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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Developing best practice across primary and urgent care

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Acknowledgements

This paper includes a Foreword from the three authors of the report, an Overview of how the review was commissioned, designed and conducted, our findings and recommendations.

We are grateful for everyone's time and patience and below we list everyone who helped with this work by reviewing our initial findings, taking part in video sessions, or by commenting on drafts.

In the end, responsibility for the analysis and the recommendations, is ours alone.

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.

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[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.

Diagnostic
What is wrong at the moment? What works and what doesn't?

Reflection
How can we improve things? What needs to change?

Solutions
Practical ideas for making improvements

Catalysing Change
Building a wider consensus for a new approach

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'.
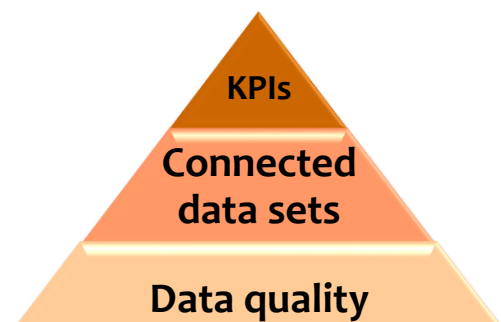
And, though we have drawn the pyramid narrowing to the top, in terms of value the picture is inverted. Once you have good quality data, joining it up adds more value – but the real value comes from the metrics (not just the KPIs) that can be derived from it and the ability to drill down into the detail 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 data[2]. For the reasons outlined above they do not provide a sound basis for comparing performance.

- 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.

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/

- 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 goood 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.
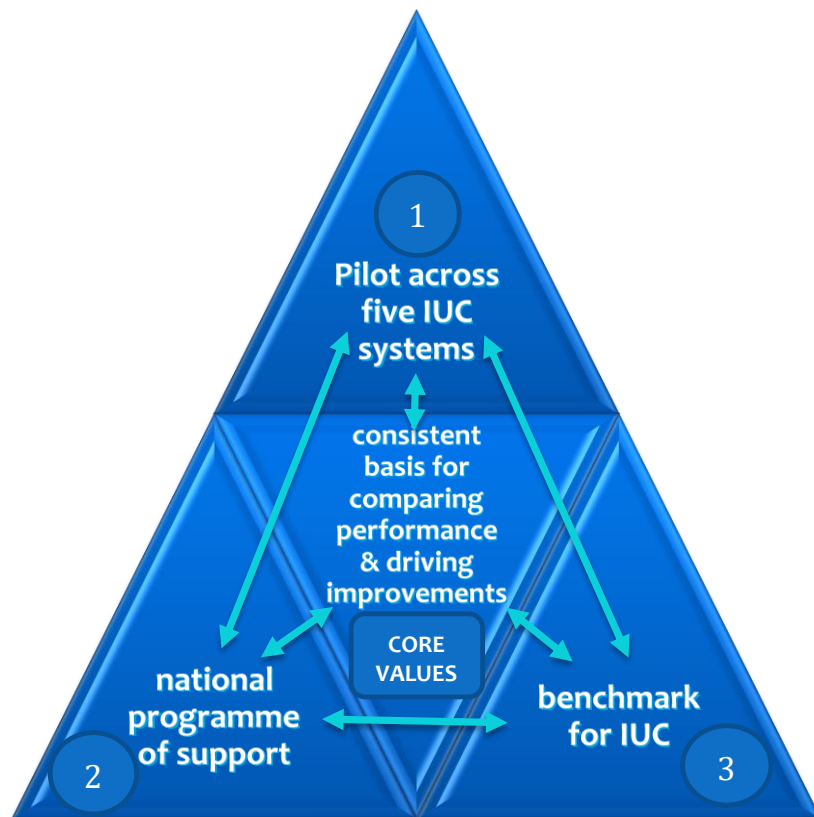
What are the benefits of being a pilot site

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.

Developing best practice across primary and urgent care

F. Appendices

If you would like a copy of any of the papers that underpins this review, offering a more detailed analysis of the national data sets and other issues addressed in this report, please email us at admin@primarycarefoundation.co.uk or you can find copies of all these papers on our website at www.primarycarefoundation.co.uk

Appendix One
Proposed changes to the IUC Key Performance Indicators (KPIs)

Appendix Two
Comparing IUC provider types: is one type of provider better or worse than another?

Appendix Three
Notes from the first review session, 15th January 2021

Appendix Four
Notes from the second review session, 28th January 2021

Appendix Five
Why is there limited uptake of RAIDR across IUC providers and commissioners? Note for NHS England and NHS Improvement 1/2/21