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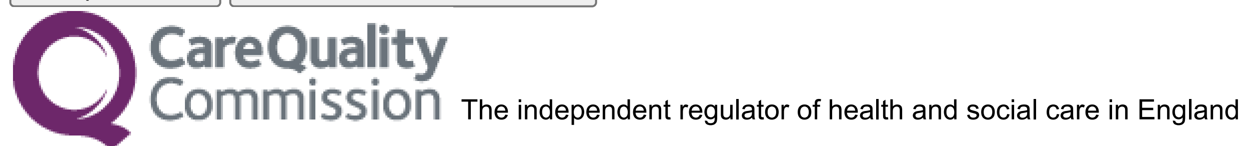

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Collaboration in urgent and emergency care

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Foreword

The COVID-19 pandemic is one of the greatest population health challenges the world has faced. It has required health and social care providers to rapidly respond as partners, enabling people to continue to receive care quickly and safely, and often working together in different ways.

Collaboration and system-working have never been so important. With this in mind, we set out to complete a national programme of provider collaboration reviews (PCRs). The aim of these reviews is to support providers of health and

social care services by sharing learning and helping to drive improvements for those accessing care. Our ambition is to look at how providers are working together in every system by May 2021.

In the autumn of 2020, we reviewed how providers have collaborated in urgent and emergency care (UEC).These reviews took place earlier in the pandemic and in different circumstances to those experienced now.

UEC services are currently under exceptional pressure because of a combination of the regular winter pressure and the pandemic. We think it is important to share some positive examples of innovation and creative approaches found during our reviews now. This reflects our continued commitment to driving improvement in the sector at a time of major challenge. Our full findings from the reviews will be published in spring.

We heard some inspiring stories of how the pandemic served as a catalyst for change. Many systems accepted that usual governance and funding considerations came secondary to meeting the needs of people requiring urgent and emergency care during a crisis. Providers have worked together to ensure urgent and emergency care services and pathways adapted quickly and safely, and that people received the right care, in the right place, at the right time.

We felt it was important to share these examples of collaboration now, to share where we have found learning and celebrate the success and opportunity that has come out of adversity.

Rosie Benneyworth
Chief Inspector of Primary Medical Services and Integrated Care

Introduction

Our review of collaboration across local health and social care systems' urgent and emergency care (UEC) services has revealed some good examples of work to help improve people's experience of care during the Covid-19 pandemic.

These are examples of creativity and innovation, as well as rapid developments where providers have worked together well in responding to the pandemic.

The reviews took place mainly in the autumn of 2020 and mostly concluded around the time that the second wave of the pandemic began.

This review is part a national programme. Later this year there will be further work, focused on a range of themes and eventually covering all local systems across England.

The local areas or specific organisations covered in our reviews of UEC were:

- Cheshire and Merseyside Health and Care Partnership
- Hampshire and the Isle of Wight
- Cornwall and the Isles of Scilly
- Northamptonshire Health and Care Partnership
- Herefordshire and Worcestershire
- East London Health and Care Partnership
- Suffolk and North East Essex
- West Yorkshire and Harrogate

A catalyst for collaboration

Providers have worked together to ensure UEC services and pathways adapted quickly. Previous barriers to collaboration were put aside during COVID-19, particularly around sharing information, resources, and staff redeployment.

- In Northamptonshire, a shared strategy for workforce planning into the winter months was in place. The workforce cell set up by the clinical commissioning group (CCG) in response to the pandemic looked at national and local staffing drives as well as staff skills. They wanted to see where it could be beneficial to move staff around, and where upskilling would be useful.
- In West Yorkshire and Harrogate, Suffolk and North East Essex, and Cornwall and the Isles of Scilly, there was 'passporting' of staff between NHS trusts. An NHS competencies passport enabled staff to move between providers within a system more easily - the aim was to reduce gaps in staffing and improve patient care.

Right time, right care, right place

To meet local population needs, providers used a range of information. It included quantitative data to predict localities with the greatest need, and to understand the needs of local populations. They used patient feedback to help inform their decisions and their learning from the first wave of the pandemic – the increase in people seeking urgent help was also an indicator for measuring local needs.

- In some places, local crisis care pathways were implemented where there were increases in the numbers of people attempting to, or taking, their own lives. The number of new referrals to mental health services showed the need for enhanced services. Across West Yorkshire and Harrogate for example, there was increased crisis phone line support in anticipation of the impact of the pandemic and the lockdowns on people's mental health.

- Some providers sought patient feedback and local Healthwatch often collected and shared people's views. In Herefordshire and Worcestershire, the CCG responded to feedback about mental health access by launching a 24-hour helpline and a programme called Now We're Talking [https://www.healthyminds.whct.nhs.uk/nowweretalking/].
- In West Yorkshire and Harrogate, there was a primary care urgent service just for people with COVID-19 symptoms. This was a collaboration between four primary care networks (PCNs) and a GP federation – a total of 27 GP practices. To protect patients and staff, and to reduce the risk of staff sickness, the COVID-19 urgent service was operated by a dedicated cohort of clinicians.

Keeping people safe

Providers tried to keep vulnerable people safe, including those who needed to be shielded, when they needed to access UEC. Home visiting services and remote consultations reduced attendance at UEC sites, and there were some designated COVID-safe pathways with cohorts of staff who had only worked with non-COVID patients.

- GPs at a Northamptonshire practice had regular calls with the ambulance service and worked together on patient cases to avoid unnecessary ED attendance. The ambulance service carried out visits to people's homes for the GP practice, in liaison with GPs, helping people to avoid going into hospital.

- In Herefordshire and Worcestershire, there were same-day emergency care virtual follow-up clinics, set up for patients who were too vulnerable to return to an ED.
- In Northamptonshire, there was good use of mental health service initiatives, such as crisis cafes, a crisis team, and crisis houses for those with acute needs. A 24-hour phone line introduced at the start of the pandemic received a reported 6,000 calls a week – 70% of these were triaged to the third sector and prevented unnecessary presentations.

Getting the public messaging right

Across our reviews, we heard about some places where fewer people were attending for UEC. There was a balance to strike between advising people to attend if they needed urgent care, or not attending in some circumstances. Systems used different methods to ensure that carers and families knew urgent care was still available if required. Social media, newsletters, helplines and primary care networks were used to communicate with the public.

- App development and online information helped local areas provide information to families. In East London, the Youth Empowerment Squad developed their own COVID-19 information for other young people - this was circulated via a social media account and hosted on a website [https://children.bartshealth.nhs.uk/our-news/play-team-2020-update-interview-about-the-new-yes-covid19-leaflet-8489].
- In Cornwall and Isles of Scilly, parents were encouraged to download a paediatric app – parents and carers could input symptoms and they could be advised whether to provide care at home or seek medical attention. Newsletters were also developed to inform families.

Supporting people’s mental health

There were good UEC examples of collaboration to support people’s mental health needs. Providers have redesigned care pathways and specialist mental health teams were put in place to provide access to UEC services, recognising that access to support in the community would be limited.

- In Cheshire and Merseyside, the Core 24 service meant that there was permanent mental health care in an ED. And with some community services closed, there was good joined-up work between health and local authority services, also involving a mental health crisis team and an alcohol liaison team.
- Mental health services continued in Herefordshire and Worcestershire. Access was extended through the provision of a new 24/7 crisis line - people of all ages could access advice and crisis support and there was self-referral to services. We heard this was advertised and well used. From March to November there were 9,838 calls for 5,444 unique (adult) patients. All crisis services and community mental health teams continued to operate – they reportedly delivered around 40% of contacts face-to-face compared with 60% pre-COVID.

Collaborations that make a difference

Providers have worked together as partners, accepting usual governance and funding considerations came secondary to meeting the needs of people requiring UEC during a crisis. In some places we reviewed, collaborations were longstanding. In others, they were forged by the pandemic. For example, in Hampshire and the Isle of Wight four independent systems came together to face the pandemic – we heard that there was a history of working independently, with separate funding and information technology arrangements. There were many positive examples of good collaboration that made a difference.

- In Suffolk and North East Essex, there was an initiative called, Home, But Not Alone. A phone line was open 9am to 5pm, seven days per week, to help on topics including food, medication, loneliness and isolation. This provided practical support to vulnerable people, particularly regarding medicines, food supplies and transport to health and care services, and for other urgent and non-urgent needs. The voluntary sector was integral in this support and this collaboration was a key feature of the approaches to tackle health inequalities. Health and council services created a single point of access for people – food, prescriptions, transport or support, and all linked into medical services. The voluntary sector helped with pharmacy collection and transport, and helped identify when people might need treatment, to support quicker intervention. The community response here was described to us as "phenomenal".
- The continued importance of the voluntary sector was clear in some local systems, especially in places where volunteering could continue. One volunteer operation in Hackney, East London, made over 5,000 deliveries of medicines from the end of March to June, ensuring patients had access to their medicines.
- On the Isle of Wight, the NHS trust collaborated with other local providers to ensure people had timely access to medicines forend-of-life-care (EOLC). This relieved pressure on UEC. Medicines were available from community pharmacies and within the urgent treatment centres, in take-away packs, for symptomatic relief and palliative treatment.

- In Cheshire and Merseyside, calls to NHS111 went from around 5,000 a day to 12,000 (and a reported record 18,000 calls in one day) as national guidance pointed people to use the service. Dedicated lines for adult social care providers were allotted after some providers reported problems accessing NHS 111.

Tackling inequalities

This is our first collaboration review that looks at local systems and inequalities. Although systems did not consistently focus on inequalities and specific population needs, our review gathered many examples of initiatives to consider people's individual needs, focused on Black and minority ethnic people. Some providers tried to work with communities to address inequality. They sought the views of specific population groups to improve their awareness of health inequalities and consider how to tackle them – we heard about listening events and the involvement of people using services in wider learning activities.

- In Cheshire and Merseyside, to better understand and to measure the needs of the people in their system who were most at risk, a population health laboratory was developed. A set of pooled data from all providers helped to influence the design and delivery of the most appropriate service for certain communities. Looking for gaps in care, daily updates were provided to the system – it showed infection rates and the patient groups affected.
- The public health team in Northamptonshire had established an equality impact framework, looking at groups that may have been disadvantaged. It was published on the county council website so that different groups of health and care professionals could use it for decision-making. They recognised the different impact of the pandemic on different groups of people and identified that as a system they could use COVID-19 to push plans to address inequality.

- A district nurse and health visiting team in Northamptonshire did targeted work with people with diabetes from Black and minority ethnic groups. They achieved this through networks in local communities. Key documents were translated into different languages and localised efforts were made to engage with people from diverse communities.
- Across various services in Suffolk and North East Essex, events were held, titled What Are We Missing? These were virtual conferences to engage and listen to people from Black and minority ethnic communities, to help inform

immediate and longer-term planning to reduce inequalities. The West Suffolk Alliance had a network of community officers in the council with strong connections. Two voluntary sector groups worked to connect with people from Black and minority ethnic communities and support their needs. This was reviewed at an alliance board meeting, with presentations from both the groups.
- People were sometimes unclear about what services were available - Healthwatch Cheshire East & West recognised extra barriers for people in poverty and in isolated ethnic groups, and they worked across the system to support an improved communication strategy.
- In East London, community leaders and influential people reached out to the local community through Bengali radio channels. The Ipswich and East Suffolk Alliance worked with the Commission for Racial Equality, Healthwatch and clinicians – the result was people from within the community being filmed to pass on messages in their own language about how to stay safe.
- In East London, transport was provided for people to access services and there was outreach work with people who might not otherwise be reached, such as traveller communities. There was also joined-up work to help asylum seekers get access to primary care in Cheshire and Merseyside.
- Where there was less understanding about more vulnerable groups, there was a commitment to do more. For example, in West Yorkshire and Harrogate, an independent review [https://www.wyhpartnership.co.uk/our-priorities/population-health-management/impacts-of-covid-19-on-BAME-communities-and-staff] was commissioned to examine the impact of COVID-19 on Black and minority ethnic communities.

Including adult social care in UEC planning

A common theme was the inconsistent inclusion of adult social care to influence UEC planning. However, we gathered some positive examples to inform learning.

- The Integrated Care Across Northamptonshire [https://northamptonshirehcp.co.uk/ican] is a new programme of transformation work driven by the Northamptonshire Health and Care Partnership to improve the quality of care and achieve the best possible health and wellbeing outcomes for older people across the county.
- There was a good example of information sharing from social care in Herefordshire and Worcestershire, where people's vulnerabilities were included on care home residents' care plans – these were shared with ambulance crews, as well as visiting clinicians and hospital staff.

Effective governance

We found effective governance arrangements that ensured oversight and flex of clinical and professional resources in the system.

- In Suffolk and North East Essex, NHS 111 services were reorganised. The service realised that there were two main types of callers: those who were unwell, and those who wanted COVID-19 advice. To ensure the callers who were unwell could speak to someone quickly, there was a filter for symptomatic and non-symptomatic callers. There was also collaboration with fire and rescue services to expand ambulance capacity – 21 Essex firefighters joined NHS staff on the frontline, working as ambulance drivers alongside East of England Ambulance Service paramedics.
- In East London, we were told how NHS trust and CCG safeguarding colleagues met virtually to ensure safeguarding risks were identified and mitigated. The CCG teams also linked in with local authority command structure meetings. We were told how safeguarding leads discussed contingency plans for the care of CYP at local

safeguarding children partnership boards, considering capacity and identifiable trends. There was also a CYP page including Covid information resources published online [https://www.eastlondonhcp.nhs.uk/ourplans/children-and-young-people.htm].
- In West Yorkshire and Harrogate, the local system had a weekly briefing call for monitoring. They looked at bed occupancy and planning for what might happen. There was a system oversight group with plans in place for bed occupancy of the intensive care unit – and at a set percentage of bed occupancy, decision-making could be escalated to stop elective activity.

Keeping staff safe

We heard about specific, additional measures for staff at higher risk, such as people from Black and minority ethnic communities. For example, in Cheshire and Merseyside, we heard that some staff had been redeployed within acute settings to reduce their potential exposure to COVID-19.

Measures we heard about included mental health support, increased informal ‘catch up’ calls or sessions, staff networks, care packages and additional breakout spaces. We heard that some mental health trusts were providing support for staff across other NHS organisations by facilitating access to counselling or other psychological therapies, and other providers were sourcing this type of support elsewhere.

Where staff were working in call-centre environments, we heard about examples of Perspex or glass screens being erected between desks, additional space being made for people to move around offices safely, and stepped-up cleaning regimes alongside other infection prevention and control measures.

Good use of technology

Technology has helped in many aspects of health and social care during the pandemic, including for many people their access to primary care services via virtual appointments. Sharing of electronic patient records across all sectors has also been a big help in many places – this led to positive and timely impacts for people who needed care.

- In Herefordshire and Worcestershire, the electronic patient record (EPR) was used to record known patient vulnerabilities - it was also available to EDs before a patient arrived at hospital. Shielding letters that had been sent to patients were also shared with EDs and added to patient records so this would flag up if the patient attended ED. We also heard how partnership work between health services and local government in Herefordshire and Worcestershire had enabled a wider range of children, with multi-agency support, to be flagged on hospitals’ ED information systems.
- We heard how all care homes across Herefordshire and Worcestershire had been provided with computer tablets to enable remote consultations with frail or vulnerable residents - this allowed virtual ward rounds from primary care and more timely access to clinical advice. Care home staff have been supported with training, and 30 care homes have been part of a social media pilot to enable greater connectivity with family and friends.

- In Cornwall and the Isles of Scilly, an out-of-hours service reported how care homes were given observation equipment and the necessary training to improve the remote triage of patients. This work started before the pandemic but proved valuable early in the pandemic as people used tablet computers for virtual consultations.

Supporting children and young people

Across the places and systems that we reviewed, there were many good collaborations and initiatives to protect children who needed urgent and emergency care services.

- Partnership work between health services and local government in Herefordshire and Worcestershire enabled a wider range of children to be flagged on hospitals' ED information systems. This was possible through multi-agency support.
- We heard how it was a challenge to meet the emotional health needs of young people in crisis, due to the increased demand on services. In Cornwall and the Isles of Scilly and Herefordshire and Worcestershire, for example, processes were implemented to try to divert CYP from EDs. NHS providers worked with the third sector and child and adolescent mental health services (CAMHS) services to adapt and meet changes in demand. In Suffolk and North East Essex, we found an online counselling service provided by a national third sector organisation for CYP - this was accessed by people after attendance at ED, where it was noted the child or young person required increased emotional support.
- Local areas prioritised hospital admission avoidance - in Herefordshire and Worcestershire, community paediatric nurses increased their home-visiting remit to support children to stay in the community. This updated process also included a follow-up call to the family 24-48 hours after attendance.
- Suffolk and North East Essex Foundation Trust set up a 24/7 first response helpline for CYP in mental health distress. This freephone was designed to divert people with a mental health crisis to help that was away from the ED. And we heard about a Suffolk parent/carer network created signposting information for families to support CYP's emotional wellbeing and mental health.
- Safeguarding was reported as extra-challenging during lockdown. In Hampshire and Isle of Wight, people we spoke with said they wanted to be sure all issues around CYP were captured. Daily calls were held with all safeguarding colleagues involved, including the local authority. We were told how GPs had access to paediatric wards for advice, to streamline CYP to the appropriate wards and bypass the ED.
- In Herefordshire and Worcestershire, we heard about a changed process at Wye Valley NHS Trust for CYP. Collaborating with the ED, a new care pathway saw every child going through one route, with senior clinical decision-making at the front door.
- In Cheshire and Merseyside, we heard about 24-hour hotlines set up for advice and referral, including children's and adults' mental health services. It meant care plans were started at the earliest opportunity. We were told that the Covid experience had improved some communications between providers, such as the ED and CAMHS, and there were now routine morning and evening 'huddle' calls. We also heard about positive new links between public health nurses and the ED, and extra work with the voluntary sector to improve safeguarding.
- In Cornwall and Isles of Scilly, we heard about a dashboard that was developed for use across the health and care system. This was to identify CYP with complex health needs, and those who were subject to child protection plans. We were told all vulnerable children had Covid plans that were regularly reviewed. Efforts were concentrated on keeping vulnerable children out of ED – and any ED attendances were monitored for trends.
- We heard about CYP generally presenting with increased clinical, emotional and social care needs. There was concern about delayed presentation and increasingly complex mental health needs. In Hampshire and Isle of Wight, they recognised this change and responded – they placed the children's outreach and support team in the 111 service to identify and address family anxiety regarding children's health.

Capturing system learning

There was a great deal of learning across local systems during the early stages of the pandemic. Providers were reacting and working together at pace. In some places we have seen how this learning has been captured.

- The integrated care system at Suffolk and North East Essex published a report [https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2020/10/SNEE-ICS-System-learning-Report-March-September-2020.pdf] that captured its system learning from the first wave response. It also explored what might come next. This report brings together evidence from a wide range of sources, including public health statistics, national and local research and consultations, case studies from people who use services, and interviews and surveys with local health and care partners, including voluntary and community sector organisations. The report was shared widely across the system, region and beyond. We heard it was used as an exemplar for system learning.

We provided feedback to each of the systems we reviewed, and they told us about some of the actions they would take to address the findings. For example:

- Proactively engaging with adult social care providers, particularly smaller providers that felt more disconnected from system planning
- Further developing opportunities to capture the voices of people who uses services and their families and carers, including through partnership with Healthwatch
- Deepening the ICS's understanding of their population needs with a focus on local inequalities, the vulnerability of some groups of people, and deprivation.

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