Provider collaboration review: Urgent and emergency care

Categories: Public

This report about urgent and emergency care (UEC) in England is the second of our provider collaboration reviews [https://www.cqc.org.uk/publications/themes-care/provider-collaboration-reviews].

These reviews aim to show the best of innovation across systems under pressure, and to drive system, regional and national learning and improvement.

We looked at urgent and emergency care in eight areas of England in October 2020. Urgent and emergency care covers a wide range of services that people turn to when they need immediate help, including NHS 111, GP out-of-hours services, urgent treatment centres, urgent dental services, accident and emergency, ambulance services and pharmacies.

Local areas and organisations covered

The local areas or specific organisations covered in our reviews are:

- 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.

Some of these areas are integrated care systems (ICSs) and some are sustainability and transformation partnerships (STPs).

We wanted to know whether people were getting the right care at the right time and in the right place, and how collaboration across local areas had made a difference. Much of the joined-up work is usually behind the scenes from the patient's perspective, but we have seen in the past how good collaboration is often evident in the better examples of care we find.

This report shares the overall learning from the review, which falls broadly into the following themes:

1. Ensuring access

- Urgent and emergency services collaborated in a variety of ways to maintain access to services, although access to the right UEC care was sometimes difficult for people.
- The pandemic served as a catalyst for change – pathways were often evolved at pace with positive impact.

2. Tackling inequalities

- There was variation between local systems in the level of focus and action on health inequalities, linked to pre-COVID oversight and planning maturity around population needs.
- The pandemic exposed where some systems lacked the full understanding of inequalities across their population groups.

3. Governance and shared planning

- Governance varied across systems, but with a number of common priorities.
- The extent to which data was shared across the system significantly affected oversight, assurance and decision-making.
- Support for adult social care varied. Some providers felt well supported by system partners, but many others felt uninformed and not supported. Some providers said they were not always included in planning or decision-making.
- Good existing relationships across a system set the foundation for the effectiveness of collaboration and shared planning.

4. Safety and staff skills

- Providers created new collaborative relationships, sometimes sharing staff or helping ensure services were adequately staffed. Staff have been flexible and risen to many challenges. But exhaustion and burnout were concerns everywhere, especially with the impact of winter.
- We saw little evidence of widespread shared strategies, at a whole-system level, for managing anticipated increased demand for UEC services this winter. Systems didn't always feel it was in their remit to plan for system-wide staffing.

5. Use of technology

- Technology increased and changed the way people were encouraged to access UEC, although some systems were more advanced than others in their approaches to equality of access.
- Many people benefitted from the quick responses of primary care to offer virtual access. Rapid technology advancements were seen to significantly improve transfers of care.
- Where electronic patient records were shared across all sectors, we heard of a positive and timely impact for people accessing care.

We have previously shared learning examples from the areas that we covered [https://www.cqc.org.uk/publications/themed-work/collaboration-urgent-emergency-care], and links to these examples are also shown in the relevant sections below.

We also share some learning in respect of three areas of focus:

- Safeguarding
- Children and young people
- Medicines optimisation

Looking forward to next winter and beyond, the main challenges we have identified for systems are:

- Develop and build on relationships: provider and system leaders must collaborate and work together to meet the needs of their local populations. Our work shows that it is crucial to establish good and meaningful relationships across local areas and systems.

- Share important information: urgent and emergency care services will be able to help people most in need of care if lasting solutions for information sharing are achieved.
- Understand staffing: to ensure the right numbers of people and skills, workforce strategies should cover a local system or area, not just localised services.
- Understand inequality: leaders need to work hard to understand the inequalities that exist in their areas and further develop strategies to address them
- Embrace technology: rapid advancement of new ways of working have shown that in many cases there is an opportunity to improve people's access to care and their experience.

Ensuring access

Key learning

- Urgent and emergency services collaborated in a variety of ways to maintain access to services, although access to the right UEC care was sometimes difficult for people.
- The pandemic served as a catalyst for change – pathways were often evolved at pace with positive impact.

There were many initiatives to try to help people to access care [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#right-time]: new phonelines for triage (keeping people safe but away from emergency departments, if possible); remote care provision, including 24/7 mental health crisis lines; new physical services included 'hot hubs', plus taxi services to get people to hot hubs; urgent dental hubs; and enhanced mental health crisis support, including crisis houses and cafes.

NHS 111 was at the centre of much collaboration, assessing urgency and directing people to the right service or pathway.

Some providers have been proactive in considering the needs of certain population groups, such as older people or people with certain health conditions. Mental health services were available in some areas, but some people struggled to get urgent mental health treatment, and in many areas UEC faced challenges in meeting the emotional needs of children and young people.

Access to the right UEC care was sometimes difficult for people. Some people could not arrange urgent GP, dental and mental health appointments due to service closures. This, coupled with reduced capacity in some services that remained open, had a knock-on effect on other UEC services and people seeking urgent care. NHS 111 sometimes struggled to point people to services because of unplanned service closures, which put extra strain on emergency services.

Community mental health services were affected and dental services that were open struggled with demand – some emergency departments helped people who could not see a dentist.

Providers and system partners faced challenges in communicating that UEC services were available, and had to strike a balance between encouraging people to seek help if needed while concerned about potentially being overwhelmed. To get the message across, services tried social media, radio and television, bus stop posters and contact through professionals such as social workers or district nurses.

Changing pathways

There was collaboration among UEC services to separate people with coronavirus and those without the virus. At the height of the first wave, services tried to avoid hospital admissions and keep people away from hospital emergency departments.

Changes meant people were directed elsewhere – urgent care and treatment happened in different ways and in different places. Telephone and online systems were established or used more often – and we were told about the challenge of directing a person safely by phone or online; without seeing someone face to face, it was not always clear how unwell they might be.

We heard how some primary and community care services decided that treatment in people's homes was a better option than the risk of an urgent care site, but not everyone could be cared for at home.

Other changes in services included some outpatient departments' services being moved to a different hospital or site. This helped make way for different patient pathways – there were codes for pathways and sites, such as 'hot' or 'cold' sites, or 'red' or 'green' pathways, determining the movement of COVID or non-COVID patients. Some hospitals were designated non-COVID only, known as a cold site.

Specialist UEC care pathways were devised to bypass hospital A&E departments. This allowed people direct admission into hospital wards or to other services that they needed. People could access a range of specialisms including mental health care, frailty, palliative and end-of-life care, children's services, gynaecology, urology, ophthalmology, and ear, nose and throat care.

Although we heard about problems for people trying to access mental health care, some acute and mental health trusts worked together to prevent people with urgent mental health needs being admitted to acute hospitals.

Hospitals worked with GPs, NHS 111 and ambulance services to try to direct people to the right places; there were adult social care and health care services that tried to reduce COVID risks and the need for UEC services through enhanced support and training in care homes; and we heard about some good cross-sector communications and information sharing that enabled better outcomes for people. The introduction of Think 111 First in some areas – enabling direct access for some appointments with GPs and EDs – was coordinated at system-level.

Providers, particularly GPs, and other organisations such as local authorities and the voluntary sector, contacted vulnerable and shielding people to offer advice and guidance and to check on their welfare.

Tackling inequalities

Key learning

- There was variation between local systems in the level of focus and action on health inequalities, linked to pre-COVID oversight and planning maturity around population needs.
- The pandemic exposed where some systems lacked the full understanding of inequalities across their population groups.

In our reviews, we wanted to know about strategies and plans for tackling health inequalities [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#tackling-inequalities].

The pandemic exposed health inequalities that were not well known before, and it provided the momentum to tackle long-standing inequalities. Work to understand and tackle health inequalities had focused on economic disparities, while the pandemic highlighted the need to address other factors, particularly ethnicity.

Some providers tried to work with communities and 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, but this did not happen everywhere - in some places there was a lack of public involvement.

Collaboration with the voluntary sector and community engagement supported providers to understand and meet the needs of different groups. Engaging directly with communities, especially using 'community connectors', was particularly important in sharing information and guidance. Community connectors will be different people in different places, but they are usually people who are well-known within their communities – for example, a leader within a local religious community, or someone else with a known reach or influence within a specific population group.

Communication about COVID-19 was provided in different languages and we heard about specially created easy-to-read information for people with a learning disability. However, we saw there were barriers for certain groups of people in some

places, including those with different languages. Some people did not get the information they needed about how to access services.

There were some initiatives to provide accommodation and health and care services for the homeless and, in some systems, this work provided learning that could also help meet the needs of homeless people in the future.

We found variation between systems in the level of focus and action on health inequalities. Some systems had strategies and action plans in place. In some, the pandemic has heightened the need for learning and improvement. Work is ongoing to understand the impact of COVID-19 on different population groups, with some systems more advanced than others. The use of data appeared to be limited and an area for development and improvement.

Several systems reported that the fast pace of change due to COVID-19 meant equality impact assessments had not been completed early in the pandemic but were happening as part of reviews and lessons learned.

Some places had captured people's recent experiences of care to inform planning, including local Healthwatch projects in West Yorkshire and Harrogate and Suffolk and North East Essex.

- Experiences of Health & Care in Bradford during the first phase of COVID-19 (Healthwatch Bradford & District) [https://www.healthwatchbradford.co.uk/report/2020-10-23/experiences-health-care-bradford-during-first-phase-covid-19]

There was a lack of evidence on equality outcomes specifically, although several prevention programmes and initiatives were highlighted. These were focused on older adults, people with a learning disability and others at greater risk of poor health outcomes.

In some, providers described approaches to understand and monitor inequalities, exploring the needs of different groups of people and the impact of the pandemic. There were processes to collect and analyse population-level data to identify where gaps in provision might be. However, in others, understanding of health inequalities was limited or there was a lack of data on demographics, particularly ethnicity.

Some providers had little to say about how they were tackling health inequalities. We were told that it was unnecessary because they tailored their care for individuals. Some systems had identified the needs of disadvantaged groups but had not put measures in place to address them.

We asked about cross-system approaches to tackling barriers for people from Black and minority ethnic groups. Some providers told us how they ensured the safety of Black and minority ethnic staff, but there was little about action to improve access to care and outcomes for patients. Some said this was not a priority because there were smaller populations of Black and minority ethnic people. This meant systems did not pay enough attention to the disproportionate effect of the pandemic or the needs of Black and minority ethnic people in their response. Some systems recognised this. This was a factor for systems in areas where visible ethnic minority populations were smaller and perhaps more isolated.

Governance and shared planning

Key learning

- Governance varied across systems, but with a number of common priorities.
- The extent to which data was shared across the system significantly affected oversight, assurance and decision-making.
- Support for adult social care varied. Some providers felt well supported by system partners, but many others felt uninformed and not supported. Some providers said they were not always included in planning or decision-making.
- Good existing relationships across a system set the foundation for the effectiveness of collaboration and shared planning.

Across our reviews, there was evidence of effective governance structures, with a developed understanding of roles and accountabilities. While there was variety across systems, with a wide range of overlapping structures, there were some common key priorities:

- monitoring UEC demand and capacity in a consistent way
- coordinating planning and sharing learning
- protecting core UEC services, through optimisation of pathways, supporting preventative services and community services to reduce use of UEC services, and increasing capacity through commissioning
- ensuring adequate numbers of skilled staff across the system.

Collaboration across urgent and emergency care has happened at multiple levels and there was not a one-size-fits-all approach. There were various arrangements for the planning and delivery of the UEC pathways across systems [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#governance] and we saw examples that went beyond system boundaries.

Priorities were often reflected in the winter planning done between services locally, and to a lesser extent at an ICS/STP level. There was a desire for operations to be managed at place level as much as possible. We saw that providers collaborated at multiple levels, with place-based partnerships leading on operational delivery of services.

Providers reported that they made their own plans and risk assessments and we saw that providers adopted their own ‘command and control’ hierarchies for escalation of concerns – and shared this planning with other providers across the system. This encouraged responsive decision-making. The structures usually had foundations in pre-existing relationships and arrangements and were in terms of ‘gold’, ‘silver’ and ‘bronze’ command layers.

We saw systems monitoring to identify which services were in high demand, identify pressures on the workforce, and determine escalation points. There were examples of modelling being used at a systems level, using historical and live data to forecast future demand and capacity, and to explore different scenarios for planning. We saw many examples of ongoing monitoring from CCGs, looking at population groups, changes to bed capacity, workforce numbers, evaluation of pathways, and monitoring of compliance with changing national guidance.

However, evidence about how well systems’ data were communicated was mixed. Some providers commented on the usefulness of shared dashboards, record systems and updates, though for other providers there was little evidence that these had informed decision-making.

Working together

There was system-wide collaboration and planning at STP and ICS levels – this was for planning of urgent care pathways and service delivery, oversight of capacity and demand, workforce solutions, and commissioning.

There was collaboration between the NHS and independent sector. For example, we were told about examples where cancer care was moved to some independent hospitals, and providers looked at different ways to try to ensure people were assessed. Some unusual environments were used for care services, including sports clubs, and in some places, people were assessed in their cars.

There was extra support for social care providers in some places, to ensure residents got appropriate urgent care. Clinicians were aligned with care homes, sometimes through a primary care network. Equipment was provided to support remote consultations.

There was also some poor collaboration. Many adult social care providers felt uninformed, not supported or included by GPs and NHS trusts, particularly around coordination of the discharge of people from hospitals to care homes or into people’s own homes.

Some adult social care providers told us that no measures were in place to ensure support from UEC providers for vulnerable people. Sometimes, support for people shielding was led by the adult social care service where people lived. Some home care

services relied on NHS 111, while some care homes were supported by a GP and could also get rapid response via a special designated 111 service.

Relationships set the foundation

Looking ahead to next winter, strong leadership and a determination for local collaboration is essential. Provider and system leaders have a duty to collaborate to meet the needs of local people.

We found that pre-established relationships and ways of working set the foundation for how systems and place-based collaboration worked during COVID-19. For many systems, UEC partnerships and networks were mature even before the pandemic and there was an advantage in areas where working relationships were already in a good position. Relationships have since strengthened and systems were keen to maintain collaborations.

For systems with distinct place-based approaches to UEC, collaboration continued to be predominantly place-based. For example, in Hampshire and the Isle of Wight, we found four independent systems that came together. The separation appeared to stem from a history of working independently, with separate funding and information technology arrangements.

Barriers were put aside

Across our reviews, we were consistently told that previous barriers to collaboration were put aside during COVID-19, particularly around sharing information, resources, and staff redeployment. We heard this included a shift of focus from financial consequences and individual provider needs, to what was right for the patient. It was described as a liberation, placing people at the heart of decision-making, removing barriers and bureaucracy where possible to be more responsive.

Funding certainty was another lever for collaboration. While this had been consistently cited as a barrier to collaboration, changes were accelerated in response to COVID and financial decisions had not been the main driver in determining provision of care.

We heard that organisations worked together when money was ‘off the table’. Interviews also highlighted the importance of joint commissioning between health and social care, providing synergy across whole systems. There were some examples of mutual aid agreements in place at both NHS trust and CCG level. However, we heard of uncertainty about future funding and there were concerns about the impact of this on future collaboration.

Adult social care and system planning

We heard how some smaller adult social care providers were not always involved in planning. In several systems, providers said they were not involved in decision-making. While this review has described positive examples of collaboration between health and social care – in care homes and home care agencies – we also heard about other problems for social care providers, including:

- Not having a strong voice in planning and decision-making.
- Absence of social care leaders in place/systems UEC programme boards.
- Limited national guidance and support from the system early in the pandemic, creating pressure on providers to source PPE (later improved with access to NHS portals).
- Hospital discharge processes into care homes: due to a lack of testing there was pressure to accept people into care homes. There was a suggestion that this had since improved, with patients only being discharged following a negative test result.

Role of the voluntary sector

The voluntary sector and community health services have played an important role in collaboration with UEC. Most systems we reviewed gave examples, including:

- identifying vulnerable groups and building community resilience
- reaching people in need before they entered crisis care pathways
- providing nursing treatment to prevent routine hospital admission
- supporting patients around their discharge from hospital.

We saw limited evidence about the involvement of voluntary and community services in UEC planning, although we know that system leaderships wanted to ensure that voluntary and community services had equal footing in discussions. They were described as “just as important as statutory services”. It was less clear how these services were represented in meetings and decision-making processes.

During the pandemic, some systems lost the capacity that these services would normally bring.

Digital governance

Across the systems we reviewed, digital governance was mostly overseen by a board to ensure safety through digital services.

We were told that quality, risk and data impact assessments were implemented to ensure digital information governance processes were followed. However, some concerns about digital governance were raised when we talked to providers about urgent and emergency care. Confidentiality issues were raised about storage of patient information and information given through remote care. Examples included people being asked sensitive questions in public places, or people being visible in the background of video consultations.

There were also concerns about General Data Protection Regulation (GDPR) compliance in adult social care. Examples included shared access to care records, as well as use of mobile phones by carers, and GPs supporting care homes to work digitally but restricting access to care records at appropriate levels.

There was awareness from providers about the need for increased safeguarding measures through digital consultations. While additional procedures and training were put in place, and it was suggested that it was positive to see the patient in their own home, there remained concerns that the safety assessment measures did not guarantee patient safety.

Learning and improvement

During our reviews, we wanted to know where and how learning and improvement was considered and shared.

Across the places and systems, there were different kinds of operational and strategic groups or teams where learning and improvement was recognised. There were local resilience forums, health and scrutiny boards, cell structures and clinical practitioner forums – all appeared to be mechanisms for learning and sharing. These groups brought providers and other system partners together for discussion, reflection and decision-making.

We heard about groups at provider, sector and system level, as well as regional groups. We also heard how STPs and ICSs played a valuable role in supporting, capturing and co-ordinating learning and improvement.

Research and evaluation activities and specific learning events were highlighted in some systems, to help to identify successes, limitations and key learning points. Other approaches that supported learning and improvement included the reviewing of data, incidents and deaths, and quality improvement processes.

We heard that enablers for learning and improvement included good leadership, supportive relationships between partners and providers, and a positive culture – the openness and willingness to change and develop.

Staffing skills and safety

Key learning

- Providers created new collaborative relationships, sometimes sharing staff or helping ensure services were adequately staffed. Staff have been flexible and risen to many challenges. But exhaustion and burnout were concerns everywhere, especially with the impact of winter.
- We saw little evidence of widespread shared strategies, at a whole-system level, for managing anticipated increased demand for UEC services this winter. Systems didn't always feel it was in their remit to plan for system-wide staffing.

Providers created new collaborative relationships during the pandemic [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#staff-safe], and built on existing ones, to share staff and ensure that services were adequately staffed.

Established relationships helped services in the height of the pandemic, but while they rallied to cope locally, we saw little evidence of widespread shared strategies at a whole-system level, for managing an anticipated increase in demand for UEC services. Some systems told us that winter planning did not always relate specifically to staffing for UEC providers.

Workforce strategies

Staffing strategies were addressed at a local provider level and some winter planning was always shared, even before COVID-19, which was indicative of a system culture that values collaboration. But it was not always clear whether plans were being shared across the whole system – or just between similar providers, such as other NHS trusts within the system.

In our 2018 report, Beyond Barriers [https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england], we said that national workforce strategies need to set the tone to ensure that health and care staffing has parity and is joined up. During the review, some interviewees from oversight bodies felt it was not within their remit to set up cross-system staffing strategies. We heard that overlapping geographical footprints and general complexity within the health and social care system are barriers to this happening. Geographically-isolated trusts were also less likely to be able to share staff.

In this review, providers explained how they had increased staffing levels and expanded skill-sets at a local level. Often, we heard these were within providers, but we also heard about shared initiatives between providers across a system.

One initiative we heard about was the 'passporting' of staff between NHS trusts. An NHS competencies passport enabled staff to move between providers within a system more easily with the aim of reducing gaps in staffing and improving patient care.

We heard about initiatives deployed across the summer months to ensure staffing levels were maintained within UEC services. These included joint recruitment strategies, use of staff from private providers and agencies, redeployment within providers, taking on apprentices, and training furloughed or non-essential staff from other organisations and workers from sectors such as hospitality.

Keeping staff safe

We found that a wide range of measures were introduced to keep staff safe. Providers changed their ways of working to support staff during the pandemic, with examples included remote working and changing the design of workspaces, such as fitting protective screens.

There were various strategies to support mental and physical wellbeing, and risk assessments for all staff to ensure that they both felt safe and were safe at work. Some providers extended risk assessments and related support to immediate families of their staff, to give extra reassurance.

We also heard about some enhanced risk assessments – in content and/or frequency – for staff from vulnerable groups including people from Black and minority ethnic backgrounds. However, this was not a universal approach and we found that not all providers appeared to be taking significant action to mitigate the increased risks from COVID-19 to Black and minority ethnic people.

Where practical, changes had been made to working arrangements so that staff who needed to work from home were able to work from home. There were also changes to job roles and greater flexibility to make best use of staff members' skills and experience.

There was extra help for staff: mental health support; increased informal 'catch up' calls or sessions; staff networks; care packages and additional breakout spaces. Some mental health trusts provided support for staff across other NHS organisations with access to counselling or other psychological therapies.

Providers were concerned for their staff members' mental health and resilience and pointed to the impact on resilience as their biggest risk, despite their workforce plans for winter.

Easy access to enough and appropriate PPE had been a problem for some providers at the beginning of the pandemic, particularly for staff at adult social care services, but was mostly no longer an issue. PPE was shared across systems, too – hospitals helped adult social care providers to get supplies nearer the beginning of the pandemic.

Using technology

Key learning

- Technology increased and changed the way people were encouraged to access UEC, although some systems were more advanced than others in their approaches to equality of access.
- Many people benefitted from the quick responses of primary care to offer virtual access. Rapid technology advancements were seen to significantly improve transfers of care.
- Where electronic patient records were shared across all sectors, we heard of a positive and timely impact for people accessing care.

During the pandemic, technology has transformed the way many people have accessed health and social care services [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#technology], but not everyone has enjoyed a good or improved experience. Some people have lost out because they cannot access the newer or replacement services enabled by digital advancement.

The pandemic has required a speedy shift towards more online care consultations. Digital consulting systems were largely viewed by patients and doctors to have improved access for people who needed UEC.

Some collaboration that improved outcomes was behind the scenes for patients. Digital consulting systems have improved access to care for many people. Electronic patient records enabled quicker access and shared information from multiple providers. We found this was underpinned by evidence of quality, risk and data impact assessments to ensure digital information governance processes were being followed.

In some places, services were aware of the groups most at risk of digital exclusion and proactively explored – and tried to counteract – any disproportionate impact digital systems due to the pandemic on people from Black and minority ethnic communities, people with a disability and those in socially deprived areas. There were also initiatives to support those who couldn't access digital services, such as deaf or visually impaired people, including helplines and volunteer networks.

Good use of technology helped collaboration over transfers of care for people and there was evidence of good sharing of records across sectors. Where people could access the right technology, they were able to communicate with GPs in real time

and sharing photos. Technology also helped collaboration with the voluntary sector.

In dentistry, video and phone consultations were introduced. People were able to send photos digitally, to help diagnosis and inform triage options or remote prescribing. But as we pointed out in our review of collaboration among services for older people, there was inconsistent use of NHS email, which was inhibiting for some communications. Also, access to summary care records is a continued barrier to ensuring people can move through a system effectively with one record.

Before the pandemic, we knew that the safe use of technology in health and care services was making a positive impact on many people's lives. In this review, we found across UEC services that technology was used to increase people's ability to access healthcare remotely. It also helped providers to share information and continue essential services. Examples of this included:

- Ambulance providers were able to share information with emergency departments regarding medication prior to the patient entering the emergency department.
- The electronic prescription service allows prescriptions to be sent to pharmacies electronically. The pandemic saw an increase in the use of this service, which promotes efficiency and convenience for staff and patients.
- Child protection meetings occurred remotely. This improved the timeliness of the decisions made as people could attend from anywhere, although there was some concern that remote meetings limited the voice of the child.

Information sharing

Information sharing was critical. When patients entered UEC services, it was important that care professionals knew about people's vulnerabilities so that care could be adapted. The electronic patient record (EPR) helped, as well as access to any 'flags' – notes on GPs' patient records highlighting important medical information about a patient. We heard how the EPR was used to record known patient vulnerabilities. It was available to emergency departments (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 if the patient attended ED. At a care home, people's vulnerabilities were included on residents' care plans – these were shared with ambulance crews, as well as visiting clinicians and hospital staff.

In our 2018 report, Beyond Barriers [https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england], we found that information sharing was a significant challenge for systems and we identified issues particularly with discharge arrangements from urgent and emergency care facilities. We also found that a misunderstanding of information governance rules sometimes led to information not being shared between health and social care services when it was legitimate to do so and in the best interest of people receiving care.

There is work to do for all local systems to achieve lasting solutions for information sharing, but during the pandemic these issues were overcome in some circumstances. Provision of UEC was supported by the way providers were able to share records across sectors: GPs accessing care records from care agencies, and ED staff accessing patient records before a patient had arrived by ambulance. There was some evidence of informal information sharing through encrypted communication such as WhatsApp.

There was also evidence of how electronic records and record sharing were used proactively to support people at home and avoid the need for urgent and emergency care. GPs and patients were in touch by mobile phone or devices, with information or photos shared directly. In adult social care, people using services and their families (if they had the rights) were able to see aspects of their care records, including visit times for home care agencies, and other information such as prescription and medication records – they were helped to be aware if issues were arising, proactively supporting that person to reduce the risk of them experiencing a crisis.

Partnership working

Partnership working was supported by digital systems, with staff using familiar software platforms to communicate and attend meetings. This has improved communication, visibility of teams and productivity. This supported care providers in connecting with local alliances such as NHS, CCGs, the Kings Fund and Healthwatch to improve collaboration and partnership working.

There were examples where safeguarding staff have been attending more meetings virtually, enabling them to be effective and inclusive when safeguarding issues occurred regarding urgent and emergency care. Video conferencing had also improved productivity and been used for staff engagement.

Partnership working between system providers and the voluntary sector has been implemented to support remote care for patients. Examples include:

- Funding for devices to be distributed to those who require it.
- Supporting people who need new technology skills.
- Devices delivered and picked up from people who are digitally excluded.

Enhanced communication

Across systems and urgent and emergency care, messaging services have been used between staff and people who use services to avoid people needing to physically attend urgent and emergency care. Systems include booking appointments, responding to queries, providing updates and advice, and disseminating training/guidance. Examples included:

- SMS service being used to detail time and location of prescription pick-up, which has decreased time spent in the pharmacy and prevents patients going to the wrong pharmacy.
- Using apps to post messages and information about services, offering communication channels for families and loved ones.

Oral health and digital initiatives

Access to dental care became a problem when lockdown occurred. Dental practices did what they could remotely and where active treatment was necessary, referred patients to urgent dental care centres.

Some places responded quickly to set up urgent hubs as they had well-established system relationships. Problems included managing people's expectations of what was classed as urgent. Digital solutions were put in place to support people with urgent and emergency dental needs, including:

- Video and telephone communication services, used for triaging patients in need of urgent and emergency dental treatment. Video and photographs were used to help diagnose patients remotely and enable prescribing.
- 'Attend anywhere' was introduced nationally to enable access for people and reduce travel needs.

Focus on: Safeguarding

Key learning

- The usual routes for recognising safeguarding concerns were affected by the pandemic.
- In the light of this, some providers put extra measures in place to ensure safeguarding concerns were recognised and addressed.

Our review looked at what measures were taken to protect vulnerable people, and this included what happened to address any increased safeguarding concerns.

Some systems identified increases in concerns. For example, Leeds Community Healthcare saw more safeguarding referrals, as did Southampton and South West CCG – specifically for children and young people and for domestic abuse.

However, GPs in Hampshire and the Isle of Wight noted a drop in safeguarding referrals when schools were closed during lockdown. This showed how a usual route for recognising safeguarding concerns was affected by the pandemic.

UEC providers highlighted extra measures in place to ensure safeguarding concerns were recognised and addressed, including additional training, specialist support and supervision, and increased collaboration and information sharing.

In east London, we heard how cases were also being re-reviewed to check if anything was missed. Locally and during the first peak of the pandemic, there were some increases in safeguarding issues locally, but the local authority in Newham described very good links between the safeguarding team and the hospital emergency department. A GP and chair of the CCG training hub in Newham described extra safeguarding training that happened. They told us that during remote consultations, GPs “were able to actually see inside patients' homes for the first time and identify any potential safeguarding issues from the patient’s home environment”. Cases were also re-reviewed by specialist teams due to increased pressures in emergency departments.

We heard about a strong awareness of safeguarding and how improvements were made, including extra training for an ambulance service so that its safeguarding knowledge was at a higher level.

Focus on: Children and young people

Key learning

- There were shared concerns about the increasingly complex mental health needs of children and young people during the pandemic.
- Systems redeployed some of their children’s workforce to meet the adult COVID demand during the first lockdown, leading to reduced capacity and support for the most vulnerable children and their families.
- There was evidence of children and young people’s safeguarding needs being part of local area strategic discussions, and efforts were made to ensure that carers and families knew urgent care was still available.

Urgent and emergency care providers have collaborated to protect and care for children and young people (CYP) [https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care#children-young-people], often by adapting their services.

Children and young people in the right place, at the right time, by the right person

Children were presenting with increased clinical, emotional and social care needs, and there were concerns about delayed presentation and increasingly complex mental health needs.

Processes were adapted in some systems to ensure CYP were seen safely and at the right place. Senior decision-makers triaged referrals to ensure CYP went to the right urgent care site and offered advice to GPs. Some GPs had access to paediatric wards for advice and could send CYP straight to the appropriate ward.

Safeguarding prompts were shared across primary care to remind practitioners to keep safeguarding on the agenda. Practitioners were reminded of the importance of face to face or video consultation when undertaking assessments.

There were some enhanced multi-agency approaches, with established teams notified of children and young people attending emergency departments. The voluntary sector was involved in meeting emotional and mental health needs via an online counselling service.

Children in care or leaving care have been supported through commissioned services, such as Barnardo’s. The early identification of a vulnerable group has meant that the right services have supported them.

The numbers of children attending for UEC in hospital dropped, so safeguarding prompts were shared across primary care to remind practitioners to keep safeguarding on the agenda and encourage face-to-face or video appointments, and to carry out the consultations with safeguarding in mind.

There was collaboration between departments and IT-enhanced oversight between ED and paediatrics. And a modified care pathway meant young people attending an ED were seen in a paediatric assessment unit, with paediatric specialists. This prevented unnecessary admission – previously, some young people would have gone to a ward to wait for their assessment. There were other examples of diverting CYP away from EDs, including a children and adolescent mental health services (CAMHS) crisis team that extended its hours and offered more home care.

The Think Family initiative [https://webarchive.nationalarchives.gov.uk/20130323053534/https:/www.education.gov.uk/publications/eOrderingDownload/Think-Family.pdf] was noticeably increased across multi-agency health and care partners to help recognise potential neglect among CYP, and we heard that some hospitals were admitting young people due to social care issues, not always medical conditions. New care pathways were created so CYP could access in-patient wards without having to go through the ED. And for young people in mental health distress, were heard about efforts to ensure quicker safe access to paediatric wards.

Shared plans and system wide governance and leadership

We consistently heard safeguarding specialists in the acute setting were not redeployed - often they offered additional support and oversight. There was evidence of CYP's safeguarding needs being part of local area strategic discussions.

There were efforts to ensure that carers and families knew urgent care was still available because there had been a decrease in attendances. Social media, newsletters, helplines and primary care networks were used to communicate with the public.

Refining systems

Most areas reported shared challenges for staff in meeting the increased mental health needs of CYP and managing their needs in ED and paediatric wards. Many had extended their mental health support through the availability of specialist practitioners and advice lines.

Areas worked with partner agencies to refine systems to identify and review vulnerable children known to them. Children were regularly reviewed by multi-agency partners; providers and CCG safeguarding colleagues met virtually to identify safeguarding risks. Some areas undertook audits to assess the impact of their work, for example of holding virtual strategy meetings and monitoring ED attendance trends.

For adults attending ED with childcare responsibility, some systems had initiated or strengthened approaches to identifying 'the hidden child'. This included confident collaborative working within ED across West Yorkshire and Harrogate, where 28% of adult mental health presentations led to referrals of children for assessment.

There was agreement that collaborative working had been strong and had helped pathways to change quickly. For example, we saw how a local authority and an ED worked together with a flagging system to increase identification of vulnerable children.

Sometimes children and young people with complex mental health issues were admitted to hospital inappropriately, but new pathways had helped to rectify this. We heard about how a daily 'mental health huddle' was introduced so that discussions about action plans for young people could happen – then CAMHS visits to the wards would help with the appropriate discharge.

We heard about system-wide monitoring of trends and there was positive feedback about collaboration across the local system. We heard there was also recognition of positive impact from the voluntary sector and its work across the integrated care system.

Collaborations between health and social care helped identify priority children on the hospital IT system in the ED with a 'flag'.

We also heard about collaboration with primary care to help avoid hospital admissions avoidance [https://wearespotlight.com/news/health-spot-has-landed]. There was an initiative to make services more accessible to young people, and dedicated GP-run clinics with a collaborative approach with youth workers, sexual health and mental health services. However, we also heard some concern about delayed presentations to ED, so social media and a primary care network were used to reassure families that services across north east London were open.

There was evidence that providers adapted the scope of their work. Feedback from partners, families and carers was sought - and services tried to get children's views to inform their work, sometimes working Healthwatch.

Ensuring the safety of staff and enough health and care skills across providers

We heard how systems redeployed some of their children's workforce to meet the adult COVID demand during the first lockdown. This workforce would ordinarily be working to identify and support families and vulnerable children, and we heard that there was concern about the reduced capacity for this as a result of redeployments.

Areas adapted their approach to training to meet their safeguarding responsibilities. Online training covered topics that were emerging during lockdown, including serious risk-taking behaviours and increased mental health concerns.

We heard a 'Think Family' model was strengthened through staff training and ambulance crews were taught to 'Think family' to strengthen their assessment of potential safeguarding issues for children. Training was also delivered in children's homes to ensure everyone was aware that the EDs remained open.

Digital solutions and technology

Local areas used virtual, electronic systems to deliver meetings. Some areas reported an increase and more timely attendance at meetings and response to safeguarding concerns. In some cases, more colleagues can attend child protection meetings through video conferencing. However, some practitioners told us that virtual consultations and 'attend anywhere' appointments limited the ability to "capture the voice of the child".

Where care pathways were adapted, providers met online to discuss adaptations. There was also online information to support children and young people in looking after themselves and those around them. Going into the second wave, some providers were keen to continue their engagement via online solutions.

At least one ED worked with a safeguarding team with a focus on mental health issues – a record was kept and then follow-up by safeguarding was initiated for any child or young person attending where there was concern about self-harm, suicide, or potential mental health problems. We were also told about the launch of the Handi app, which gives specialist paediatric advice to parents, carers and professionals.

We heard about learning such as data analysis that showed the cause of someone's attendance at ED. In East London, there was also something called the 'YES' group, where COVID information was shared for other young people [https://children.bartshealth.nhs.uk/our-news/play-team-2020-update-interview-about-the-new-yes-covid19-leaflet-8489] and circulated via social media and on the organisation's website.

Online solutions had helped with timely responses to children and young people's need – and there were efforts to share important information, using local radio and social media, to ensure families knew that it was safe to attend the ED.

Focus on: Medicines optimisation

Key learning

- There was significant planning across medicines optimisation teams to help avoid admissions to hospital.
- Medicines teams were involved in pathway redesign to support people moving through services, but their level of integration was mixed.

Through the UEC reviews we were told about significant planning across medicines optimisation teams, focused on avoiding admissions to hospital. This was across many of the areas and to help ensure that capacity was maintained.

People at the centre of their care

There was a range of initiatives that included changes to the range of medicines available from ambulance crews to treat people with COVID, as well as for other medical conditions that might otherwise result in admission to UEC.

We found systems developing processes to support and ensure access to intravenous (IV) antibiotics administered in people's homes and access to medicines for end of life care (EOLC). One provider delivered an admission avoidance initiative in their locality – this included 'rapid IV pathways' where both first dose IV antibiotics and IV fluids were administered in people's own homes to help reduce admission risks.

We were told about systems for the delivery of both regular and urgently dispensed medicines to people's homes, and about triaging to community pharmacy via NHS 111 and the Community Pharmacist Consultation Service to support the flow of medication to the right people at the right time. An ambulance service deployed pharmacists in NHS 111 or 999 call centres, where they were able to refer people to the pre-existing community pharmacist consultation service (CPCS). In one example, over 6,000 repeat prescription requests were received in a month, and appropriate referral to CPCS helped to avoid undue pressure on ED footfall and wider primary care providers.

Supporting end of life care

Initiatives were seen to avoid admissions and support EOLC. Medicines were available from community pharmacies and within the urgent treatment centres, in take away packs, for symptomatic relief and palliative treatment. A patient group direction for end-of-life care medicines was also developed for use by hospice community nursing teams and ambulance service paramedics [https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-19-patient-group-directions-pgdspatient-specific-directions]. This meant patients had rapid access to immediate doses, with arrangements for follow up treatment on prescription the following day. This followed EOLC guidelines and was supported by the appropriate governance. We heard how one acute hospital provided symptom control packs (EOLC medicines) to allow these to be easily accessed by healthcare professionals for their patients when needed. This reduced over-ordering of stock and ensured a sustainable supply throughout the pandemic.

Medicines in care pathway redesign

Medicines teams have been involved in pathway redesign to support people moving through services. However, across different areas, the level of integration of medicines differed. Where there was engagement, we heard of areas where physical changes to wards and ED areas were made to support safer movement of patients through different clinical areas. Where changes had been made, pharmacy teams responded by ensuring that enough of the right medicines were accessible in the right area. This helped to support timely access to treatment for patients. We also heard of pre-packed medicines were provided in some areas, to help facilitate faster discharge out of hospitals and where providers looked to increase the capacity of UEC services, medicines were also part of these considerations.

Some providers in systems redesigned medicines supply and administration pathways, specifically with infection prevention and control in mind to ensure that vulnerable people, including those who needed to be shielded, were kept safe. Other providers ensured that spaces which were used for blood tests, including those for monitoring medicines could provide a high level of assurance around infection control. For example, one system created a 'super green hub' specifically for shielding patients. This helped to provide extremely clinically vulnerable patients with a safe space for clinical monitoring, including blood tests for monitoring medicines

Systems

Across the systems we reviewed, we were told local medicines optimisation leadership cells supported UEC providers and other bodies to work more collaboratively than previously. In planning to provide assurances around availability of medicines, we saw examples of providers that put in place a memorandum of understanding to support this.

Across systems we were told there was a proactive response to flu vaccination which was supported by medicines teams. Flu vaccination of staff is key in supporting staff working in UEC services and, more widely, during the winter period. This feeds into service capacity by preventing avoidable sickness. Providers, including the community pharmacy sector, have been involved in the planning and delivery of this.

We saw examples where system leaders and service providers were, and are still, working creatively to deliver agreed services and manage increase in demand. To avoid admission, virtual ward rounds were piloted and trialled in one area. This included monitoring of patients remaining at home with oxygen saturation monitors. Patients also received daily support calls from clinicians who could escalate any concerns quickly or refer to community pharmacy, where appropriate.

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