria that are relevant.

General comments and introduction

The existing process for collection and collation has lots wrong with it. We, too, feel that the metrics and processes should be reviewed. But before changing them we should consider:

- The value of continuity and trend analysis. We should be cautious about changing the metrics if they already provide a reasonable mechanism for measuring performance. The old adage, that "if it ain't broke don't fix it" should apply!
- Some of the questions that we should check are;
 - Does the change make it easier to ensure comparability?

- Are we certain that the new metric can be consistently counted and will provide a better and more useful comparator than its predecessor?
- Have we evaluated whether any new indicative target is realistic?
- Have we tested data collection across a number of provider processes, systems and ways of working to ensure that we will get good quality, trustworthy and valuable data?
- Is each of the KPIs important and valuable? Does it usefully contribute to monitoring and comparing patient safety, patient experience, effectiveness of the service and clinical quality? If it does not do this, we should ask ourselves if it need be a KPI.
- There may also be good reason for collecting data that relates to an important element that we should monitor or an important change that we are looking to drive. But, whilst we should collect the data for this, and we may even choose to set goals or targets we should be very wary of defining it as a KPI. There may also be contextual data that we should collect – but, again, this does not a KPI make.

There are three further points that we feel are important if the KPIs and data collection instructions are to be revised

- The term call should be used for telephony measures only. Thereafter use of the term ‘case’ instead of ‘call’ is much clearer. There can be many calls (incoming and outgoing) about one case. The use of the term cases also allows for cases that originated through 111 online to be included in the count of the metrics that follow triage in the pathway. There was also a commitment made to the IUC forum by NHS E that when the KPIs were revised this change in terminology would be implemented. It should!
- An associated issue is that the data should include cases that do not commence with an incoming phone call to 111. To us the following types of cases are all part of the workload of an IUC:
 - Cases that commence with a call on 111
 - Cases that commence online
 - Cases that commence with a 999 call but are passed to the CAS
 - Calls from health professionals seeking advice from the CAS (whether they come in through 111 and the ‘star’ lines or, because of difficulties with masts, on a separate number)

These are all part of the workload on the service and there is no logic in only counting calls as defined in ADC 24 or, in the new guidance, C01. Should it be thought important to separate cases for purposes of understanding the mix that can be done – but for the later metrics we feel it is best to include all cases. All are part of the work carried out by the provider and, as far as we can tell, many providers do this in any case. Most importantly each interaction is part of the integrated urgent care system that commissioners and providers are working to improve – and the online element can reasonably be expected to grow over time.

- And, to understand the process by which dispositions are arrived at, the guidance should recognise that cases may be completed by an IUC in a variety of ways (and the recent pandemic has highlighted just how useful some of these are). We recommend the following as the basis for some definitions:

Face to face consultations are those consultations where the patient and clinician are physically in the same room, allowing the clinician to undertake a full range of observations. Such a consultation is still a face to face consultation if the clinician also provides some guidance online or by email. However, if the first consultation is followed up with a second consultation by phone or email then these consultations should be recognised as two consultations, one face to face and one remote.

Face to face consultations include both

- Home visits and
- Face to face consultations in an IUC

Remote consultations are consultations that take place when the patient and clinician are not in the same location and these include

- Telephone and voice only consultations using VOIP (Voice over internet protocol)
- Video consultations
- Email consultations or email guidance given after an online assessment
- Consultations, advice and guidance provided online through an 'app' or through a 'chat' function

We suspect that it is easy to revise the KPIs and guidance to include these definitions and then to make changes as appropriate to reflect the change in the wording through both documents. The categorisation needs to be recognised in the planned new specification too.

Finally, there is that elephant in the room. The majority of services that we spoke to, when we explored the details of their IUC, reported that they operated on two different systems or instances of systems. Most use Adastra, but most have a separate system for health advisers and clinical advisers from that used by the 'OOH' service. This means that they do not find it easy to report on the totality of the operation. When we looked at the published data and followed up in discussion we found that services are reporting on very different parts of an IUC service. We could find no service that reports on the entirety of the "integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call-handling and former GP out-of-hours services" that the specification for an IUC describes.

There is a legitimate argument that until they can correctly report against the KPIs and until they are able to follow the route that every case took through the entirety of the IUC from call receipt (or online access) through to the end of the case within the service that they are commissioned to provide, the service has failed to meet the most basic requirement of being an integrated service.

It may be that in the planned changes towards integrated care systems, the environment will make such a change easier. But, even now, it is a contractual requirement that is written into the specification that ‘data and information can be shared between providers’ and that ‘commissioners should ensure that providers are contractually obliged to share any corporate data required to performance manage and inform the ongoing development of the service.’

We have spoken to several services that riled against our assertion in our initial draft paper for discussion that *“services seem to have lost sight of the ambitions spelt out in the change to IUC (and the specification). Certainly, there is no evidence from the data that any are operating the CAS as it was envisaged”*. In nearly every case where this has been challenged we have found this same problem persists. To characterise it brutally, they are still operating too much like separate ‘111’ and ‘OOH’ services and, certainly they are failing to report on the operation of the ‘111’ and ‘OOH’ services as an IUC.

Commissioners need to insist that the data is joined (and NHS E need to remind them of this responsibility) – it is in the interests of all of us that IUC services work better and until this obstacle is cleared away IUC services will continue to operate less efficiently and less effectively than they could if they were fully integrated in this respect.

Clinical assessment

Existing metrics	New metrics proposed by NHS E (2021)
KPI 3 % called back within 10 minutes by a clinician (≥50%)	KPI 5 % called back in agreed timeframe by a clinician (≥99%, a or 95%, b&c)
Average time to call back can be calculated from Q022 and Q043	Average time to call back MAY be calculable if the guidance to B10 changes Q019 to Q043...
KPI 12 Average time to telephone assessment outcome	Discontinued and no analogue metric introduced
KPI 15 % of cases assessed by a clinician (≥50%)	KPI 4 % of cases assessed by a clinician (≥50%)
KPI 8 % of callers recommended self-care at the end of health adviser input (≥15%)	Discontinued and no analogue metric introduced
KPI 9 % of callers recommended self-care at the end of clinical input (≥40%)	KPI 6 % of callers recommended self-care at the end of clinical input (≥15%)
KPI 10 % of calls where prescription medication was issued (≥80%)	Discontinued and no analogue metric introduced

Note that KPI 8, 9 and 10 are included here as they relate to the outcome from clinical assessment but they are discussed under the section on effectiveness rather than here.

Design criteria

The IUC Service must be designed around the patient’s expectations that:

- *Their problem is dealt with on the initial call, including receiving a consultation from a clinician where appropriate;*
- *The assessment will be quick and not involve unnecessary questions;*

- *Their call will be warm transferred to a clinician where clinically appropriate (even if that resource is not co-located);*
- *When a call back is necessary during periods of peak demand any call back is within safe timescales;*
- *For the majority of Patients, their call is completed on the telephone (the “consult and complete” model)*
- *Any prescription required will be sent directly to a convenient pharmacy where appropriate; and*

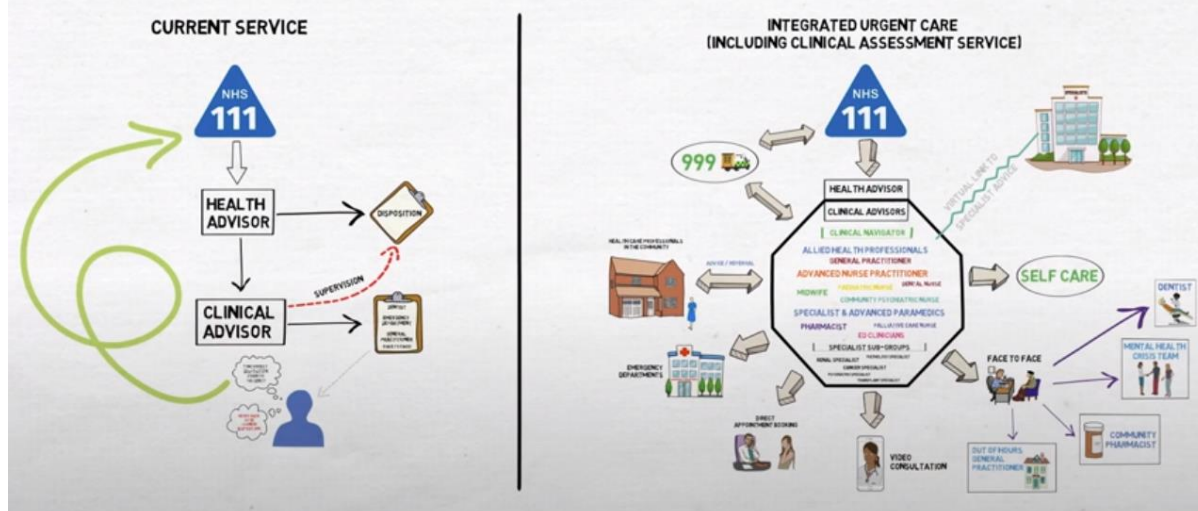
Two important parts of the vision of an IUC were that:

- *The CAS would direct cases to the right place (including providing advice by phone if that was the right thing to do) at the right time*
- *The CAS would work in such a way as to make best use of the available skill mix, avoiding the need for a patient to be passed from one person to another for repeated phone assessment.*

There are few services that measure up well against this vision. Relatively few calls are dealt with on the initial call **including receiving a consultation from a clinician where appropriate**. Only a small proportion of cases are warm transferred and call-backs are the general rule. Certainly they are not confined to periods of peak demand. Very little progress is reported in reaching the point of the majority of cases being completed by phone (and the proportions of ‘speak to’ dispositions have barely changed).

Before talking about the detail of the KPIs there are several points that are worth making about clinical assessment.

- One of the key elements of an Integrated Urgent Care service (IUC) was always that the CAS would transform the front end of the existing service. A mix of clinicians would work with non-clinicians to deliver, as near as practical, all of the advice that could be given over the phone to any caller. The CAS was envisaged as working at the heart of the system as shown in the shot from the video produced at the time included below. Importantly it was anticipated that services would become smart in how they used the resources available to them (the wide range of clinical skills and the non-clinical health and service advisers) so as to work effectively in directing patients to the right service or outcome in a timely fashion and in a minimum number of steps, so avoiding additional queues.



- Prompt clinical assessment is important. Accepting that any call that has been assessed by a health adviser through NHS Pathways has received at least a measure of assessment, there is still clinical risk associated with those cases awaiting definitive clinical assessment. That risk is of particular concern when cases are passed from one queue to another so that the final clinical assessment takes place many hours after the initial call. Yet, whenever we have joined data from '111' to the 'OOH' service we find significant numbers of calls that wait for many hours for definitive clinical assessment to be completed. This is a safety concern.
- Assessment by a clinician is not essential – NHS Pathways was designed for use by non-clinicians and includes suitable advice and guidance to give the patient/caller. We see no value is added by requiring clinicians to speak to patients/callers who are happy with the guidance given by the health adviser (though we do understand why the precautionary principle was applied when NHS Pathways was first used and this was demanded).
- KPI 3 allows the first attempt to contact a caller to be counted in measuring the time to call back – the new KPI 5 allows the same leeway.

KPI 3 and time to call back

Data Quality

We have analysed the information about the total time to call-back and calculated the average time to call back in the hope that this might provide a more helpful crude but quick comparator. Unfortunately, this is inconsistent with the numbers that are reported against KPI 3. More than half of contracts show a total time to call-back in at least one month that is impossibly short, even if all those that were called back within 10 minutes had been called instantly and if those that took more than ten minutes had

been called at exactly 10 minutes. This places great doubt on one or other of the sets of data. We find the planned amendment to ADC Q019 (to become B10) to state that “Calls should only be included if the corresponding call back waiting time is also captured in B11” puzzling as this appears to make it equivalent to ADC Q043, though this metric is reportedly to be abandoned.

The KPI

The current KPI 3 provides a simple measure of the overall responsiveness of the CAS in ringing patients back. It is a crude measure in that a service which manages to warm transfer significant numbers of calls to clinicians is obviously responding very rapidly to those cases, but they are not counted in the metric (though a possible change that would address this issue would be to count warm transferred cases in both the numerator and the denominator). Equally it provides no indication of the length of the very sizable tail that extends beyond ten minutes. The metric serves as a simple but crude measure of responsiveness and patient experience. Because of the long tail and because it counts only to the first attempt, it provides no reassurance about the clinical risk in the queue for call-back.

We can see no merit in changing this metric to the three new measures (New KPI 5 a, b & c) that still have exactly the same problems. Not only does it introduce a discontinuity over time, it also makes it a complicated but crude indicator. But what is really puzzling are the targets that are being set – is it really credible that achievement of 99%, 95% and 95% can be delivered?

If you accept our assertion that the metric is only a crude, simple measure of responsiveness and patient experience then there seems little point in changing KPI 3. Maybe, in the future when the data can be trusted, it could be replaced by the average time to the first attempt to call a patient back as an alternative – but either does the job of giving a quick indicator of how responsive the service is – and it is an indicator that does not penalise the provider when the patient fails to answer, which seems appropriate for an indicator serving the purpose described.

KPI 12 Time to telephone outcome (definitive clinical assessment)

Data Quality

Even based on the reported figures it is clear that most services fall some way short of the old NQR level. But the situation is far worse than this as a large (but unknown) proportion of these figures fail to include the phone assessment that takes place in the ‘OOH’ organisation. Certainly when we have joined data between organisations it is not uncommon to find cases that take more than 6 hours to the telephone assessment outcome. Such cases are clearly a clinical risk and, frankly, it is no surprise if callers waiting this long choose to go to A&E.

The KPI

We believe that the time to definitive assessment is important for the safety reasons outlined above. We agree that the current KPI 12 (average time to telephone outcome)

does not address this safety issue well as the length of the tail beyond the average is unknown and, in most services, unreported and unexamined (though a very few do undertake regular reviews of a sample of those where time to telephone outcome is extended, these are the exceptions). KPI 12 does, however, at least encourage commissioners and providers to look at the time to definitive assessment – though, were it to be continued, it needs to include other types of remote consultation such as video or online responses via chat or email. Were it to be measured properly, the existing KPI 12 – average time to telephone assessment also provides a useful measure of the overall responsiveness in dealing with cases remotely – and this is something that is valued by patients and a key measure of effectiveness. For these reasons we believe that it is valuable and s

But to remove KPI 12 and not replace it means that there is NO metric covering time to definitive clinical assessment. This seems to us to be a grave mistake. In the NQRs for OOH services the relevant timescales to the start of definitive clinical assessment were 20 minutes for urgent cases and 1 hour for less urgent (with an expectation of 95% being achieved within these timescales). When reporting on the OOH benchmark findings we used to equate getting near to this standard with an average response time of 20 minutes. Looking at the current report for November, admittedly for the time to the end of phone assessment, only 12 out of 39 contracts report an average of 20 minutes or less – but this is rarely measured to the final telephone assessment because of the additional triage often carried out by the ‘OOH’ part of the service.

We feel, that to focus attention on the clinical safety issue, there should be a KPI that looks at the number of cases where the total time to remote assessment outcome (remote is chosen to include phone, video, chat and online consultations, but to exclude face to face) exceeds two hours and that they should also report the number that take more than 6 hours. We also recommend that a requirement be included within the new contract specification that a suitable sample of such cases be reviewed and the results of the audit be reported routinely.

In cases where the IUC service is processed on separate ‘111’ and ‘OOH’ systems such a report should be compiled using data from both systems based on the call start time that is included in the ITK message. Whilst laying out the specification for such a metric attention should be drawn to the fact that ‘case type’ whilst revealing the queue to which the case was expected to be sent to is NOT a reliable indicator of phone assessment. This is because sometimes (most notably in the recent pandemic, but on other occasions too) consultations in the queue for a face to face consultation actually receive a phone/remote consultation so the case type does not reliably identify contact by phone. This is an issue that we suspect most providers need to resolve.

As a final note, a small number of services use non-clinical ‘appointment bookers’ to ring patients and book the appointment after the definitive clinical assessment. This adds yet another queue and delays the point at which the patient gets the reassurance of knowing that they have an appointment, how to get there etc. Although this delay does not increase the clinical risk there could be an argument for making the measurement to the end of telephone outcome to the later of the end of the definitive clinical assessment or the end of the call in which a face to face appointment was

booked. This may help to limit any delay and provide a better measure of patient experience.

KPI 15 Proportion of cases assessed by a clinician

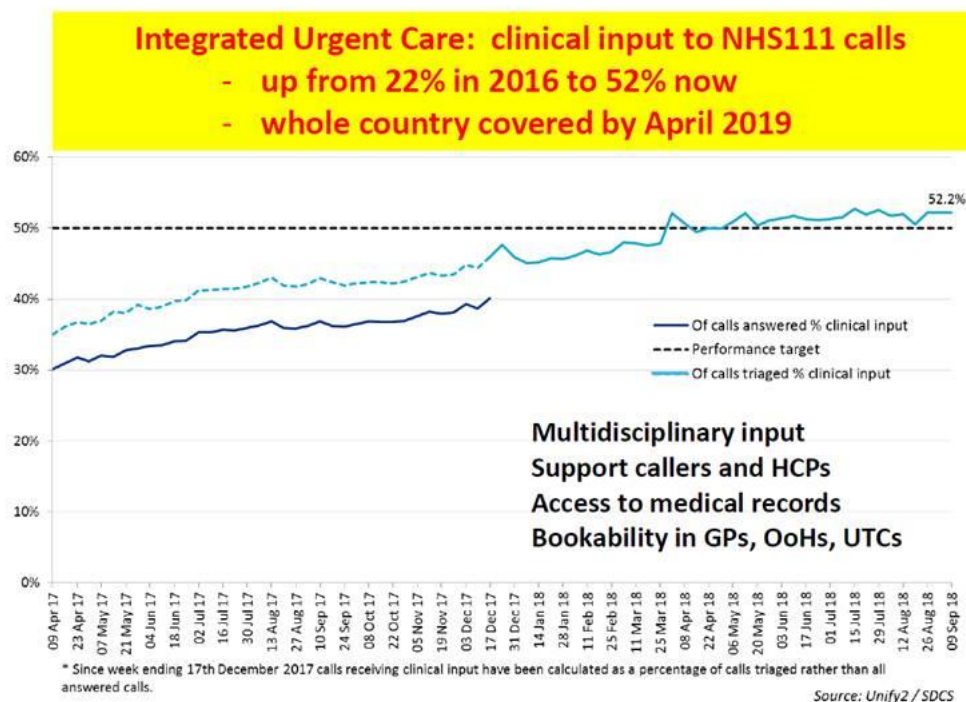
Data Quality

This metric is inconsistently reported and the trend lines shown are downright misleading.

- **Inconsistency.** This is calculated in SO many different ways that it undermines its credibility completely. We have found:
 - IUC services that report only the cases that were assessed by clinical advisers, but not those assessed by non-Pathways clinicians or in the downstream 'OOH' service as, presumably, they cannot get that data
 - IUC services that report cases assessed by clinical advisers and the non-pathways clinicians within the first stage of the CAS, but they have a further stage of phone assessment done by the 'OOH' providers and these are not included in the number reported as being clinically assessed
 - IUC services that report cases assessed by clinical advisers and the non-pathways clinicians but also collect data from the 'OOH' providers to include the phone assessment done by clinicians in those organisations
 - IUC services that report cases assessed by clinical advisers and the non-pathways clinicians but also collect data from the 'OOH' providers to include ANY contact (by phone or face to face) by clinicians in those organisations (so they are including face to face contacts as a clinical assessment within the CAS)
 - IUC services that have agreed mechanisms (such as that described below) for estimating the proportion going to a clinician based on the dispositions and the organisation to which they were sent.

These alternative mechanisms mean that the data is useless – it is not comparable between contract areas and is not comparable over time as the way that it is counted has often changed

- **Misleading.** NHS E set a target of 50% of cases to be assessed by a clinician – and this drove the change in reporting. The graph below was used on a number of occasions to demonstrate success in reaching the target. But it completely misrepresents the underlying picture which we believe started and remains far higher than the 50% shown.



Careful examination of the published data since November 2016 when calls to a CAS clinician was first reported to MDS reveals that in the beginning most providers simply reported the same number as was reported for cases transferred to a clinical provider. But NHS England staff had a target to meet – a promise had been made that 50% would be reached!

Gradually, as they were reminded that the new metric included all calls assessed by any trained clinician, whether using NHS Pathways or not, people became inventive in what they should include. These changes led to the line sloping upwards. There is little or no evidence that the actual proportion of cases assessed by a clinician grew at all – in fact the slow acceptance in some areas that health advisers could book some appointments for a face to face consultation (starting with the very young who so often need to be seen face to face) may have meant that the proportion speaking to a clinician by phone fell.

By March 2018 there was an exchange on the IUC forum that illustrates some of the approaches adopted. Here a service described how they had agreed to estimate this figure by counting:

- Home visits done by the OOH service (because the patients are rung before they go)
- Direct appointment bookings into a GP practice where the practice confirms that they offer phone appointments only and 50% of those where they offer a mix of face to face and phone appointments (so they are counting GP practices as part of the CAS)

- Speak to dispositions sent to out-of-hours and extended hours services (and they also extended the definition of 'speak to' to include a wide range of other dispositions)
- Contact dispositions sent to an out of hours service that re-triages calls passed to them.

Although the IUC delivery team response did suggest that the service should continue to monitor the assumptions on which these estimates were made and made clear that the service should have evidence to corroborate their calculation they did not question how phone consultations within a practice could be counted as part of the CAS nor ask why the CCG was not collating the data from the OOH organisation so that they could report all of the KPIs associated with their CAS including, for example, the time to end of telephone assessment.

Our conversations with a number of services reveal that this KPI is still being counted differently as we summarised under the 'inconsistency' heading above. But it is also one where very few providers report the same information to the MDS as they do to the ADC. Interestingly, although we might expect the ADC data to show the higher figure because there is more time to collate the information from the 'OOH' organisation than the MDS which is collected daily, it is the MDS figure that shows the higher proportion of cases assessed by a clinician when we include all services. When we look at individual services some are higher, some are lower and a very few (even excluding odd months where an error might have occurred in reporting) seem to report the same value in the two data sets

Finally, to confirm the useless nature of the figure, not one provider has shown a significant increase in the proportion of cases assessed by a clinician since Covid struck in March. We know that patients have only been seen face to face when it is absolutely essential so this metric should have climbed dramatically (the exact extent being dependant on which of the many approaches to calculating the figure had been adopted). The fact that there has been no change demonstrates that we are not counting anything useful – whatever approach has been chosen to report the number it does not reflect reality.

The KPI

We are uncertain of the value of this metric, even were it to be counted consistently across all providers and over time. It seems to us to be simply a measure of activity. What, for example, is the value of a clinical contact to a patient who is happy with the self-care advice given to them over the phone by a health adviser using NHS Pathways (Pathways was, after all designed to do this)? Of course there is value if the patient wants reassurance from speaking to a clinician – but it is perfectly possible to ask if they are concerned and would like a call-back. It adds no value to make a call just to confirm the guidance already given.

Similarly, if one service trains call-handlers to ask probing questions so they safely and appropriately reduce the numbers of ED and category 3&4 ambulance dispositions that go to the 'wrong' destination they are surely performing better than another service

that has to revalidate more. Not only do the former service direct more patients to an appropriate service immediately they also reduce the proportion that will have their outcome changed if they are revalidated.

For this reason, we are very surprised to see that the metric has been proposed as one of the bundle of measures included in the proposed new bundle of urgent and emergency care standards from the clinically-led review team (out for consultation to Feb 12). It is even more surprising that it should be the ONLY measure of the performance of an IUC. What would it tell you if one service reported that the proportion of cases assessed by a clinician rose or fell? What light does it throw on the clinical effectiveness of the service?

But what makes the choice absurd is that the metric as currently reported is nonsensical. It is reported MOST inconsistently and it has been used to present some thoroughly misleading information.

In short, this KPI and the process for collecting, collating and reporting it is a mess. We strongly recommend that it NOT be included (as has been suggested by the clinical review team) as one of the metrics in the bundle of urgent and emergency care metrics. We maintain that none of the IUC metrics matches up to the pillars described in the code of practice for statistics from the office for statistical regulation – but, of all of them, this falls furthest short. If you were to choose one figure to most dramatically undermine the credibility of the new bundle, KPI 15 would be it.

KPI 8 Proportion completed by a health adviser with self-care advice

Data quality

Two things concern us about the data quality for this indicator. The numbers of cases reported as triaged in the ADC data is often different to the number reported as part of the MDS and the numbers of dispositions reported to ADC doesn't match the numbers reported as triaged. These throw doubt on the denominator. How can we use the count of cases closed by a Health adviser when we know that the total of cases by skill group does not add up to the total cases triaged and this in itself is not the same as is reported in the MDS. And, since we doubt the count of dispositions, how do we know that the count of cases completed by a health adviser as self-care advice is right anyway?

The KPI

KPI 8 aims to measure the effectiveness of the health advisers in completing cases with self-care advice. In practice this remains low for most, if not all, providers. But we strongly suspect that this is because services have not unshackled themselves from the initial requirement when 111 was introduced that such cases should be passed to a clinician for call-back as a precautionary measure until confidence had grown in NHS Pathways. Since Pathways was developed to allow health advisers to give such advice there seems to us to be no reason not to save clinician time by training health advisers to ask if they are happy with the advice given or whether they would like to speak to a clinician. It would then only be necessary to ring back such patients when they have

requested it. This is a part of the vision that seems to have been forgotten – indeed when we spoke to a number of providers they were unaware that the freedom NOT to require clinician call-back for these cases had been granted. We reminded them that the process would require suitable oversight and risk management, but they were delighted to hear that it might be possible to save themselves what they agree is unnecessary work. The removal of this metric from the proposed new KPIs appears to indicate that NHS E have forgotten or given up on this part of the vision for an IUC too.

We feel that, as part of ensuring that skills are used most effectively, the vision of healthcare advisers being allowed to use NHS Pathways as designed is valuable. Collecting this data provides at least one metric about how effective the health advisers are so it is a pity to remove the requirement from the data collection.

KPI 9 Proportion completed by a clinician with self-care advice

Data quality

Exactly the same argument applies to this metric as for KPI 8. If cases are counted inconsistently it is difficult to trust this data. But there is another problem too. Too many services are reporting on only part of the operation. Although the contract is for the call answering, clinical assessment and face to face consultations when required, there are many IUC services that are not reporting on the additional telephone assessment that occurs in the 'OOH' service, even when this is on the same instance of the clinical system. It seems highly likely that, for many of the services shown below, the actual level of self-care is much higher because cases are completed over the phone (or by video) in an unreported part of the service. For all these reasons the KPI as currently reported is meaningless.

The KPI

Were the data to be reported consistently this metric is an important measure. Knowing what proportion of cases are safely and appropriately completed over the phone by clinicians (as well as from KPI 8 the proportion completed by non-clinician health advisers) is a useful way of assessing how good the service is at reducing the pressure on the rest of the system. The data will also be available in the analysis of dispositions, but we can see the value in keeping both metrics as a KPI.

KPI 10 proportion of repeat prescriptions issued by phone

Data quality

Again, as for KPI 8 and 9 the inconsistent count of dispositions is a worry.

The KPI

KPI 10 as currently reported is a strange metric. It counts only repeat prescriptions that are issued by the service and we can't see that it adds any value – indeed we have little understanding of how to interpret the data. One provider reports that 100% of repeat prescriptions are issued by the service every month whilst the proportions reported by

many others oscillate wildly. But there is a useful indicator that could be measured here and that is the proportion of all prescriptions provided by the IUC service that are made available through a pharmacy local to the patient without requiring a face to face consultation with an IUC clinician. We have, with one service, drilled into the detail of this by looking at prescriptions for nitrofurantoin and trimethoprim to look at the proportions of patients receiving these medications for UTI that are provided with them after a phone consultation (as will be done by most GP practices unless there are complications).

Some alternative Metrics

There are other metrics that could get much closer to providing a measure of speedily directing patients to the appropriate service. These look at two things – the proportion of patients that do (or do not) follow the recommendation given and the number of ring-backs required as part of the phone assessment (looking at the total care pathway, to include any calls by the 'OOH' service).

RAIDR is far from perfect. We understand that it is funded by NHS E who commissioned the North East Commissioning Support organisation (NECS) to link the ED Data set with that from 111 to allow the reported recommendations to attend A&E (or not to do so) to be compared with what people actually did. This ought to be valuable information by helping commissioners and providers to understand more about whether the dispositions are "right" and whether the process inspires sufficient confidence that callers follow the recommendation. It is easy to see how this tool could provide useful high level KPIs that will focus attention on whether the service really is directing patients to the right place.

Unfortunately, the tool is little used and has not been developed to address the criticisms made of the dashboard – the main one that was reported to us is that it is not possible to drill down in sufficient detail to support improvement activity. We agree with this and with many of the other criticisms, but the tool is at present the only one that does this job for England and it DOES focus attention on how good services are at guiding patients to the right place. When we visited New Zealand and looked at their service they had an interesting perspective. If the patient did not follow the advice given then, in their view, no value had been added. For this reason, they focused considerable attention on the metric even, we understood, to making it one of the measures of those speaking to callers.

We recognise that, in time, it will be possible to provide richer, more timely data from ECDS, that this data should be joined at patient level with ambulance data and with BOTH parts of the IUC data (about all of the clinical contacts from the '111' and 'OOH' stages) and that it would be even better if the data is joined to primary care and other information. Then it will be possible to be smarter. But until then (and with some quick work to revisit RAIDR if some things do need fixing) it would provide a really useful outcome based measure of the service.

The second important part of the vision described above was that the response to patients would not involve too many separate calls – that services would become smarter at identifying which sorts of cases could be completed (remember the promise

of 'consult and complete'?) by each skill group so as to make best use of resources and to stop the case being passed on for one ring back after another. Too many patients receive a ring back from a clinical adviser, a CAS non-pathways clinician and still they get another call from the OOH service.

For this reason, we recommend that NHS E introduce a requirement to report the number of calls involved to the end of telephone assessment to go alongside the measure we have suggested above about the numbers of calls taking more than two hours to telephone outcome. Both require data from both the '111' and the 'OOH' part of the system – but it is already the responsibility of commissioners to ensure that this data is merged to allow reporting on the whole of the IUC contract. The data is probably best presented as a histogram – to remind people that sometimes there are many more stages than we believe should have been needed. But we have suggested that the KPI should be to report the proportion of cases that receive 3 or more remote consultations (the initial incoming contact being counted as 1). For cases dealt with only by phone implies two or more ring-backs.

We also considered asking services to report the proportion of 'speak to' dispositions that has remained stubbornly at around 10% of cases. We suspect that this is, in many cases, not a real figure and is a result of the reporting from only the first part (the '111' part) of the service. But our feeling is that it would be useful to establish a target (say that 'speak to' dispositions are to be lower than ~3%) so as to ensure that, not only does reporting cover the whole of the CAS, but also that the service really is carrying out all of the remote (phone, video, etc.) consultations that are reasonably practical, without passing the work on to other parts of the NHS.

We also debated whether it might be worth reporting the proportion of cases that meet the objective of 'consult and complete'. This, after all, was one of the important aims of an IUC and the recent pandemic has demonstrated just how much can be dealt with in this way. But the requirement to report the proportion of cases completed as self-care effectively is the same measure. In our view it is best if this includes where a prescription is issued in the CAS to be collected from a local pharmacy, but others may feel that these two should be counted separately.

Proportion given a booked appointment

Existing metrics	New metrics proposed by NHS E (2021)
KPI 4 % given a booked appointment at an IUC treatment or extended hours centre (≥95%)	KPI 12 % given a booked appointment at an IUC treatment centre or home residence (≥70%)
KPI 5 % given a booked appointment at a UTC (≥50%)	KPI 13 % given a booked appointment at a UTC (≥70%)
No current equivalent and data is not reported as part of the ADC	KPI 11 % given a booked appointment at a GP practice or GP access hub (≥75%)
No current equivalent and data is not reported as part of the ADC	KPI 14 % given a booked appointment slot with an ED (Type 1 or 2 A&E) (≥75%)

No current equivalent and data is not reported as part of the ADC	KPI 15 % that were booked into a same day emergency care service (SDEC)
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Design criteria

The IUC Service must be designed around the patient's expectations that:

- *If further care or advice is required they will be referred automatically (electronically) where possible, or signposted to another service including those outside the scope of IUC.*

And there was also an expectation defined in the specification that:

- *If an appointment is required, it should be booked electronically on behalf of the patient, negating the need for the patient to make a further phone call*

And there was a clear expectation that the number of services for which patients could have appointments booked would grow over time (as, indeed, it has)

All KPIs measuring % given a booked appointment

Data quality

In the past it was difficult to assess the quality of these two metrics. Although it was apparent that the proportion of booked appointments varied dramatically, there was no other information against which the quality of reporting could be assessed.

But since March 2020 the change in operational model because of Covid means that we should have seen a DRAMATIC reduction in the proportions of face to face appointments. The data collected to support KPI 4 does not show this change. We examined the number of all booked appointments as a proportion of 'contact' dispositions but this did not appear to change the general pattern, except that it highlighted that on some occasions some providers were reporting more booked appointments than 'contact' dispositions – even though, by definition, all of the booked appointments should be a sub-set of 'contact' dispositions. Our conclusion is that this data (and, we assume, that supplied in relation to KPI 5 too) is not a reliable comparator.

The KPIs

We like data – and we can see the value in collecting information about the proportion of callers that have their appointment booked. We believe that the reassurance from having an appointment booked means that patients are more likely to follow the recommendation, resulting in fewer DNAs (not to mention the obvious value to the patient of reassurance in its own right).

We support the move towards booking a wider range of appointments and to collecting data on the numbers booked with GP practices, ED and SDEC. A number of those that

we have spoken to have stressed how having a booked appointment removes many of the objections that they sometimes met - *'Oh, I can never get an appointment in my practice, I need to see someone now'* or *'I am not going to wait hours in the UTC waiting room when I feel like this/just catching something else'*.

But, though we welcome the data being collected at a detailed level and we can see that they allow providers, commissioners and NHS E to measure progress, we feel that one KPI to measure the overall proportion of booked appointments would perhaps be more appropriate to allow a more balanced mix of metrics placing more emphasis on patient safety and effectiveness whilst maintaining a modest number of KPIs

To us, home visits are different to consultations in the IUC treatment centre. We believe it is confusing to include both together in the requirements for the ADC (G04 and G05), especially as they are then referred to as 'DoS selection - IUC Treatment centre' or Number of calls where the caller was booked into an IUC Treatments Centre'. This terminology is counter-intuitive and potentially misleading and it goes against the DoS Service type mapping that clearly distinguishes an ADC service type of home visits from that for the IUC treatment centre.

It is not just the terminology either, for home visits the complexity of balancing the available resources (cars and clinicians) with the upcoming home visits taking into account the location of each requires that a despatcher manage the booking process. We recommend that providers are asked to separately collect information about the number of home visits that are selected and booked.

Alternatively, as it is almost inconceivable that a home visit will not be agreed with the caller and we already have data on the number of home visits undertaken (collected as part of KPI 14, proposed KPI 16) you could simply exclude home visits from the proposed KPI 12.

Finally, under this heading, to make one point about the glossary and one about the DoS service type mapping. We have not seen the new glossary (if there is to be one) but the present glossary appears to allow providers to count the numbers of callers that receive a booked appointment from the disposition. It says *"For purposes of reporting (e.g. direct booking) providers can use DoS service type to determine cases where an appointment has been booked at a IUC Treatment Centre. Service Types: GP Access Hub; GP OoHrs Provider; MIU; UCC; WIC"*. This seems to imply that it is only necessary to count these dispositions to arrive at the total number of cases booked – even if no booking was made for the patient. We feel sure (perhaps almost sure?) that this cannot be intended....

We have to admit to finding the DoS service type mapping spreadsheet confusing. We are puzzled as to what it is telling us, particularly as it does NOT include self-care as a quasi-service type. In most providers when self-care advice is given we would expect the final service to be the IUC CAS. It is thus a puzzle to see that this service type appears to be only mapped to the IUC treatment centre or a home visit. We worry that if this confuses us, despite a considerable effort to understand what it is or is not intended to do, it will confuse others too. Perhaps we are missing something important - but we certainly think further explanation would be helpful.

Revalidation of ED and Cat 3&4 Ambulance dispositions

Existing metrics	New metrics proposed by NHS E (2021)
KPI 6 % of calls initially given a cat 3/4 amb'ce disposition that are revalidated (≥50%)	KPI 7 % of calls initially given cat 3/4 amb'ce dispositions validated with 30 mins (≥50%)
KPI 7 % of calls initially given an ED disposition that are revalidated (≥50%)	KPI 8 % of calls initially given an ED disposition that are validated (≥50%)

Design criteria

The IUC Service must be designed around the patient's expectations that:

- *In an emergency an ambulance will be dispatched without delay;*
- *Their call will be warm transferred to a clinician where clinically appropriate (even if that resource is not co-located);*
- *When a call back is necessary during periods of peak demand any call back is within safe timescales;*
- *If further care or advice is required they will be referred automatically (electronically) where possible, or signposted to another service including those outside the scope of IUC.*

But there was also a clear expectation that users of NHS Pathways and non-pathways clinicians would ensure, through the improved DoS that patients were directed to the right service at the right time. The presentations associated with the launch of IUC talked about:

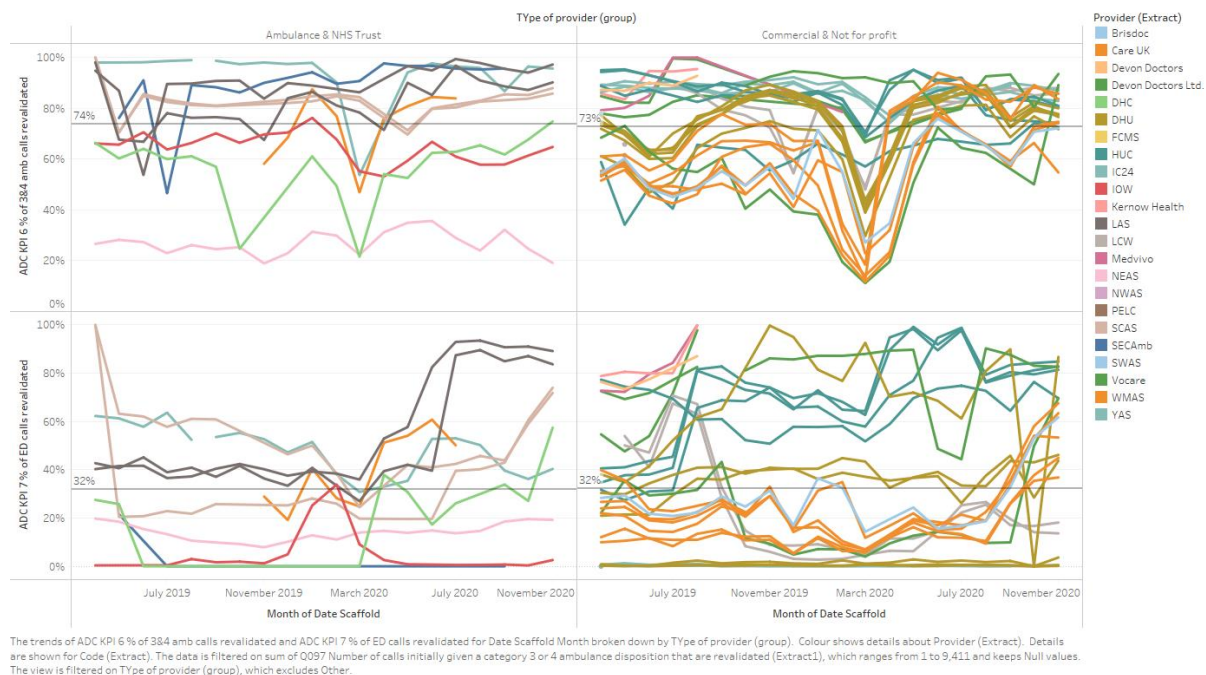
- *Right advice or treatment first time – enhanced NHS 111 – the “smart call” to make.*

Both revalidation KPIs

Data quality

We have no reason to challenge the validity of the data provided about the proportion of cases that are revalidated and that are shown below for all providers. It is, however, a pity that data for one of the largest services has yet to be reported. And we cannot but worry that, with so many services failing to report the same number of final dispositions as cases triaged (see below), it is difficult to be confident that the information is accurate and comparable.

KPI 6&7 revalidation results



The KPIs

These KPIs aim, presumably, to focus attention on minimising unnecessary referrals to the ambulance service and ED departments so reducing the workload on both. This is laudable – but the metrics are simply a measure of the work done. They provide no indication about effectiveness. Interestingly neither do they relate at all to the design criteria outlined at the start of this section. There is no measure of the timeliness of an emergency ambulance disposition, revalidation generally involves delay for a call-back. The use of this process and metric is something of an indictment - the fact that we need to do it is a poor reflection on the overall system involving NHS Pathways, the DoS and the training of the health advisers. What we are doing is measuring the failures to get it right the first time.

Accepting that the process is necessary for now, there is, we feel, better and more useful data that should be collected.

We would far rather that providers and commissioners looked at the effectiveness of the service in redirecting Ambulance and ED dispositions to other services (when appropriate).

Taking ED dispositions as the example, the data that would need to be in the ADC collection would be:

1. Number of cases with an initial ED disposition from a health adviser. Note that the current mapping of Dx codes would require some modification to map intermediate dispositions appropriately, for example (and most obviously) a

disposition of 'speak to a clinician immediately, refused ED disposition' came from an initial ED disposition that was refused

2. Number of cases with an initial ED disposition from a health adviser that are directed by that health adviser to a UTC, WIC or MIU
3. Number of cases with an initial ED disposition from a health adviser that are validated by a clinician
4. Number of cases with an initial ED disposition that are validated, confirmed as an ED disposition and directed to an ED (type 1 or 2 A&E)
5. Number of cases with an initial ED disposition that are validated, confirmed as an ED disposition and are directed to a UTC, WIC or MIU (type 3 & 4 A&E)
6. Number of cases with an initial ED disposition that are validated and that trigger an ambulance despatch
7. Number of cases with an initial ED disposition that are validated and that are diverted to contact primary care, speak to primary care or result in a prescription being issued
8. Number of cases with an initial ED disposition that are validated and that are diverted to dental or pharmacist
9. Number of cases with an initial ED disposition that are validated and that are diverted to self-care
10. Number of cases with an initial ED disposition that are validated and that are diverted to other outcome

Note that:

- Only one of these data items (3) is currently collected, but all will be available within the system
- $SUM(4+5+6+7+8+9+10)$ must = 3
- The metric for the KPI could be either:
 - $SUM(5+7+8+9+10)/3$ if the focus is on the effectiveness of the validation - % of **validated cases** that are diverted or directed to a lower acuity service or alternative outcome
 - $SUM(2+5+7+8+9+10)/1$ if the focus is on the overall effectiveness in directing patients away from type 1&2 A&E services - % of **cases initially given an ED disposition** that are diverted or directed to a lower acuity service or alternative outcome

Our preference, because it looks at the eventual outcome compared to the initial ED disposition is the latter

- The categories of disposition chosen for numbers 4 through 10 should all match the mapping used for the final dispositions reported for the ADC
- The data allows one to calculate and compare the percentage of ED dispositions that are directed to a UTC, WIC or MIU as $SUM(2+4)/1$

Clearly, having devised this approach it would make sense to do something similar for type 3&4 ambulance dispositions.

Collecting this data also allows us to monitor how often NHS pathways, the DoS and health advisers get it right first time so that, hopefully, we see a progression to the point

that revalidation is no longer worthwhile. But if progress is not made it should also prompt a different approach. Perhaps a return to a simpler non-clinical assessment focused only on real emergencies together with a prioritisation process for clinical assessment is the best that we can actually achieve?

Timeliness of face to face consultation

Existing metrics	New metrics proposed by NHS E (2021)
KPI 13 % receiving face to face consultation in the IUC centre within specified period ($\geq 95\%$)	KPI 17 % receiving face to face consultation in the IUC centre within specified period ($\geq 95\%$)
KPI 14 % receiving face to face consultation in their home within specified period ($\geq 95\%$)	KPI 16 % receiving face to face consultation in their home within specified period ($\geq 95\%$)
Both the above are really three KPIs reported for 1, 2 and 6 hour targets	For the proposed new metric each is counted as one KPI (and aggregated data is collected)

Design criteria

In describing the criteria and changes to be made for an IUC no great emphasis was placed on the face to face consultation. This was not because it is not an important part of the process, but rather because it was already happening. Out of hours services were effective at seeing those patients that require a face to face primary care consultation and the IUC specification simply described how this element would be delivered as part of the IUC service (often this is done by the same OOH organisation). The one change was that, as part of the IUC, providers were to offer such consultations 24 hours a day throughout the year (as opposed to the previous requirement on OOH providers to do so overnight, at weekends and bank holidays). The specification required them to ensure:

- Face-to-face consultations with a clinician are offered, including where necessary, at the patient's place of residence
- They operate the telephony, online and face-to-face elements of IUC service 24/7 365 days a year (including leap days)
- And the KPI target was identical to the long-standing OOH quality requirement.

Both metrics for timeliness of the F2F consultation

Data quality

We have no reason to doubt that services are reporting information in line with the definition. But the definition has elastic time-limits and services define very different standards of urgency so comparison of performance against the KPI requires analysis. Both of these issues are long-standing and are described fully in the section on the KPI.

The KPI

The measurement is taken from “after the final disposition has been reached” to “when the face to face encounter begins”. There are four categories that relate to priority.

- Emergency – Consultation to begin in one hour or less
- Urgent – Consultation to begin in two hours or less
- Less Urgent – Consultation to begin in six hours or less
- Any other timescale – not part of the current three KPIs, but to be included in the proposed new metric.

There are a number of problems with the current KPIs (six of them, 13 a, b & c for appointments at the IUC treatment centre and 14 a, b & c for home visits).

- Variability in the proportions that are identified as emergency, urgent and less urgent – variability depending on what tool or guidance is used, variability between services (presumably shaped by their assessment of the risk, as described below) and variability between individual clinicians and their comfort with managing the risk for each patient.
- The freedom that it allows for a service to undertake an additional phone assessment to restart the clock
- The ‘any other timescale’ that may be 30 minutes, 3 hours or 30 hours that are not included in the metric.

The problem stems from the tension between NHS Pathways, a risk averse decision support system that defines a high proportions of cases as emergency or urgent and the reality that if the proportion of such cases is too large it becomes impractical to give these cases the priority it deserves. The old maxim that “when everything is urgent, nothing is urgent” applies. We understand this tension and, whenever we have looked at the proportions of cases that are defined as emergency and urgent we have found them to be close to 15% and 25% of primary care dispositions (‘Speak to’ + ‘contact’). In our view that is too many for it to be practical for services to prioritise these cases. Arguably, the risk averse system is making the position less safe.

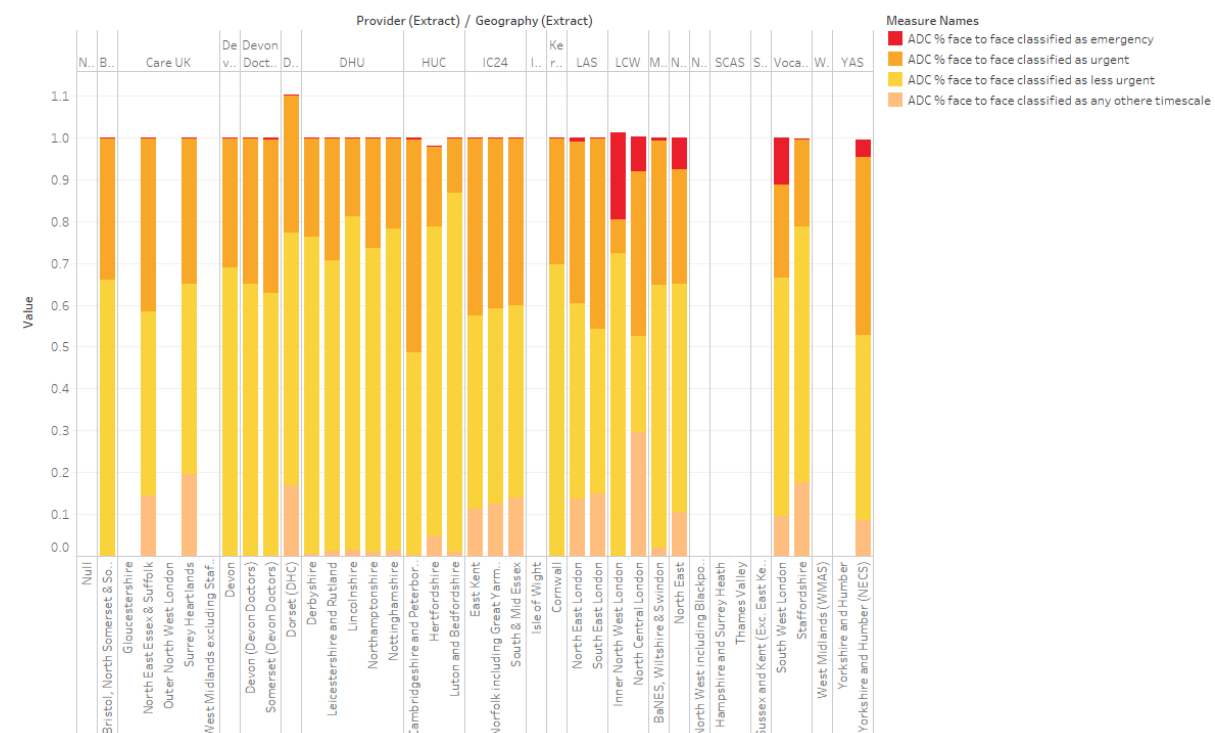
For this reason, clinicians downgrade the NHS Pathways priorities dramatically – sometimes to the extent that some services report having no emergency cases. So thorough is this that some providers even have mapped the NHS pathways ‘emergency’ priorities to ‘urgent’ and many or all of the urgent dispositions to ‘less urgent’.

We have always believed that, though the old emergency category is really important, measurement against the 1 hour timescale is not helpful. What emergency implies is ‘this patient needs seeing as soon as possible’ – as soon as possible after arrival at an IUC treatment centre and, if they are to be seen at home, the case is to be given top priority. But, however urgent the case is, the 1 hour target is very difficult to meet and the number of cases so few that monthly performance against KPI 13 a and KPI 14 a oscillates widely. The change to the KPI will reduce the impact of failure against the very difficult 1 hour target – so we support it. But, as described below, we do NOT support the failure to collect the data at a granular level within the ADC.

The graph below shows the classification by urgency for those providers that report against this metric (and why is it not all of them?). This demonstrates that the KPI does not provide valuable comparative information, but it also starts to raise important questions about whether those that show no emergencies and relatively few urgent cases might not be too cavalier in downgrading priorities.

For these reasons we firmly believe that the ADC data collection should continue to collate the same level of detail as at present. Not to do so means that the combined metric is far from smart – it becomes really difficult to interpret. For example, if performance improves is it because the service is now downgrading many more cases to the much easier 6 hour category, or is the case mix the same and they are seeing more within the various timescales. We cannot believe that the change simplifies reporting for the submitting organisation, they still have to collect the detail to correctly compare each case against the appropriate timescale.

Variation in proportions of face to face appointments by urgency (1 hour, 2 hour, 6 hour and any other timescale)



ADC % face to face classified as emergency, ADC % face to face classified as urgent, ADC % face to face classified as less urgent and ADC % face to face classified as any other timescale for each Geography (Extract) broken down by Provider (Extract). Colour shows details about ADC % face to face classified as emergency, ADC % face to face classified as urgent, ADC % face to face classified as less urgent and ADC % face to face classified as any other timescale. The data is filtered on sum of Q003 Number of answered calls (Extract1) and Date Scaffold (MY). The sum of Q003 Number of answered calls (Extract1) filter ranges from 148,968 to 2,967,945. The Date Scaffold (MY) filter keeps 43 of 43 members.

One other suggestion. It would be much better to define categories of up to 1 hour, 1 to 2 hours, 2 to six hours and any time longer than 6 hours. This provides more information than having a category of 'any other time' which could be 4 hours or 40.

There is another change too that is to allow cases that DNA, arrive late or where a caller has agreed an alternative timeframe to be excluded from both the numerator and the denominator. We can see the logic in this change, provided that those producing the figures believe that they can reliably identify such cases and separate them out.

However, a better pair of measures would be to measure first to the booked appointment offered to the patient and then to have a separate measure of the timeliness at which the patient was seen that is measured from the latest of the booked appointment time or the patient's arrival time – with DNA patients automatically excluded from the latter metric. We suspect that this way of thinking of the issue not only gives more information about the care provided to the patient it is probably also simpler to calculate.

Telephony

Existing metrics	New metrics proposed by NHS E (2021)
KPI 1 % of calls abandoned ($\leq 5\%$)	KPI 1 % of calls abandoned [new denominator] ($\leq 3\%$)
KPI 2 % of calls answered in 60s ($\geq 95\%$)	Data will still be available
Average time to answer calls	KPI 2 Average time to answer calls (≤ 20 s)
Data not available	95 th Centile call answer time (≤ 120 s)

Design criteria

- *It was not specifically mentioned as a patient expectation for the IUC at the start of the new specification, but patients DO expect the phone to be answered promptly!*
- *The specification was clear in describing the service should have timely call answering via NHS 111 (memorable, free to call number).*
- *The standards suggested were in line with the existing NHS 111 standards for call answering which, in turn, were very similar to those for out of hours services and NHS Direct*

Proportion of calls abandoned

Data quality

We welcome the change to the denominator for KPI 1 to ensure that the metric is consistent between providers. The problem has been that services have been measuring calls offered at different points. We first raised this issue with the DH in 2012 and it is about time it was sorted.

We remain concerned that there are differences in clock start times between providers. The historic diagram from NHS E³ about the measurement points to be used for different system configurations seems likely to have been at least partially responsible for this.

³ The "Call flow scenarios" diagram showed the clock start for abandoned calls and the clock start for calls answered in x seconds in different relative places for each of the three scenarios. It will thus be no surprise if providers measure from different points.

The KPI

A prompt answer to the telephone is important. As outlined in 'Integrated Urgent Care Key Performance Indicators and Quality Standards' abandoned calls represent an unquantified clinical risk and prolonged delays in answering increases that risk.

It is interesting to note that, both for the period from April 2019 to the end of the 2019 and for the period from May to November 2020 a minority of the contracts met the new target for the percentage of calls abandoned ($\leq 3\%$), so the tightening of this standard appears to leave most services with some way to go to meet it.

Speed of answering the calls

Data quality

Again we have concerns about whether all services are using the same start point for this metric. Certainly, we do not believe that one service is providing comparable data when they report 100% of calls answered in 60 seconds and an average time to answer that is faster than the reaction time of a racing driver.

The KPI

It seems surprising to move away from the standard definition of service level used in the majority of call answering services and astonishing that, for a service that claims to arrange an ambulance quickly if it is required, the standard is being watered down below that of normal commercial services. We are well aware that the majority of IUC services fall short on the current standard for answering calls (even in normal times, excluding the pandemic peaks) – but we feel that commissioners should expect providers at least to match commercial standards (which requires sufficient funding for the appropriate number of trained staff to answer calls).

The standard usually applied to commercial services is typically 80/20 (80% answered in 60 seconds) or even 90/15. Using the Erlang formula and reasonable estimates of call lengths we can calculate the required numbers of staff to meet the existing standard of 95% answered in 60 seconds and this is very close to the normal commercial standard of 80% answered in 20 seconds.

Examination of the data across providers indicate that when providers have achieved 95% of calls answered in 60 seconds their average response time is around 10 seconds - so the proposal in the new KPIs to use 20 seconds as the average time to answer and a 95th centile target of 120 seconds is not just watering down the current standard, it is taking it to a lower level than is generally applied commercially.

There appears to be no good reason for moving away from the existing way of measuring KPI 2 – it simply introduces a discontinuity into the data and, as always with a change there is a danger that the new data is not accurately reported.

We know that ambulance services measure the average response time. There is perhaps a legitimate argument for this and for looking at the 95th and 99th centile for the ambulance service because the average time to answer runs at a few seconds with the vast majority of calls being answered immediately but the change proposed for IUC appear odd.

Our concerns about the changes are thus that the requirement is being watered down to a level that is lower than is normal commercially, a discontinuity in measurement is being introduced that will make interpretation of trends difficult, two metrics are now required instead of one and there appears to be no reason to think that the change will improve the comparability of data. It is possible to argue that using the two measures provides a little more information but it feels as if there are more important things to worry about.

Metrics for DoS

Existing metrics	New metrics proposed by NHS E (2021)
KPI 11 % receive no service available other than ED from DoS (ED catch-all) ($\leq 3\%$)	KPI 9 % receive no service available other than ED from DoS (ED catch-all) ($\leq 0.5\%$)
No current equivalent	KPI 10 % callers allocated the first service offered by DoS ($\geq 75\%$)

Design criteria

The IUC Service must be designed around the patient's expectations that:

- *The IUC service has accurate up-to-date information regarding the 'locations of care' and pharmacies in their locality including but not limited to knowing opening times and services offered;*
- *The service has accurate and up-to-date information regarding local capacity, including new GP extended access offer, and to make appointments;*
- *Any prescription required will be sent directly to a convenient pharmacy where appropriate; and*

The Directory of Services (DoS) is crucial to achieving the above. Users have to know what services are available so that patients can be recommended to attend the right service. Aside from the obvious things, like opening hours for each service, this non-trivial task requires information about the mix of staff, equipment etc. that can link to the symptom group and symptom discriminators that NHS Pathways has identified to ensure that service recommended is the right one.

Metrics to look at completeness of the DoS and to inform decisions about service availability

Data quality

We have no reason to question the data quality for this metric.

The KPI

An IUC service is built on the Directory of Services (DoS). It is important to have metrics that allow those involved in maintaining them, commissioners and providers, to check that suitable services are available (and open at the right time) to meet the needs of patients that phone or use NHS Pathways online.

We agree that, even though in every area the proportion of ED catch-all cases is minimal, that the metric should be maintained (though perhaps not as a KPI). It provides a simple check that the information held in DoS is still being maintained and that the right services are available.

It may well be that the second metric will also be useful. But it is unclear to us exactly what is to be measured. Consider the following examples:

- A caller rings 111 and the assessment with a health adviser results in a 'speak to' primary care disposition. The health adviser informs the caller that a clinician from the CAS will ring back and this is accepted. The clinician rings back and arrives at a disposition of a UTC, but because this is a long way away it is refused and instead an appointment is made for the patient at a nearby extended hours centre. In this example the first DoS service offered was accepted, but the second was rejected.
- A caller rings 111, reaches an Emergency treatment centre (ETC) disposition and is offered a UTC by the health adviser. This is refused. A clinician calls back and the patient is persuaded to go to the UTC. In this example the disposition first offered was eventually accepted, but the first time it was offered it was refused.
- A caller gets an ambulance disposition online and rings 111 because they are not sure it is appropriate. They ring 111 and when the call is assessed by a clinician the outcome is a primary care disposition and the caller agrees to go to the IUC treatment centre. The service recommended online was refused but the one offered on the phone accepted.
- A caller rings 111, the health adviser reaches a contact GP next working day disposition, DoS is queried and the health adviser offers an appointment with the practice – but the caller demurs and suggests that the case is really more urgent 'listen to the trouble the child is having breathing'. This leads the health adviser to reassess the case using a different pathway to arrive at an IUC treatment centre disposition within 2 hours which the caller accepts. In this example the first service offered was refused, but the second, when the health adviser realised that they needed to revisit the Pathways algorithm was accepted.

We are unsure in each of these examples what is intended when the ADC refers to "where the caller rejects the first service offered" and particularly because of the use of the words 'A call counts once, regardless of the number of searches undertaken'. We are also unsure how the report will be written to guarantee that the right answer is chosen.

We recommend that the ADC specification be changed to count the ‘number of times the DoS is opened’ rather than CASES. For most of the metrics, such as reporting the mix of dispositions, we only want to count each case once. But the examples above seem to allow the metric to work, to be easier to calculate and easier to develop a report for if we count each occasion that the DoS is opened. As written currently we fear that the proposed new measure will be a nonsense. As always, we would be delighted to be persuaded otherwise.

Measures of disposition and of outcome

Existing metrics	New metrics proposed by NHS E (2021)
Dispositions are reported to:	Dispositions are to be reported against the same or very similar categories in the proposed new metrics
<ul style="list-style-type: none"> Ambulance A&E 	
<ul style="list-style-type: none"> Primary Care Dental Pharmacy Prescription Self-care Another service Other outcome 	But the plan is to collect other data too that brings us tantalisingly close to being able to calculate the outcomes for the cases – something that commissioners and providers will find much more useful. In this section we explore this opportunity further.
There are sub-categories for some of these and minor differences between the ADC and MDS data	

Service expectations

It may well be that the patient is not interested in the reporting of where patients are directed, how the urgent care system is utilised, how effective this means that we use resources and so on. But all those involved in working in the urgent care system should be interested. If we do not measure this right there is no way that we can sensibly begin to answer questions about how we might improve the operation of the urgent care system. We expect to be able to look at the proportion of cases that are directed to different services and to measure any changes that occur. It is a vital part of the vision that the IUC would *direct cases to the right place at the right time*

Data quality

We have already referred to the fact that the dispositions reported do not add up to the cases triaged and that the numbers of cases reported as triaged is frequently different in the MDS data from that in the ADC. We would be happy with this if the notes from the various providers explained why this was the case. It could be, for example, that the dispositions reported in the ADC are for all cases including those that commenced online or came into the CAS not through a caller ringing 111, whilst the cases counted as triaged only counted those that came in by phone.

Unfortunately, there are no such explanations and the variation from one month to another makes it difficult to believe that there is some consistent reason for the discrepancy. We conclude that, for too many contracts, the data is of poor quality.

The measures

The trouble with the existing reporting of dispositions is that, even were they to be complete and accurate, they do not report where patients are actually recommended to go. This has long been a complaint from those involved. We have historically looked at the level of ED dispositions, but have NOT known how many are directed to a UTC (or, historically WIC, MIU etc.). Yet, clearly, there is a big difference between two IUC systems that have a similar level of ED (or emergency treatment centre) dispositions one of which steers many more towards the UTC rather than the A&E department.

The new ADC starts to get closer to allowing information about where people are recommended to go. It is tantalisingly close, but not quite there. We strongly recommend that the ADC specification be developed to fill this gap.

Just to take one example – dispositions to primary care are counted as:

- Contact primary care – bookable (E07)
- Contact primary care – non-bookable (E08)
- Speak to primary care – bookable (E10)
- Speak to primary care – non-bookable (E11)

Then we also have data on:

- Of the number of bookable primary care (E07 + E10) how many were GP practices or access hubs selected on DoS (G02)
- Of the number of bookable primary care (E07 + E10) how many were an IUC treatment centre or home visit (they have defined an IUC treatment centre as including home visits) selected on DoS (G04)
- Of the number of bookable primary care (E07 + E10) how many were a UTC selected on DoS (G06)

This gets very close to allowing us to understand not the disposition reached but the final recommendation for the service. But it doesn't quite do the job because the focus is on measuring the proportion of bookable that are actually booked as appointments. This is a shame and an opportunity missed.

The ones that we cannot track appear to be (we would welcome the opportunity to discuss and refine these):

- Dispositions that are not primary care (say a recommended ED disposition) where the patient chooses to go to primary care. It would be great to report on the numbers recorded as being directed to the various types of service.

- Non-bookable dispositions that are sent to primary care (non-bookable appear, generally, to be those that have very short timescales). Was this agreed with the caller?
- Bookable primary care dispositions that are in the end recommended to go to somewhere else (say to A&E) – or even where the patient says ‘I am sorry, I think I need to go to A&E’

These ideas need developing – but we feel that we are asking for so much detail to allow us to count the numbers of booked appointments that it would require little more to give us much better information on which services all patients were directed towards, not just the final disposition. Again, we would be happy to explore the practicality of this as a direction of travel.

Data from surveys

We should not forget the other activity that is also undertaken to provide information and detail to improve IUC services. Some of this (for example the end to end reviews and the clinical audits) are a vital part of ensuring that the service works well. But, as they look at specific cases and lessons are learnt from the detail, these do not provide a suitable mechanism for comparing one IUC system with another and there is no simple way of capturing the detail for inclusion within the standard data collected.

However, there is an opportunity to take some of the metrics from patient and staff surveys and include key metrics as part of the data that is reported (albeit the reporting frequency will be six-monthly or annual rather than daily or monthly).

Patient survey

We note that NHS England have said in the new KPIS that *“NHS England is reviewing how best to collect patient experience for Integrated Urgent Care and the wider urgent and emergency care system in future.”* This sounds encouraging!

We are fans of collecting and collating feedback from patients. It provides one of the key sources of information, particularly about the ‘caring’ heading that is used by the CQC. But for the data collected to have value it needs to ask the right range of questions of a reasonable proportion of patients and to be based on a representative sample (or, at least, be weighted in such a way to make it more representative).

The current survey for 111 has been in use since 111 was launched and asks 5 questions about the care provided (though individual services can add others):

- How helpful was the advice given by 111?
- Did you follow the advice?
- Seven days later, how was the problem?
- Overall, how satisfied or dissatisfied were you with the whole process?

- If 111 had not been available would you have contacted another service (and which one)?

The survey can be carried out electronically, by phone interview or through posting out questionnaires.

We feel that there is an opportunity to collect data that may be more helpful in identifying areas that need improvement and to do it in a way that is simpler for providers, that can provide a greater number of more representative responses and that will ensure that it is more directly comparable because of the standard way in which the data is collected. There will be good reasons for differences between different IUC systems because of demographic variation, differences in the local configuration etc. But these are legitimate explanatory factors that do not invalidate the comparison, though they do need to be understood in interpreting what the results mean.

We strongly recommend that NHS England explore the possibility of using the GP Patient Survey to gather data about the urgent and emergency care system. A small number of questions are already included that ask about what happened when you could not speak to your practice so the opening is already there. And, the great advantage to providers is that they would not be involved in the process (it is sent to a sample of patients from every practice, typically more than 100 responses are received from each). This frees up providers to focus less on collecting the data specified for the current 111 survey and allows them to focus more on a process that allows them to gather more understanding of how things could be done better.

Not every respondent need answer (the criteria could be if you have used 111 online, rung 111, visited a UTC or ED or called an ambulance in the last year) but it would be possible to ask questions that identify how the patient entered that urgent care system (ED, online, 111, UTC etc.) the process that they went through (whether they received phone advice, a video consultation, which other services they were seen face to face by etc.) and also to ask some of the detail that allows one to begin to assess the quality of care provided. This last is by using questions similar to those included in the GPPS for practices about giving you enough time, listening to you, treating you with care and concern, involving you in decisions about the care.

A questionnaire developed along these lines should provide good quality information about the performance of the whole of the urgent and emergency care system as well as (provided the data is made available to allow sub-sets to be analysed) some specific pointers for the various parts of the system, most notably the IUC.

We urge NHS England to explore options along these lines as they consider the way ahead.

Staff survey

Just as we believe that valuable information is collected focusing particularly on 'caring' through the patient survey, we also believe that data from a staff survey provides a valuable indicator under the 'well-led' CQC heading.

The NHS Staff survey provides a valuable starting point for such a survey – but the nature of the sessional workforce for whom their work within the IUC may not be their main employment (indeed many will not be employees at all) means that there are some elements of the survey that are probably inappropriate. It is also very long and something of an imposition on the members of the IUC workforce that only work part-time within the service. But there are advantages in using the same questions in that the survey has been carefully designed and tested so provides a good basis from which a shorter version can be developed for the IUC setting. An additional benefit is that the answers can be compared across the urgent and emergency care system by collating the responses from the ambulance service, UTC staff, ED etc.

There is clearly work to do here, but we have suggested some of the metrics that we felt might be particularly valuable in the table and discussion below.

An alternative set of KPIs

What shaped the thinking?

A number of constructive suggestions were made during our meetings with managers and leaders from the sector including that:

- The KPIs should, so far as is practical, focus more on outcomes than process. This is, of course, easy to say or to agree with, but it is much more difficult to devise such indicators. Nevertheless, as part of those discussions and in follow-up calls we have tried to take up the challenge
- It would be helpful to reorganise current KPIs against the framework used by CQC (are they safe, effective, caring, responsive, well-led). This highlighted that most current and proposed KPIs focus on responsiveness and a good proportion simply count activity. But it also highlighted the opportunity to include a wider range of metrics.
- The KPIs must focus on the whole of the patient pathway – there was a feeling that the present metrics focus exclusively on the 111 ‘front end’ rather than the clinical value added later in the process. This may, however, sometimes be more a reflection on the fact that data is not collated for the whole pathway rather than being a problem with the KPI itself.
- Genuinely comparable information assembled as a benchmark would offer real value in highlighting where services might be improved. Such a comparison would also be able to highlight the clinical value that good providers deliver in reducing the pressure elsewhere on the system
- If KPIs are to be valuable, we should be clear what purpose they are intended to serve. There is a big difference between the conversation that takes place when they are used to highlight areas where improvement may be possible (so leading to collaborative improvement work) from metrics that are used for contract management (where the conversation can be simply about when it may be expected to ‘turn green’).

As part of these meetings and in discussions that followed we have developed an alternative set of indicators that are outlined below. In developing them they were shaped by the following:

- The IUC KPIs can never provide definitive detail for performance or contractual management. But they can, if chosen well, provide a bundle of indicators that allow one to compare the operation of IUC systems ‘in the round’ and identify possible areas that might be improved. Investigation to look at the detail, often by categorising the cases and following a sample of those through the entirety of the care pathway will still be necessary to inform the detailed changes required.
- If KPIs are to focus on what matters, we need more metrics that focus attention on patient safety, effectiveness, whether services are caring and if they are well-led. But if the bundle is to be manageable there should not be too many – which implies removing or merging some of the existing KPIs
- In choosing KPIs we should consider what data is required and how it will be collected. Unless we are sure that the data is available or can reasonably be collected the KPI is not viable.

- Cost is an important element ⁴– but this is far more than a simple ‘cost per call’ for the totality of the service. If we are to assess the cost effectiveness of the service compared with others it is important to recognise the different elements of the service and to understand the scope of each
- Our proposals are a starting point. Although we have consulted and sought feedback, others may have suggestions and improvements that they can offer. A wide engagement that includes IUC providers, commissioners and that engages with the emerging ICS leaders is important to getting the metrics right and garnering support for the changes. This does not need to take long, but it is essential.

And two final points. None of this is useful or possible unless the underpinning issues with data quality and the failure to join information from different systems/providers within the IUC (and beyond to other parts of the urgent care system) are addressed. And secondly, of course, we have had the advantage of starting with what has already been developed. Standing on the shoulders of giants may allow us to see further...

What might the KPIS look like?

Choosing which of so many of the possible metrics should be included in a list of KPIs that are designed to focus attention on particular aspects is difficult and requires judgment. And the choice changes over time – as an example the DoS ‘ED catch-all’ was a useful metric in the past and we would want to continue with it in the dataset, but levels are now so low that it is of little value except for ‘keeping an eye on it’.

Similarly, the two metrics that we propose for A&E and ambulance revalidation should, we hope, be needed only temporarily. Since they measure the failure to get it right the first time we hope that, in due course, these become redundant because the numbers that require or benefit from revalidation become comparatively small.

Nevertheless, we have proposed a number of KPIs through the earlier pages and have pulled together a summary in the table on the next page:

⁴ The overarching transparency principles for all government contracts describe a presumption in favour of disclosing this information, though providers are not required to describe how they arrive at any price, how they expect to realise a financial return or to reveal any intellectual property associated with their bid.

Proposed KPI	Safe	Effective	Caring	Responsive	Well-led
Telephone answering					
Proportion of calls abandoned	✓				
Proportion answered in 60 seconds				✓	
Clinical assessment					
Proportion taking more than 2 hours to phone/remote outcome	✓				
Average time to telephone outcome				✓	
Proportion of cases with 2 or more ring-backs		✓			
Right first time					
Proportion of ED attendances that were not expected		✓			
Proportion completed with a 'speak to' disposition (so still require further phone assessment by another NHS service).		✓			
A&E/Ambulance revalidation					
Proportion initially given Ambulance disposition appropriately diverted to a lower acuity outcome		✓			
Proportion initially given ED disposition appropriately diverted to a lower acuity outcome		✓			
From staff surveys					
2 metrics from the NHS Staff survey, from the questions about 'engagement' or 'team working'					✓
1 metric from the questions about 'safety culture'?	✓				
From patient survey					
2 metrics about quality of consultation – ?listening to me? and ?explain things to me?			✓		
1 overall metric of satisfaction with the service seen/spoken to?		✓			
Proportion reporting that the advice received was helpful ?perhaps for advice given remotely?			✓		
Face to face consultations					
Proportion with appointment booked in IUC treatment centre for a time that is within timeframe				✓	
Proportion seen within 15 minutes of the later of appointment time or arrival			✓		
Proportion with home visit taking place within timeframe				✓	
Appointment booking					
Proportion of all bookable appointments for which the appointment is booked			✓		
DoS					
Proportion of DoS searches allocated to first service listed					✓
Dispositions and outcomes					
Proportion of cases booked/recommended to attend type1&2 A&E		✓			
Proportion of cases given self-care advice (including prescriptions sent to the local pharmacy from the CAS)		✓			
Proportion of cases where an ambulance was despatched		✓			
Costs					
Annual 'arms length' cost, broken down into three core elements (Call answering, CAS and F2F) plus other services in the 'defined scope'		✓			

There are some important points to note about the table above:

- The list is our suggestion for further development – as we describe in the next section we feel it is really important to explore alternatives and develop each of the metrics further through a process of inclusive consultation. We have tried to describe in the detail above our view on the current and proposed KPIs – but exclusion from the list does not mean that they have no value – for example, as we hint, the revised 2 KPIs for call answering do have merit, it is just that our preference in this area would be to use the established metrics and focus on ensuring comparable data for every contract
- The full set of data that is to be collected from the system should provide much more detail. The KPIs that we have chosen are intended to focus attention on what seems important in the present environment. If a new KPI is adopted we would expect that the underlying data is likely to be there and if a KPI is to be dropped the data should continue to be collected
- We have allowed ourselves one tick per KPI and categorised each under the ‘CQC questions’. It is sometimes difficult to decide which heading is most appropriate but we are suggesting:
 - 3 KPIs related to safety
 - 10 KPIs relating to effectiveness (reflecting the emphasis in the vision on consult and complete, a response in one or two calls and “right place, right time”))
 - 5 KPIs related to caring
 - 4 metrics related to responsiveness
 - 3 KPIs related to ‘well led’
- This is a total of 25 KPIs – compared to the current 19 (allowing KPI 13 and 14 as three each) and a proposed 20 (allowing three for new KPI 5). But the like for like comparison as we have included 6 KPIs from the patient and staff surveys and one about costs (all of which will be reported, say, only once a year) is that we are proposing a very similar number of KPIs. We argue that it provides a more rounded set of metrics that focus more on patient outcomes than those that (too often) count activity.

Contextual information

There is something else that we feel would be valuable to publish alongside the KPI data. This is contextual information that allows those using the data to understand what is included within the service. This information spells out the scope of the service and the mix of cases that are included within the IUC dataset.

The scope for each IUC contract should be defined and agreed between the commissioner and providers involved. Three elements need to be described – there is a minimum ‘core’ part for each and some additional services or features that may form part of one IUC, but not another. We would expect these to be detailed more fully in the promised revised version of the specification – but here are our suggestions.

Call answering

This includes answering of the call, checking who they are calling about, identifying the patient and collecting/validating essential data such as their address or practice name. It also includes the use of CDSS software for assessing patients and/or protocols for identifying and prioritising patients if NHS Pathways is not used. This is the work currently done by service advisers and health advisers. Incoming calls that are answered directly by clinicians who perform these tasks are also counted as part of this activity (though these clinicians are also part of the CAS).

We know of a small number of services that provide additional non-clinical services alongside the IUC – for example responding to the personal alarm that may be carried by an elderly or partially mobile person. We feel that these types of non-clinical service, valuable though they are, should be excluded from the scope of an IUC not just because there are few of them, but also because they are separate from the main activity of the clinical service. Others may have a different view – and we would like to hear those please...

The CAS

This is the activity of remote assessment by clinicians and includes the booking of appointments and triggering the transfer of information to other services. It includes all of the remote consultations (whether by phone, video, chat, email or through any app) that take place within the '111' operation, any 'OOH' organisation and any dental service that is part of the IUC. It also includes any 'despatchers' that plan home visits or 'appointment bookers' that book appointments for face to face consultations if this is not done by the clinician themselves. The CAS deals with calls from patients, carers and with those from health professionals.

The telephone assessment by other services that are counted as part of the IUC is also part of the CAS. It may also include others that provide phone consultations as part of the telephone assessment such as that provided by mental health crisis teams, Emergency department or same day emergency care staff and other services and specialists such as midwives, extended hours hubs/services, community nurses, geriatricians, paediatricians etc. But these additional services should only be counted as part of the IUC if the full details of all of the interactions by phone (start and end time, clinician type and identifier, type/mode of consultation, clinical details, referral/outcome/disposition etc.) can be collated and reported as part of the IUC caseload. Where this is not possible then, by definition, they fall outside the scope of the IUC (even though they are a valuable part of the system, though it is important that cases are passed to them and that the IUC should form and build close links with such services).

Face to face consultations

These are the face to face consultations that are provided as part of the IUC. Again we would expect this to include consultations within the IUC treatment centre, home and residential home visits conducted as part of the IUC (including the 'OOH' organisation). It is perhaps less likely to include dental services as face to face treatment is often provided separately from the IUC service with patients calling 111 with dental problems being prescribed antibiotics or analgesics by the IUC service but with treatment being booked for the day-time with a separate organisation. Similarly, though the IUC may book patients into UTCs and EDs as well as into their own practice we would expect any face to face consultations within these services to fall outside the IUC. Extended hours hubs may, however, deliver part of the IUC face to face service – for example they may provide the face to face consultations in some localities during the day ahead of (or at weekends alongside) the more traditional out of hours service. Again, if these are to be defined

as part of the IUC it must also be possible to collate the detail of the consultations that they provide for reporting, analysis and improvement of the IUC service.

The scope should also make clear the mix of cases that feed into the IUC. Apart from calls to 111 from patients and carers we would expect it also to include online cases that are passed into the system for call-back by a clinician, the calls from health professionals that come into the CAS (whether through 111 or through an alternative number in those areas in which the use of 111 and 'star' lines does not work well), 999 calls if they are also assessed as part of the same CAS and calls to test and trace or the Covid 119 number if these, requiring clinical advice, are passed into the CAS.

The description should try to outline the full range of cases that are to be delivered as part of the IUC and it may be helpful to define a check list to ensure as full a picture as possible is provided. Such a list would need to include, for example:

- providing a first line response for falls
- putting in place the clinical and social care support necessary to allow patients to be discharged home from hospital
- referrals from laboratory services when test results are found to be worryingly outside the normal range

We see that this contextual information is vital to interpreting the data that is collated about the IUC. It will also allow users to identify other IUC contracts that cover a similar scope of service and mix of cases so as to provide more valuable comparators. The extent to which some of the data needs to be broken down is a matter for debate – but our feeling is that it is useful to be clear about the numbers (and so the proportion) of types of cases coming into the service – but that the later measures (for example the proportion of cases given self-care advice or self-care advice plus a prescription issued by the CAS for collection from a local pharmacy) need not be broken down by the same detail.

What next to take these proposals forward?

Review current plans for Metrics/KPIs

The first complication is that NHS England is already well down the track with two sets of changes. The first of these is that they are proposing to introduce a new process of data collection and the proposed new set of KPIs in April 2021. We would recommend delaying this to allow for much fuller consultation of the sort described below.

NHS England is also well down the track with the replacement for the four-hour target in A&E with a bundle of metrics as described in "*Transformation of urgent and emergency care: models of care and measurement*". In our view it is important that at least one (and preferably more) metrics about the IUC system are included within this basket. But, also in our view and as described in the detail above, the one selected, proportion of IUC cases assessed by a clinician should be removed from the list (we responded to the consultation which finished in February with details). There is a real

danger that the reputation and acceptance of either the bundle of clinical indicators or the IUC system will be severely damaged if this metric remains.

Develop the KPIs and metrics to be collected and reported against

Whatever the short term decision about the two points above, it is important to develop the KPIs and data collection for IUC systems to be much more outcome focused, to ensure that they are true measures of the system in total (not just of parts of it) and to be much more ambitious in doing this. The effort that we have put into preparing this detailed paper (in our own time, without payment for this work) reflects just how important we think that this is.

But our proposals need testing and developing with a much wider group. We will be happy to contribute to that discussion but an inclusive consultation process is required as well as some very detailed work to check the practicality of each of the metrics.

This is not a quick task – but neither is it one that need take too long. Clearly the NHS has had far more pressing priorities over the past year but looking ahead it seems reasonable that widespread consultation could take place over a period of a few months whilst the detailed work could mostly be carried out in parallel. Clearly progress may be slow in the early days because of the restrictions of lockdown so the timescales above might need to be extended a little – but there seems to be no reason not to plan on preparing a much fuller, more useful and comparable set of metrics to be introduced by the end of the year (allowing a period for preparation for each area).

We feel that it is particularly important to include within the consultations not just the ‘111’ providers but also:

- Commissioners. Of course these are to be included - but they should particularly address the difficulties with joining data to report on the entirety of the service. But much more important to support improvement activity by allowing the whole of the patient pathway through the IUC to be mapped out and analysed.
- Services providing the ‘OOH’ part of the current contract. We are concerned that many of these that we spoke to were unaware of the planned changes in data collection and KPIs. Yet the separation of current services into ‘111’ and ‘OOH’ is an important reason for why the present metrics are problematic – they ought to be fully involved. These providers are the ones that have demonstrated so dramatically just how high the proportion of cases that can be completed with phone advice is. That understanding needs to be harnessed in designing the new metrics
- System providers – including phone systems as well as clinical/workflow management systems. It is important to be sure that systems collect the relevant data and enable reporting from the same ‘clock start’
- Those elements of the system that may sometimes provide services as part of the IUC system such as extended hours services, dental treatment ...

- Other parts of the urgent care system that will perhaps never work within the IUC but are also an essential part of the wider urgent and emergency care system (ED, UTC etc).
- Related community health, social or volunteer services that may also work alongside (or within) an IUC. This may include district nurses, midwives, social services and volunteer organisations that provide support to those that are frail or elderly
- And the consultation needs to recognise and build in the direction of travel described in “Integration and Innovation: working together to improve health and social care”, the Department of health and social care’s legislative proposals for a health bill that places so much emphasis on the sharing of health and social security.

Address the incomplete reporting

The significant hurdle (the elephant in the room again) is that of ensuring that the data for the entirety of the IUC service (covering all of the core elements and the agreed additional parts of the service) is collated and extracted from the various systems. This appears to be a persistent problem – but it is a challenge that commissioners have to address. Getting it right will set them up ahead of the game for the demands of integrated care systems that will have to learn similar lessons if they are to develop in the desired direction.

Based on the scope that has been defined, commissioners and providers should go through the full set of metrics that they expect to be reported about the IUC service that has just been scoped so as to identify all of the data points that are required. In many services, configured as they are at present, they will find that some of the data comes from one instance of the system and some from another. As an example, data about remote assessment of cases will come from both the ‘111’ system and the ‘OOH’ system. To be clear about some ground rules here:

- If parts of the data related to the core service are not completed and available to be collated as part of the data about the operation of the IUC service, then the commissioner has failed to commission and the provider to deliver an IUC that is compliant with the specification. As an example, if an extended hours hub provides the face to face treatment to patients as part of the IUC but fails to code cases in such a way that all of the relevant details about the consultation are available then it is difficult to see how it can be part of the IUC contract.
- If the data is available but providers are not willing to share it, then commissioners have failed in their duty to ensure that data is shared to support performance management, reporting and inform the ongoing development of the IUC service. It is a puzzle when this occurs – it is clear in the contract that this will be required and we find it hard to believe that any lead provider would not have included that obligation as part of the sub-contract terms. Equally if the commissioner has issued more than one contract for different parts of the service we would expect the requirement to be included in every contract. We note that for at least one contract the data is collated and reported by the CSU (perhaps not just for the expertise that they may bring but also because they may be seen to be an independent organisation). But even here this does not seem to have resolved the problem and allowed them to report on the totality of the service.

For each metric that is to be reported (and we would expect it to considerably more than just that required for the KPIs and for locally agreed metrics) and for each of the dashboards that are to be assembled that will allow users to drill into the detail it is necessary to define exactly where the data will come from and how the measurement is to be calculated. This is a significant task and there is much that others (such as NHS England and system providers) can do to help. But it is the responsibility of the commissioner to ensure that this data is available, that it is collected so as to feed the necessary KPI and metrics that are reported publicly, the local measures and dashboards with their associated data and capability to allow drill down to case level.

G. Appendix Two: IUC – a comparison of provider types

The exam question

This report focuses on the question asked of us by Practice Plus Group. “Is there any evidence from the published data that one integrated urgent care (IUC) provider type performs better than another?” The provider types that we categorised each contract into were Ambulance Trusts, Other NHS Trusts, Commercial and Not for Profit organisations. This categorisation is a little more complicated than it might seem as there are many services that involve more than one provider type (for example with an Ambulance trust dealing with the ‘111’ front end and a Not for Profit OOH service carrying out some telephone assessment and seeing patients face to face in the IUC treatment centre or at home). In these cases, we allocated the provider type according to the main or lead service.

What data is published?

There are two main sources of data - the Minimum data set (MDS) that has been collected and compiled (with various changes) since NHS 111 was introduced and the Aggregate data collection (ADC) that has been collected and published since April 2019. There is some overlap (though much of the MDS data is reported daily the ADC is collected monthly) and sometimes there are minor differences in what is counted – but the main difference is that the ADC data should drive the KPIs that are reported nationally and may sometimes allow more time for additional information to be included (for example about the timeliness of face to face consultations) or generated by linking datasets (for example the time to telephone outcome).

Regrettably the ADC data, despite being the one that drives the KPIs seems to show more signs of being of poor quality. But neither dataset compares well against the three pillars defined in the code of practice for statistics that it is suggested are tested before any data is adopted as an official statistical set. These pillars are **Trustworthiness** (Confidence in the people and organisations that produce statistics and data) **Quality** (Data and methods that produce assured statistics) and **Value** (Statistics that support society’s needs for information) (<https://code.statisticsauthority.gov.uk/the-code/>)

How did we go about this work?

The work is based on very detailed analysis of the published data. We looked at the MDS data from July 2017 up to December 2020 and the ADC data from April 2019 to November 2020. We carefully examined what was reported pre-Covid (generally to the end of 2019 or to February 2020) and what was reported from May 2020 onwards for differences. In general, all services were hit by a large increase in demand in March 2020 until alternative arrangements were put in place to provide information to and to respond to questions from the public about Covid in April. As a result, for most measures, we tended to discount these two months unless we were interested specifically in how they responded to this pressure.

We also collated data from the 111 survey and looked at the GP Patient Survey data and the responses given to the questions about ‘when your GP Practice is closed’. Of course,

we also used our previous experience of working with services to inform our thinking – but in reaching our conclusions we have tried to make sure that each one is supported by recent evidence.

To test our emerging findings and to provide greater insight and understanding about the differences that we found, the difficulties, opportunities etc. we spoke to 39 individuals (and counting) from more than 20 organisations all of whom had a good understanding of the system. Details of who we spoke to are included in the acknowledgements at the front of the report. We are very grateful to all those that contributed so fully to the sessions and provided so much help in getting that detail.

How did the data and KPIs look?

We found that the data collection, collation and reporting processes were so problematic that it was very difficult to make any reliable comparison of how one IUC system or contract compared with another. We have little faith in the comparability of any of the KPIs. We have addressed these issues much more fully in Appendix One. Some of our analysis showed that:

- Percentages are not aggregated correctly because NULL is counted as 0
- Published data doesn't add up when it should
- There are big gaps in the data
- There are inconsistencies between MDS and ADC data – even for simple data like number of calls triaged
- Services are reporting on very different parts of an IUC service – and these differences mean that data is difficult to compare. We could find no service that reports on the entirety of the “integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call-handling and former GP out-of-hours services” that the specification for an IUC describes.
- Providers count calls and start clocks for telephony at different points so results are not comparable
- Some results are just not credible – e.g. 100% calls answered in 60 seconds with an average time to answer faster than the reaction time of a racing driver, wholesale changes in skill mix and changes back, results that add up to more than 100%, numbers that are mathematically impossible, dispositions that range from >180% and <30% of calls triaged
- Very different approaches are taken to estimating the number of calls assessed by a clinician – some only report on the same calls as are reported as triaged by a clinician, others use a range of approaches to arrive at some wildly different numbers
- Priorities are mapped/downgraded so that some report no emergencies whilst others have hundreds – comparison is thus not possible

What else did we conclude about IUC services?

The wider report also describes how the data demonstrates that little progress has been made towards the vision of an IUC spelt out in 2016/17 and how we fear that in the majority of cases this is not just because of the poor quality of the data but because too many services are still operating too much as separate ‘111’ and ‘OOH’ (out-of-hours) services.

So what can we say about how provider types compare?

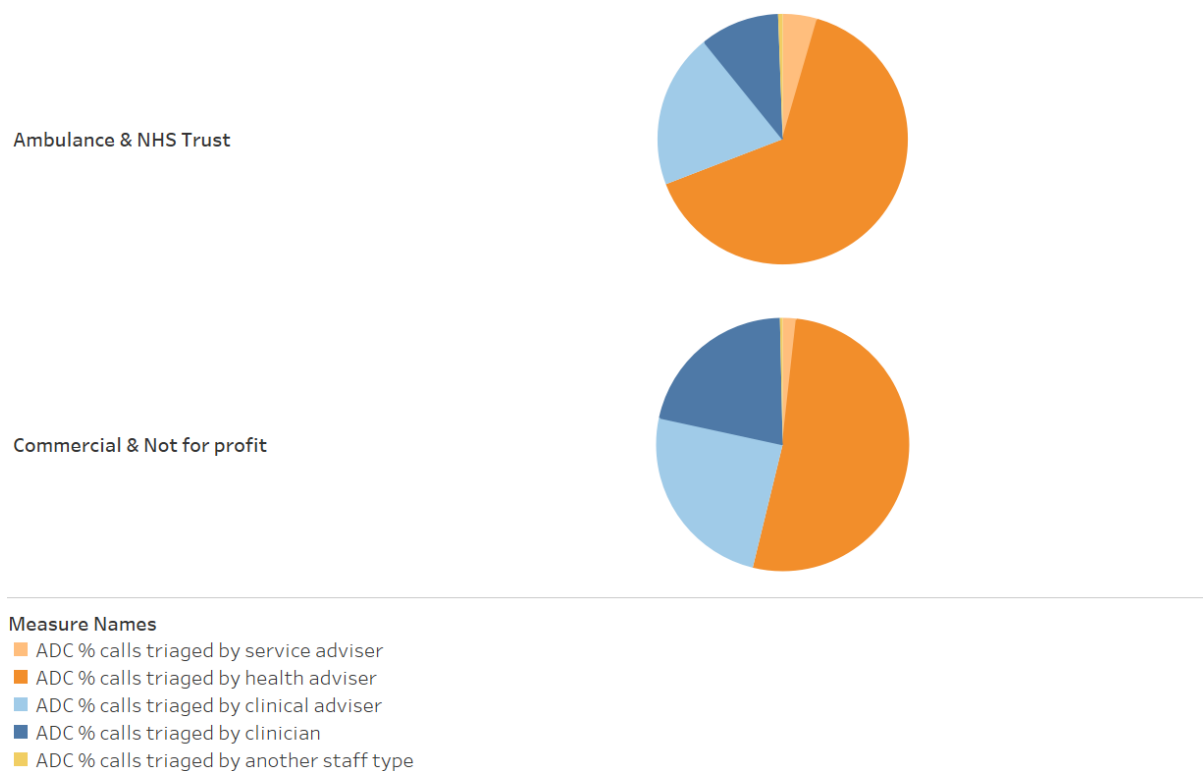
Despite these difficulties we have been able to reach some conclusions about the differences between provider types – as well as about the similarities between provider types.

Commercial and not for profit providers appear to utilise more clinicians

Commercial and Not-for Profit providers appear to utilise a mix of clinicians that includes significantly more Non-Pathways clinicians (likely to include more GPs and ANPs) compared to the services from Ambulance and NHS Trusts. Since across all provider types a similar proportion of cases are triaged by clinical advisers (clinicians that use NHS Pathways), the figures show that Commercial and not for profit providers use more clinicians to triage cases. The diagram below shows this:

Model of service, triage by adviser type as pie

Type of provider (group)



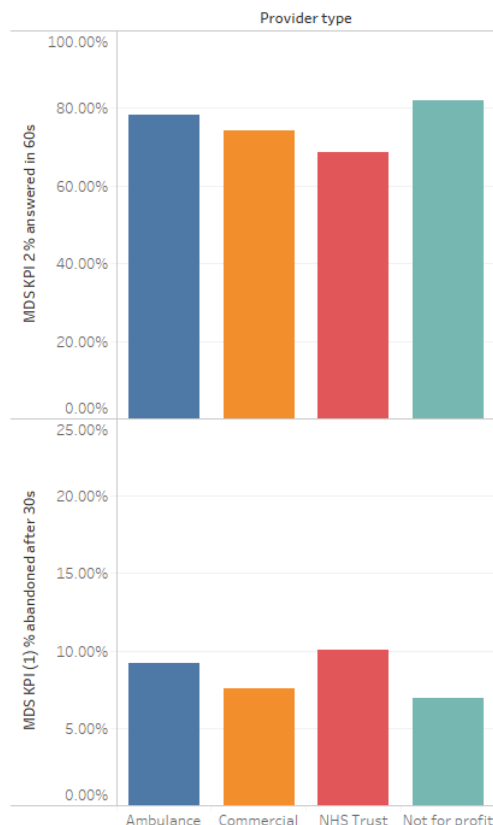
The top pie chart shows less than 1/3rd are triaged by clinicians compared with the bottom where approaching ½ of cases are triaged by clinicians.

Were this to be real, then it might indicate that Commercial/Not for Profit services had more clinical resource giving a better chance that, compared to a health adviser using NHS Pathways, they can take a full history, consider the condition and diagnosis, advise on the appropriate treatment and action to take and provide any necessary explanation and reassurance. Unfortunately, it also seems that this difference may be because some of the Ambulance and NHS Trusts are less integrated in the way that they work so are reporting only on the '111' part of the service whilst the commercial and not for profit services are more likely to report the non-Pathways clinicians as the group that completed the telephone triage.

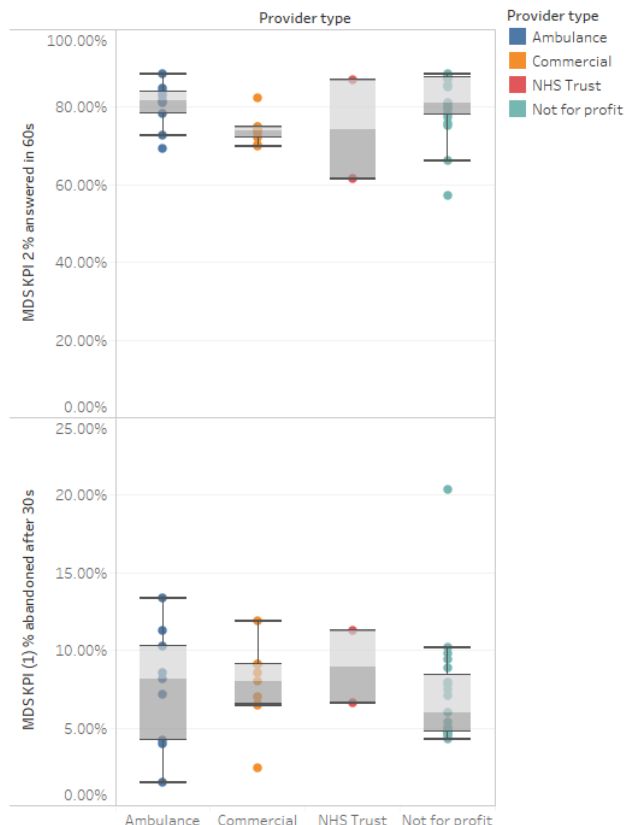
There is relatively little difference between provider types compared with the variation at contract level in performance in answering the phone

There is relatively little difference between provider types in their performance in answering the telephone, whether this is measured by the proportion of calls answered in 60 seconds or the proportion abandoned. There was far more difference at contract level within a provider type compared with the small differences at provider type level.

KPI (1) & 2 from MDS showing average values by provider type



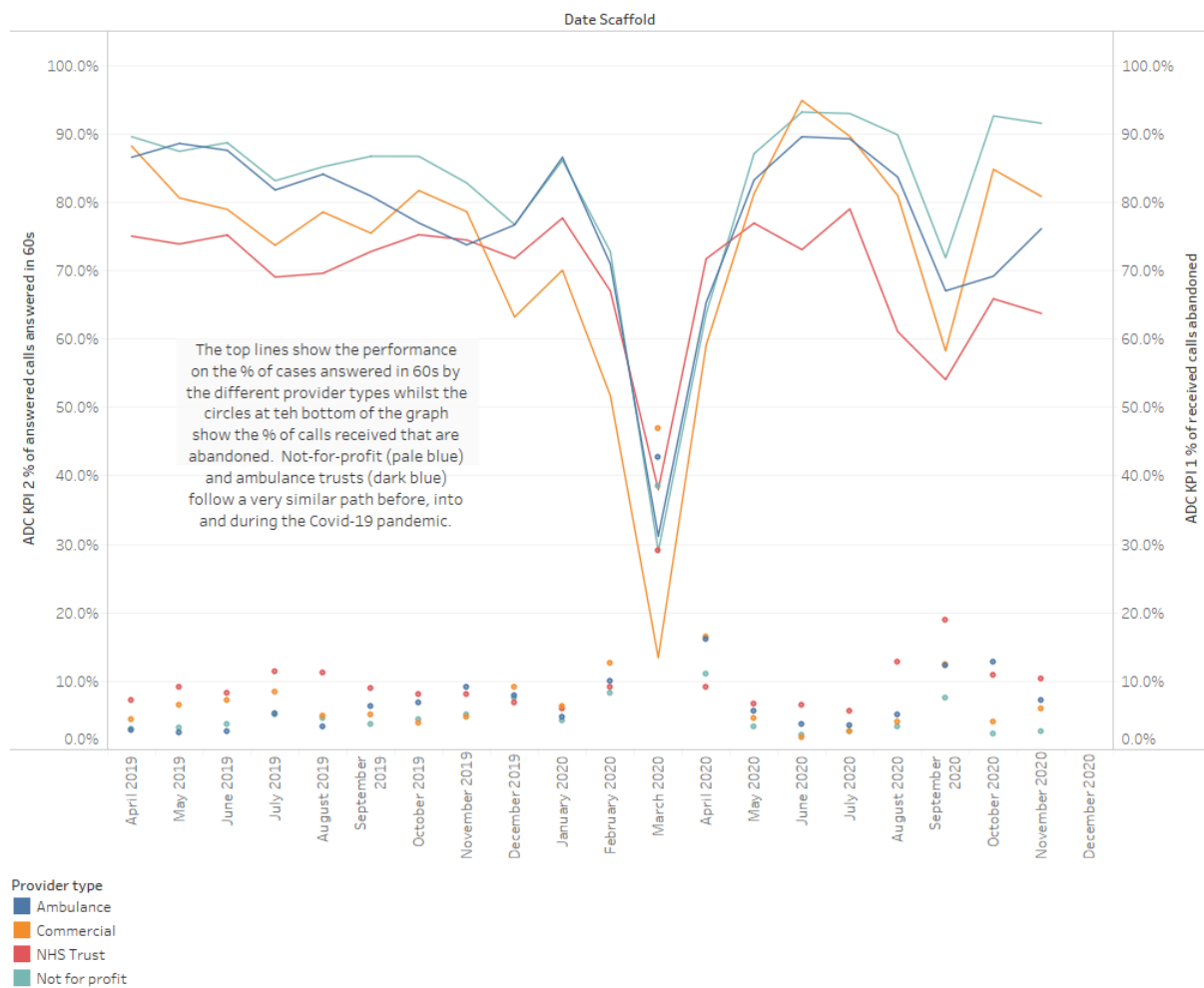
KPI (1) & 2 from MDS showing average values by contract



Date Scaffold
01/04/2019 to 30/11/20..

Also there is little difference in the performance of the different provider types over time in the lead up to and then through the recent Covid-19 pandemic. All types were hit hard in March 2020, all recovered by May and all were hit again as the second wave began. We found no support for the claim from the Association of Ambulance Chief Executives that that “an integrated commissioning of 999 and 111 services has the potential to bring about significant economies of scale and quality improvements... particularly in relation to call answering... [providing] resilience and interoperability of systems, workforce and services to deal with major incidents as demonstrated thought (sic) the recent COVID-19 pandemic”.

Telephony KPI Performance over time



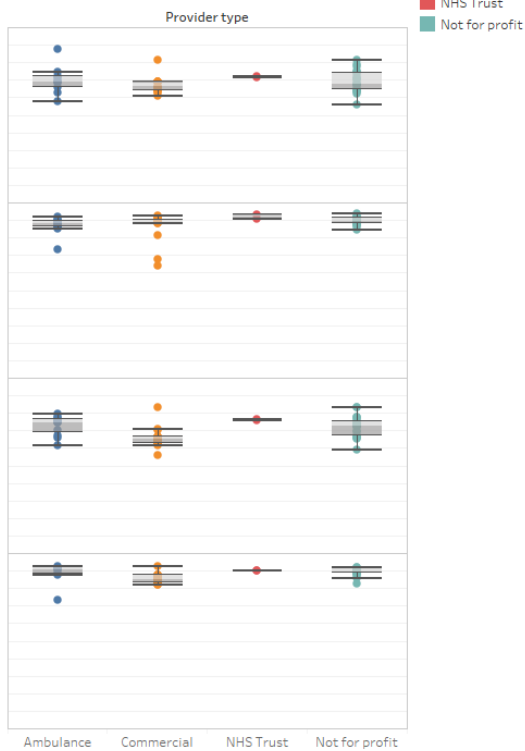
Survey data shows little difference in patient perceptions between provider types

Looking at survey data from the NHS 111 survey and from the questions in the GPPS about ‘when your GP Practice is closed’ we again found very little difference at the provider type level, with much more difference between contracts within each type. We looked at both the data from the 111 survey which again showed much more variation at contract level than between provider types...

Analysis of NHS 111 Patient Survey data - bar chart



Analysis of NHS 111 Patient Survey data - box and whisker

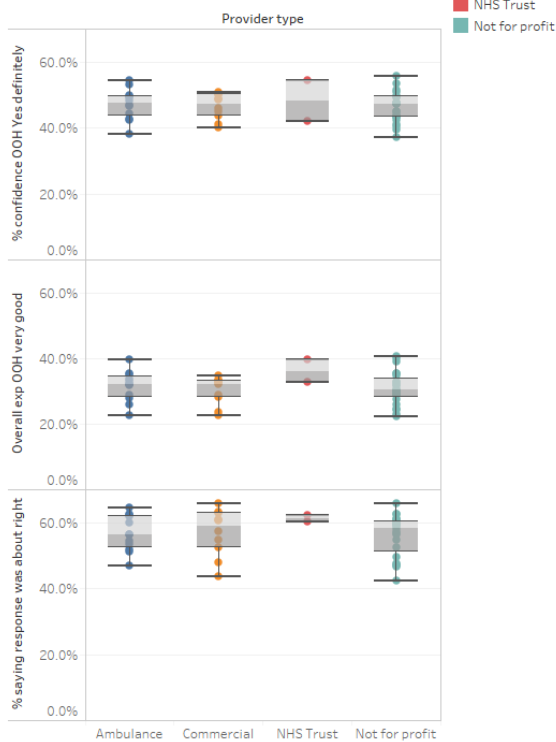


...and the data from the GP Patient survey showed the same.

GP Patient Survey, measures when GP Practice is closed - bar chart



GP Patient Survey, measures when GP Practice is closed - box and whisker



There seem also to be little difference in disposition by provider type

We also looked at the differences in dispositions – specifically the relative proportions directed to the ambulance service, recommended to attend A&E and those given self-care advice. This was problematic as there was considerable mismatch between the MDS and ADC data for cases triaged for some contracts and in some cases the dispositions added up to a very different number compared to the number of cases triaged. As a result, the small differences between provider types varied according to which data set was chosen and how it was analysed. Overall, however, our conclusion remains the same that any difference between provider type is small compared to the difference between contracts. For detail see the example for ED dispositions shown on the final page.

But for most of the metrics it was very difficult to make any comparison

As part of this work we also looked at every one of the KPIs and many of the other metrics that can be derived from the data and we were particularly recommended to look at KPI15, the proportion of calls assessed by a clinician. As mentioned above and described in the linked reports this data was so problematic that it was difficult to make any reliable comparison.

In conclusion

The questions about the quality of data, the comparability of the KPIs and much more is addressed in the other reports. Our answer to the exam question is simple. It seems from the available data that there is no significant difference between IUC provider types on average. There is much more difference between individual contracts. We believe that this is more than just the mathematical averaging effect and that what really counts is having enough resource of the right skill type, suitably trained and available at the right time to meet the expected demand also that there is sufficient management headroom to ensure that the processes are well designed, established, understood clearly defined and ready for when they are needed. A necessary (though not in itself sufficient) condition for this is that the funding is adequate.

And a confusing picture for referrals to ED...

We also looked at ambulance dispositions, home advice and other measures before rejecting them, because data was not comparable



This shows the percentage of cases referred to the emergency department. It is a confusing picture because a considerable number of providers sometimes report a different number of final dispositions to the number of calls triaged (>180% and <30% in some instances)

The top graph shows the proportion of triaged calls going to ED from the MDS dataset whilst the bottom shows the same calculation but using the ADC dataset. The middle graphs use the total of all dispositions reported as the denominator.

The bar charts on the left show very different results depending on which one chooses – the only conclusion that I think we can draw is that, again, the variation at contract level is much greater than by type of provider



H. Appendix Three: Notes from the first review session, 15/1/21

Background

Senior staff from across a range of IUC providers and commissioners were invited to one of two video sessions during January to understand and challenge emerging findings, and to explore how data quality and comparability could be improved.

Participants

There were 10 people on the Teams videocall from 11.30 – 1300 on 15/1/21 – see full list below.

	Name	Role	Agency
1	Kevin Brown	National IUC Director	Practice Plus Group
2	Tim Davison	Chief Strategy & Transformation Officer	Mastercall
3	Marcel Ogurchak	Management Info & System Integration	Medvivo
4	Claire Old	Urgent Care Director	NHS Shropshire, Telford & Wrekin
5	Kathy Ryan	Medical Director	Brisdoc
6	Colin Simmons	IUC Programme Director	Sussex NHS Commissioners
7	Peter Stott	Clinical Governance Lead IUC	KMSS
8	Henry Clay	Director	Primary Care Foundation
9	Ossie Rawstorne	Associate	Primary Care Foundation
10	Rick Stern	Director	Primary Care Foundation

Key Issues discussed

Please note these are our best attempts to capture the sense and spirit of what was said – we would welcome any corrections or improvements.

A. Challenges to the data (after 15 minutes slide presentation)

- The type of provider organisation has little impact on outcomes – the key issue is the quality of clinical staff.
- Different information systems make it very difficult to make genuine comparisons.
- There is a real challenge in factoring in complexity. It matters how individual clinicians manage risk or use the DOS. The narrative of complexity is important and adds context.
- A lot of comparisons are happening at the 111 level rather than at the higher level indicators – there is a challenge with bringing together different data sets.
- Systems for collecting data have evolved over time. People tend to look at the trends at local level rather than differences across the system.
- There is sometimes a reluctance from commissioners to support changes.



B. Responses to the emerging conclusions

KPIs and the data that supports them is not comparable. How can we improve this? Are there some indicators that are missing?

- KPIs are very hard to compare if we can't trust the data. Currently, there are too many examples of where the data does not reflect what is actually going on.
- It's a misnomer to refer to urgent care KPIs – they are really about 111. Local data sets look more at areas that are relevant to clinical work but this tends to be ignored in systemwide or national decision making. It often seems that NHS England don't care about this and are exclusively interested in the impact on the front end of hospitals.
- A number of people reported that they have their own set of data and dashboards and they use this to monitor many of the aspects of performance rather than the KPIs. There is sometimes a reluctance to change the existing metrics because it introduces a discontinuity making it more difficult to look at trends.
- Whilst there should be one organisation that takes the lead for compiling data from different providers this doesn't seem to happen.
- There is not enough attention on patients who fall outside the targets e.g. we should look more closely at those patients that take longer. We need to look at the tail of the queue if we want to focus on the real clinical quality issues. When investigating clinical incidents it frequently seems that the problem was the delays as patients sat in one queue after another.
- Example of issues with statistics on delay: To improve the patient experience our service has introduced COMFORT CALLS (call backs by non-clinician when there might be a delay in getting a call back from a clinician) - but this improvement will not be measured in standard KPIs/metrics.
- The use of different code-sets means that apples are often compared with pears. There is also a danger that the weakest code-set is adopted as a default which is a disincentive to try to improve the data collection process.
- It does seem that nobody is validating the data, nor are they really looking at the system benefits. It sometimes seems as if NHS E is focused on the front end and they don't seem to be interested in some of the things that we do and are proud of.

The data indicates that the small variations between provider types are insignificant compared to the variation at contract level. Do you agree?

- There was agreement that it is probably easier for not-for profit to recruit clinical staff compared to ambulance trusts. And it is the Non-Pathways clinicians that have the confidence to override the NHS Pathways disposition.
- Participants were comfortable in this conclusion about provider types.

Too few seem to know about and use RAIDR and look at the effectiveness of referral. Why?

- There was more awareness of RAIDR. There were concerns about how easy it was to use and the current limitations in drilling down into the detail. It is therefore of little use in driving change.
- Just contacted our informatics lead - he says the main problem with RAIDR is not getting raw data and the upper level DX descriptions can mask the data.
- It would be good to ask NHSE about extending RAIDR so that local providers and commissioners can use it more effectively.
- Assembling all the data in a pseudonymised form would be very helpful.
- It doesn't currently help us look at the impact of KPIs.

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- It takes a lot of hard work to track cases, so a way of doing it more efficiently would be great.
- RAIDR is based upon an NHS number which is not used by all GP OOH services. Also, it is not available in real time - relies upon Hospital Trust updates which can take a couple of months.
- I think ultimately we are looking to determine if the service/experience for certain patient cohorts could be improved (this could be something like RAIDR data leading to tweaks to Pathways). On an individual IUC provider level RAIDR data set may be too small to find improvements - may be better analysed at a national level.

How can we further integrate urgent care services to improve them for patients?

- Is the language of integration helpful – what do we all mean by it? Could look at care that straddles the borderline of different services.
- Integration is at heart about how services work together.
- At the heart of integration is good relationships.

Can we assess value for money better than we do?

- We need to look much more closely at ‘patient value’. How do we measure and focus on things that matter and make a difference to patients?
- Patients report that one of the things that they value is there not being too much delay. We look carefully at delays in answering the phone but too little attention is paid to delays in the CAS and in OOH. We need some markers for these steps too.
- We also should use histograms to inform the discussions between commissioners and providers. Averages and Median do not draw attention to keeping the tail to a sensible maximum limit.

C. Top priority for improving the current system

We asked each participant to highlight their priority for improving the current system of collecting data and comparing performance across IUC services. Many focussed on establishing KPIs that were better at capturing ‘patient value’, impact on improving health and wellbeing rather than recording activity.

- Measuring quality is vital, but KPIs don’t really begin to touch it. We need measures that focus on patient care and a better understanding of how to improve data quality and learning.
- It would be helpful to have a regular forum of leaders across urgent care to share ideas and learn from each other.
- We need metrics that look at whether we improve patient experience rather than simply supporting contract management.
- It would be good to reframe this study using the CQC lines of enquiry.
- We should focus more on the impact of delays in the patient pathway – understanding more about the risks involved in holding patients in queues.
- The starting point needs to be consistency, so that we can make valid comparisons and create a meaningful narrative of how patients get from one end to the other of their care.

Follow up

Conversations are continuing offline so we can better understand the detail within individual organisations.

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We would welcome any corrections or further comments arising from these notes. We would remind you that while all participants are welcome to share the issues raised at the session and in these notes, please do not share who said what.

Notes circulated 18/1/21



I. Appendix Four: Notes from the second review session, 28/1/21

Background

Senior staff from across a range of IUC providers and commissioners were invited to one of two video sessions during January to understand and challenge emerging findings, and to explore how data quality and comparability could be improved.

Participants

There were 17 people on the Teams videocall from 15.30 – 17.00 on 28/1/21 – see full list below.

	Name	Role	Agency
1	David Archer	CEO	Herts Urgent Care
2	Fiona Butter	Management Consultant	Working with Gloucestershire CCG
3	David Davis	Head of integrated governance	SECamb
4	James Gibson	Commissioning & Innovation	Sandwell & W Birmingham CCG
5	Chris Green	Commissioning & Innovation	Sandwell & W Birmingham CCG
6	Caroline Gwilliam	Senior Contracts Manager	NHS Gloucestershire CCG
7	Nickie Jakeman	Consultant Emergency Physician	Royal United Hospital, Bath
8	Deb Lowndes	Programme and Service Director	Brisdoc
9	Robert Mauler	Quality Team	NHS Gloucestershire CCG
10	David Porter	Head of Contracts and Procurement	NHS Gloucestershire CCG
11	Michelle Reader	Chief Operating Officer	Medvivo
12	Liz Rugg	CEO	Medvivo
13	Oliver Short	Business Intelligence Manager	Herts Urgent Care
14	Tony Spencer	Commercial Director	Practice Plus Group
15	Henry Clay	Director	Primary Care Foundation
16	Ossie Rawstorne	Associate	Primary Care Foundation
17	Rick Stern	Director	Primary Care Foundation

Apologies:

John Horrocks	CEO	UHUK
Jeannette Hudson	Associate Director of Commissioning	NHS Gloucestershire CCG
Keely Townsend	Associate Director of IUC	YAS

Key Issues discussed

Please note these are our best attempts to capture the sense and spirit of what was said – we would welcome any corrections or improvements. We have also added comments from the ‘Chat’ and follow up emails.



Challenges & responses to the data (after 15 minutes slide presentation)

- It is really worrying to see that some organisations submit no data or incomplete data and that comparison reveals mathematical impossibilities. Shouldn't there be financial penalties for this?
- What is the impact of NHS online on the targets? In some areas it is a really significant part of the workload, yet it is (officially) excluded from the data.
- Is this work just missing the point? Over time algorithms just don't work as they fail to keep up with the increasing complexity of our work due to co-morbidity and frailty. Metrics tend to reduce down complex decisions to misleading numbers. There was a reminder that the original vision was that services would get smart at using resources – so that Health advisers completed some of the cases using Pathways, but that more and a wider mix of clinicians would also be involved to deal with the complex cases.
- It is difficult to identify metrics for the CQC category 'well led' – good leadership should be judged by collective success on all other indicators.
- Has it been possible to ascertain if there is any link to the telephone closure rate and functionality available to the clinician? EPS, SCM all impact on enabling more cases to be closed as telephone cases.

Responses to the emerging conclusions

KPIs and the data that supports them is not comparable. How can we improve this? Are there some indicators that are missing?

- If we sort out the reporting, we still have the problem of each system for urgent care services having a different configuration which will influence the reporting. Not sure we will ever be comparing apples with apples.
- It is difficult to compare services as there are so many factors involved. It will always be challenging to benchmark providers because of the variability of the availability of other services, and the relative level of integrated commissioning - e.g. whether the contract includes F2F, etc. impacts on 'performance'.
- There are occasions when one comes across people from organisations that work within one part of the system and that ask questions like 'where do your calls come from?' because they only do OOH call-backs.
- National KPIs are not the only way of measuring performance. I suspect many, like us, have their own dashboard with their commissioners that lets them value the service.
- The new metric about adherence to the first choice is a welcome change.
- At this point I think we need to separate KPIs/quality measures and the comparison of Providers/IUC Services - we did refer to comparing "apples and apples" but I think we need to take into account not only the service model being delivered but also population sizes and deprivation levels, contract value/resources etc. Maybe there is some complex formula that can be added after we determine the quality of a service.
- "KPIs" infers number counting and not quality measures - we need to measure quality in terms of patient journey and outcomes. It should be about the value/quality for the patient not for the Commissioner - a big step I know!

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- Undoubtedly there is value in some simple measures e.g. did 111 answer the call, but more important is the CAS element and what value it added to the patient journey.
- Quality measures need to be system wide and based on the patient journey and outcomes, so we need some internal measures of the patient journey and whether they followed advice and the outcome (this would be onerous in some cases and probably have to look at the patient activity over a few days). This could be linked to a patient survey - why did the patient take an alternative path etc.
- Patient experience is invaluable so adding this in more than currently as a quality measure might help.

The data indicates that the small variations between provider types are insignificant compared to the variation at contract level. Do you agree?

- I am not sure that comparing the type of organisation providing the service is of value.
- **No-one else picked up on this issue or disagreed with this finding.**

Too few seem to know about and use RAIDR and look at the effectiveness of referral. Why?

- There was more awareness of RAIDR.
- RAIDR is difficult to use under the current circumstances (home working) as it cannot be accessed without an N3 connection.
- RAIDR is not intuitive and is difficult to use.
- Its not the best tool, we tend to rely on our own – there are problems with all dashboards.

How can we further integrate urgent care services to improve them for patients?

- Key to success is case flow mapping and including the interim dispositions to work out how to best use the resources available.
- We have comparisons of ED clinicians vs clinicians using pathways and it may sound obvious, but the results using ED clinicians are outstanding.
- The challenge is a better platform that has the joined up data. Has anyone heard of the NHS digital project TEMs which is working to develop an IUC data set/dashboard?

Can we assess value for money better than we do?

- We need to have a national benchmark in a way that learns from the earlier GP Out-of-hours benchmark.
- A benchmark is possible but would need to acknowledge that now we are looking at IUC we are dealing with larger and more complex units across other sectors.
- We need to look at value for money across the whole system not just the separate parts of different services.
- I agree with national benchmarking, as this might generate more investment for IUC for further development.
- Yes – previously, benchmarking generated more investment in our contract.

Top priority for improving the current system

We asked each participant to highlight their priority for improving the current system of collecting data and comparing performance across IUC services. The two main themes were the challenge of getting genuinely comparable data and the need for outcome base metrics – any ideas for useful and measurable outcome-based KPIs would be gratefully received!

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- Ensure there is a consistent way of reporting data from our operating systems – this means finding a way of getting Adastra to establish a common approach across all providers for reporting on KPIs.
- Ensuring standardised reporting – some people are too precious about this – it is really important to get the bigger picture and this requires comparable information. Ought we to fine people if they don't do it properly? We also need to ensure that any new approach is more carrot and less stick, with reporting being more open and transparent and a common understanding of what we need to do to improve the system.
- We are looking to launch a new procurement for our IUC service. This will involve scoping out what others do, but it is also crucial to have common and consistent KPIs.
- We really need outcome-focussed KPIs – a big shift from where we are now – so that we have an ability to value the impact of the whole service rather than small individual parts.
- Is standardisation really a good thing? And how does sharing data more openly protect confidentiality. We need to focus on outcomes.
- It would be an improvement if we shifted the focus of attention away from 111 and on to the CAS.
- There is an important gap between what it recommended to patients and what actually happens.
- We need to simplify the data collect, limiting it to what we need to make meaningful comparisons. Too many metrics look at whether we offer a fast service rather than a good outcome, which can't be right.
- However we move forward, there needs to be more shared learning. Before we make any further changes to the KPIs, we need to ensure that there is a high degree of consensus – otherwise we will be doing this all over again in another 12 months' time.

Follow up

Conversations are continuing offline so we can better understand the detail within individual organisations.

We would welcome any corrections or further comments arising from these notes. We would remind you that while all participants are welcome to share the issues raised at the session and in these notes, please do not share who said what.

Notes circulated 1/2/21



J. Appendix Five: Why is there limited uptake of RAIDR across IUC providers and commissioners?

Background

This note follows up on a video session between the Primary Care Foundation and the Performance Analysis Team at NHSE&I to explore the initial findings of a review '**comparing performance of urgent care providers across England**'. Julie Stroud asked if PCF could share their understanding of what constrains IUC providers and commissioners from making use of RAIDR.

Key Issues from Interviews and Review Sessions

To date we have carried out a number of 1:1 discussions and two 90-minute video sessions with leaders from IUC services across England. The first review session was held on 15/1/21 with 10 participants and the second on 28/1/21 with 18 participants. Below are the issues as presented by local leaders, as well as some additional commentary and analysis. The comments are taken from our notes (not a recording) but should capture the points made.

Awareness

More people than we had thought are aware of RAIDR – but, where it is used, this tends to be by commissioners and it appears to be little used by providers. A number of providers reported that they didn't think that access was available to them.

Accessibility

The dashboard is reported to be not easy to use **“(It's) not user friendly, not the best tool – we tend to rely on our own”**.

And others reported that RAIDR was very difficult to access if you are working from home **“It is difficult to use under current circumstances as it requires an N3 connection”**.

Timeliness of Data

One participant commented **“RAIDR takes a long time for the data to come through as it relies on hospital Trust updates that can take months”**.

Data quality and digging into the detail

“It is REALLY important to check the number of cases submitted to RAIDR against the number triaged for the same area. These should agree (at least near enough) and if they don't it is difficult to rely on

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any reports from RAIDR". This problem seems to have been resolved more recently in the area where the issue was raised, but they have no idea what changed or whether it was a widespread problem.

One provider reported that they had looked at it but the limitations in not being able to drill down to the detail was the main problem. Comments included:

"It can't be used to drive change as it is not possible to find out where the problem lies".

"Just contacted our informatics lead and he says that the main problem is not getting raw data and that the upper level Dx codes can mask detail".

"Assembling all of the data in a pseudonymised form would be really helpful".

Improving integration

"It might be better to join with the ECDS data that provides clinical information" ... it seems an approach along these lines is being developed in at least one location.

"UTC outcomes (in at least some areas) are coded within 111 as primary care dispositions yet patients attending these centres appear in the ED dataset. This sets hares running about the number of primary care dispositions going to A&E unnecessarily".

"Ultimately we are trying to determine if the service/experience for certain patient cohorts could be improved (for example RIADR data leading to tweaks to Pathways) and this analysis might be best done at a national level".

Current limitations of the agreement between NECS and NHSE&I

I spoke to NECs and my understanding is that, subject to appropriate clinical governance agreement being made between the provider organisation and NECS, NECS can provide data that allows the user to link the information from the ED and hospital so that they can analyse groups of cases to look at the flow through the face-to-face consultation in the IUC treatment centre or OOH service and even identify the specific case to, for example, listen to the voice-recording.

But there is a problem. At present the data is supplied to them with an agreement under an arrangement with NHS England that they should only make available the dashboard that does not allow the detailed questions of the sort that allows providers to get to the bottom of the problem. This constrains providers and commissioners from working together to improve the operation of their urgent care system.

Do users really understand what RAIDR can do?

It was noticeable, especially in the video review sessions, that local leaders twice picked up on the point they want to be able to look at the gap between what people are advised and what they actually do. But they can do this with RAIDR. It seems that some providers and commissioners may not understand what RAIDR can do and tend to be put off by the other issues highlighted above. Two comments clearly refer to this:

- ***"Quality measures need to be system wide and based on the patient journey and outcomes, so we need some internal measures of the patient journey and whether they followed advice and the***

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outcome (this would be onerous in some cases and probably have to look at the patient activity over a few days). This could be linked to a patient survey - why did the patient take an alternative path etc.”

- ***“There is an important gap between what it recommended to patients and what actually happens.”***

And even the comment above that suggests that the analysis might best be done at National level seems to understate the potential of this sort of data to transform the service by changing how health advisers and clinicians interact with patients. In New Zealand, with their (much smaller and very different) service, they firmly believe that it is a failure (failure to provide the necessary reassurance, failure to explain, failure to listen to the worries of the caller, failure to agree the management plan with the patient etc.) when a patient does not follow the advice given. As a result, one of the metrics that they told me that they judge their staff by (over time) is how often the patients that each staff member has spoken to follow the advice given.

Can RAIDR be used as a data source for future KPIs?

In addition to improving the dashboard and allowing ‘drill-down’ there is clearly scope to develop RAIDR or to develop alternative solutions to bring together a much wider set of data for commissioners and providers. Such a dataset must include full details of the IUC pathway, not just the final Dx code, but also the intermediate steps and information from any face to face consultation. It should also include data from the Ambulance Service and, in time wider sets of data from other primary and secondary care services.

But, even now, with small changes to RAIDR there seems to be a strong case for introducing new KPIs that actively make use of RAIDR. This will focus attention on the effectiveness of the service in directing patients to the right service in a timely fashion. Such metrics could include, for example, a measure of ‘DNA’ for ED dispositions and/or a measure of the proportion of patients given homecare advice that subsequently attend ED.

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1st February 2021