Developing best practice across primary and urgent care

primary care FOUNDATION

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.

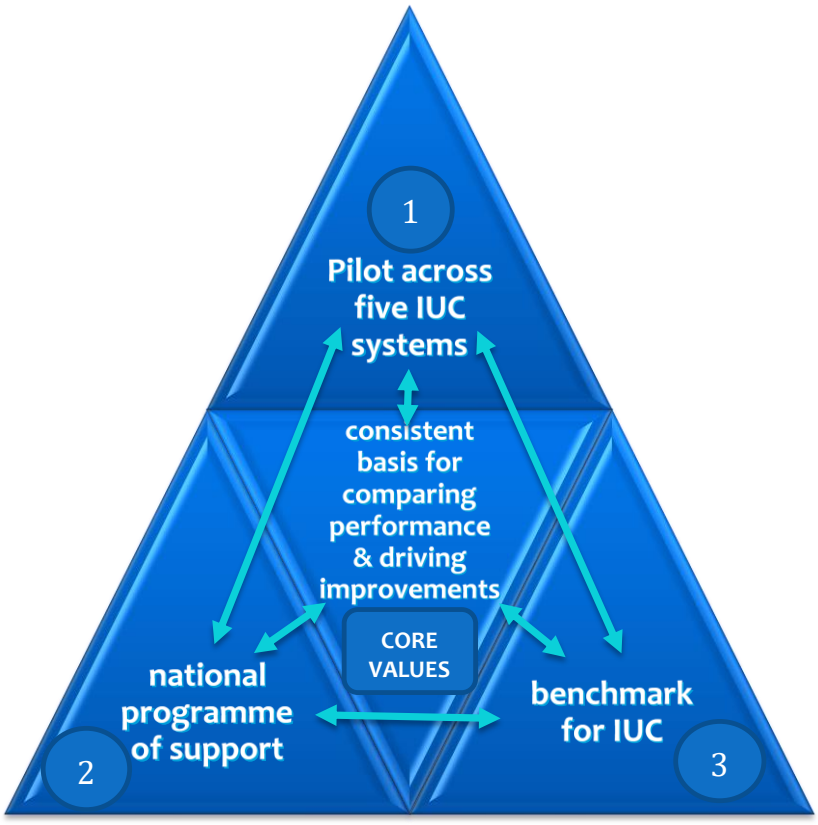
The Primary Care Foundation and Methods Analytics have a clear view of how this can be put in place and we propose to work with a small number of services to develop the proof of concept.

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.