2 Hour Urgent Community Response: Programme Logic Models

NHSEI

March 2022

Introduction

The 2 Hour Urgent Community Response Programme

The NHS Long Term Plan (2019) set out a new standard for all Integrated Care Systems (ICSs) in England: that crisis response care will be provided to people within their homes (or usual place of residence) within two hours, from any referral source.

The programme requires a shift in resources to home and community-based services, reflecting the NHS commitment to transforming community health services and providing the right care, at the right time, to people closer to home.

2021 guidance[1] established a minimum level for the standard (Urgent Community Response 2 Hour Target (2HCR)) to be met by March 2022, with ICSs provided with additional funding.

From 2022 onwards there will be further expectations for the provision, with monitoring against the achievement, effectiveness and quality of delivery of the standard across the country.

Seven accelerator sites were established in 2020, one in each NHS England & NHS Improvement (NSHEI) region, to provide early learning for national roll-out during 2021. Some systems are basing their provision on existing services; in others it is entirely new. The national guidance enables different areas to develop their services in different ways according to local contexts.

The Strategy Unit (Midlands and Lancashire CSU) was commissioned, with our partners Ipsos, by NHSEI to provide a national evaluation of the programme to implement the new standard. The Strategy Unit undertook a scoping study to develop the national evaluation framework.

The 2 Hour Urgent Community Response Target

The NHSEI guidance sets out how 2HCR should be delivered and outlines how NSHEI regional teams will support ICSs in implementing the standard as well as monitoring their performance.

- The minimum requirement for April 2022 was a seven-day service from 8am to 8pm, across the full geography of the ICS

[1] NHSEI (2021) *Community health services two-hour crisis response standard guidance: Guidance for providers of care, integrated care systems and clinical commissioning groups (10th May 2021 Draft 9)*

- Assessment and care should start in under two hours, with interventions typically lasting under 48 hours
- Performance monitoring data will be recorded in the Community Services Data Set (CSDS), which should be regularly reviewed and include a focus on reducing health inequalities
- Provision must be aligned with urgent and planned care and coordinated through a single referral point (ensuring 'no wrong door') and providing access to multi-disciplinary clinical and non-clinical support
- Inter and multi-disciplinary working is required to match the professional deployed with the needs of the person in crisis. How this is configured will be determined by ICSs based on their current provision, but a flexible workforce is expected to include: registered nurses; advanced clinical practitioners; physiotherapists; occupational therapists; social workers and paramedics – as well as working in partnership with a wide range of health and care agencies
- Assessment and care should be holistic and personalised, taking a shared approach across services – and delivered primarily in-person

There is also detailed clinical guidance for the service.

- Adults over the age of 18 should receive 2HCR if they are at risk of (re)admission to hospital without intervention to prevent deterioration and to keep them safe at home:
  - They are experiencing a crisis which can be defined as a sudden deterioration in health and wellbeing
  - A crisis has been caused by a stressor event that has exacerbated an existing condition, or a new condition, or significant deterioration in clinical state or baseline functioning
  - The health or social care need requires urgent (not emergency) treatment or support within two hours and can be safely delivered in a home setting
- A non-exhaustive list of common conditions or needs that would prompt a 2HCR service include: falls; frailty related conditions; reduced function; urgent equipment provision; delirium; unpaid carer breakdown
- Trusted assessor principles are encouraged to promoted shared, and reduce multiple, assessments

- In support of the multi-disciplinary, system-wide approach it is recognised that workforce development will be required to ensure the right skills are in place for the service to be configured to meet local populations' needs.

Programme Logic Models

For the scoping stage of the national evaluation, the Strategy Unit held a series of participatory workshops to develop logic models capturing key features of the programme.

A logic model is a tool to capture the theory of change behind an intervention or programme. Best practice in evaluation[2] uses a logic model to summarise key features of the intervention. In the Strategy Unit's approach,[3] we identify:

- The context – both for understanding but also as this can change and affect the intervention
- The rationale – why the intervention is being introduced, essential for establishing the theory of change
- The inputs – the resources – that will be required
- The links between activities, the outputs that they are intended to deliver (what will change or be achieved) and the outcomes that are intended to result (the benefits)
- The long-term impacts – outside of the scope of the evaluation but intended to be wider benefits from the outcomes achieved
- Assumptions – which are dependencies – and enablers, external to the programme but important for its success.

The logic model provides a summary of these key features to inform an evaluation framework:

- Evaluation questions and key lines of enquiry, exploring the delivery of activities and what works, barriers and facilitators
- Stakeholders to involve in the evaluation
- Quantitative and qualitative measures of process and impact outputs and outcomes.

We brought together stakeholders in the 2HCR programme from the national and regional NHSEI teams with leads from accelerator sites in a participatory (online) workshop[4] to develop an initial logic model for the programme. The content was detailed and we identified three strands to delivery:

[2] HMT (2021) *The Magenta Book: Central Government guidance on evaluation*
[3] Strategy Unit (2018) *Your Guide to Using Logic Models*
[4] 29th April 2021, with 18 participants

- System level delivery – the activities at a system level to create the infrastructure and system-wide approaches necessary for success
- Workforce development – the activities necessary to ensure the right roles, skills and teams are in place
- Service delivery – the detail of the 2HCR intervention.

We developed the workshop material into three logic models, one for each of the three strands. A second workshop brought together a subset of the first participants to check and refine the content.[5]

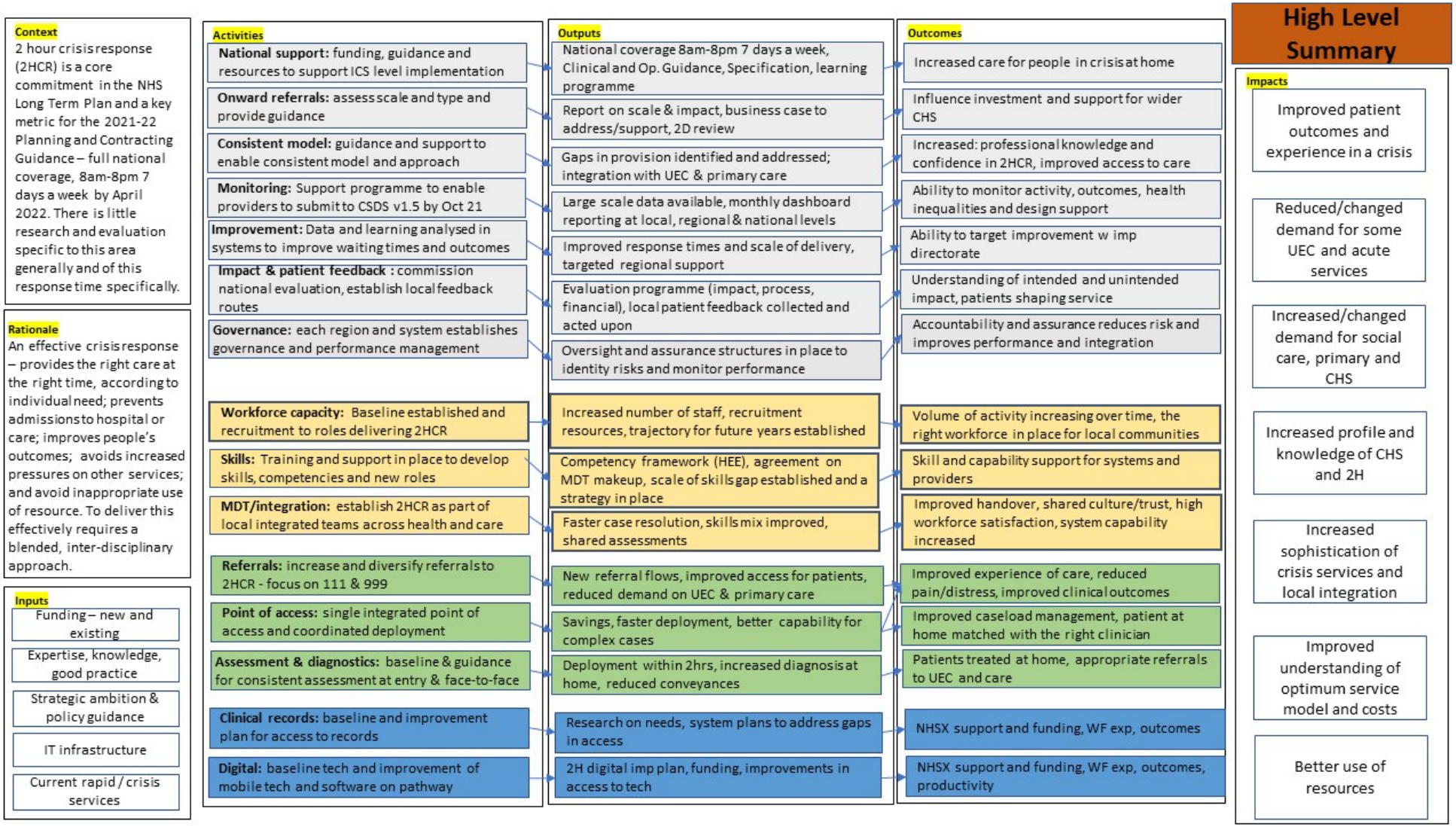
A final set was then created using additional insights from the NHSEI policy lead and the draft policy guidance.[6]

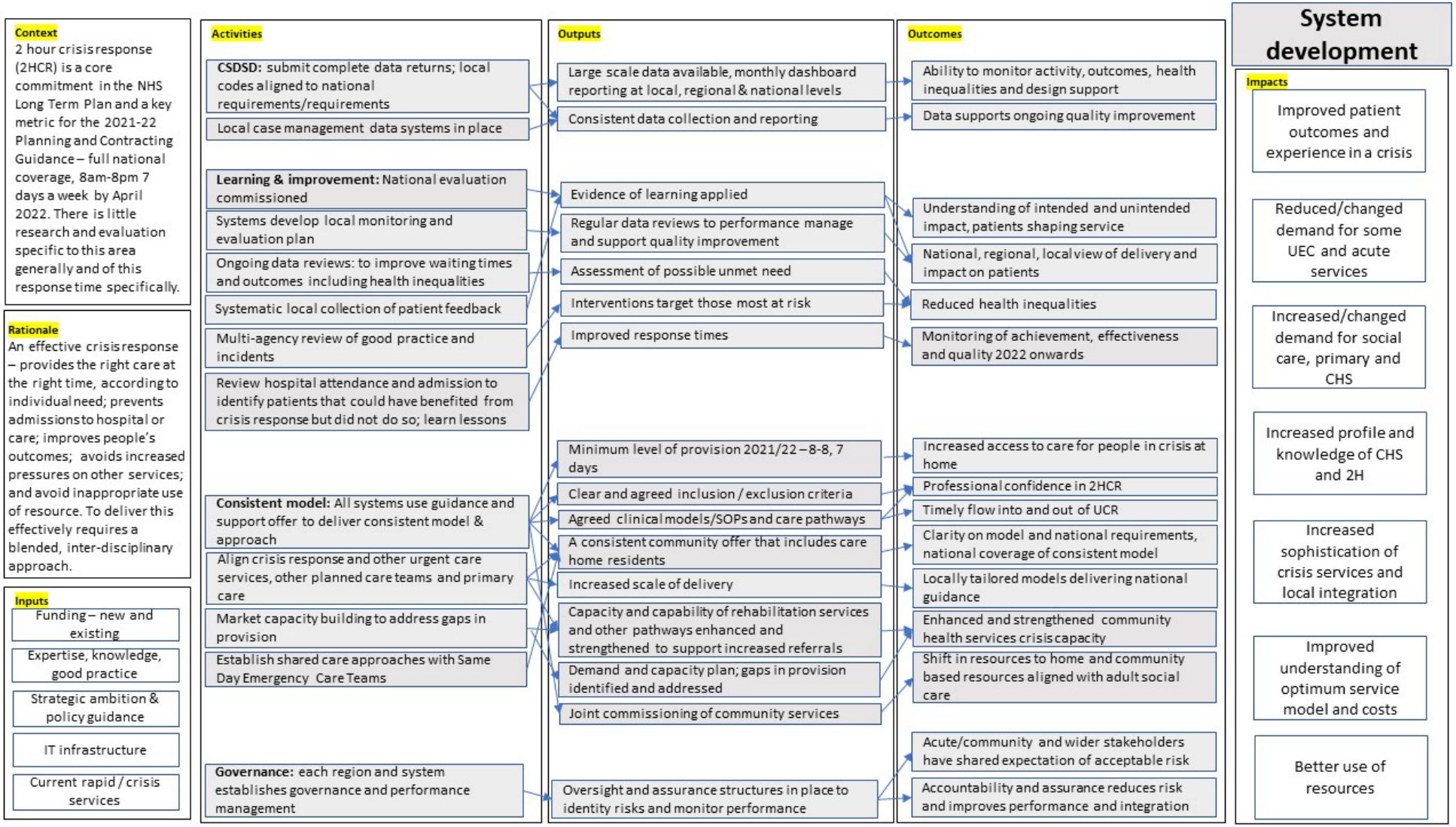
The four logic models – one high level summary[7] with one for each of the three strands, are presented in this report.

[5] 27th May 2021, with 8 participants

[6] NHSEI (2021) *Community health services two-hour crisis response standard guidance: Guidance for providers of care, integrated care systems and clinical commissioning groups (10th May 2021 Draft 9)*

[7] The High Level Summary model includes content (in royal blue) specific to potential work with NHSX and is not further developed in the supporting models


Context
2 hour crisis response (2HCR) is a core commitment in the NHS Long Term Plan and a key metric for the 2021-22 Planning and Contracting Guidance – full national coverage, 8am-8pm 7 days a week by April 2022. There is little research and evaluation specific to this area generally and of this response time specifically.
Rationale
An effective crisis response – provides the right care at the right time, according to individual need; prevents admissions to hospital or care; improves people's outcomes; avoids increased pressures on other services; and avoid inappropriate use of resource. To deliver this effectively requires a blended, inter-disciplinary approach.
Inputs
Funding – new and existing
Expertise, knowledge, good practice
Strategic ambition & policy guidance
IT infrastructure
Current rapid / crisis services
Activities
National support: funding, guidance and resources to support ICS level implementation
Onward referrals: assess scale and type and provide guidance
Consistent model: guidance and support to enable consistent model and approach
Monitoring: Support programme to enable providers to submit to CSDS v1.5 by Oct 21
Improvement: Data and learning analysed in systems to improve waiting times and outcomes
Impact & patient feedback : commission national evaluation, establish local feedback routes
Governance: each region and system establishes governance and performance management
Workforce capacity: Baseline established and recruitment to roles delivering 2HCR
Skills: Training and support in place to develop skills, competencies and new roles
MDT/integration: establish 2HCR as part of local integrated teams across health and care
Referrals: increase and diversify referrals to 2HCR - focus on 111 & 999
Point of access: single integrated point of access and coordinated deployment
Assessment & diagnostics: baseline & guidance for consistent assessment at entry & face-to-face
Clinical records: baseline and improvement plan for access to records
Digital: baseline tech and improvement of mobile tech and software on pathway
Outputs
National coverage 8am-8pm 7 days a week, Clinical and Op. Guidance, Specification, learning programme
Report on scale & impact, business case to address/support, 2D review
Gaps in provision identified and addressed; integration with UEC & primary care
Large scale data available, monthly dashboard reporting at local, regional & national levels
Improved response times and scale of delivery, targeted regional support
Evaluation programme (impact, process, financial), local patient feedback collected and acted upon
Oversight and assurance structures in place to identity risks and monitor performance
Increased number of staff, recruitment resources, trajectory for future years established
Competency framework (HEE), agreement on MDT makeup, scale of skills gap established and a strategy in place
Faster case resolution, skills mix improved, shared assessments
New referral flows, improved access for patients, reduced demand on UEC & primary care
Savings, faster deployment, better capability for complex cases
Deployment within 2hrs, increased diagnosis at home, reduced conveyances
Research on needs, system plans to address gaps in access
2H digital imp plan, funding, improvements in access to tech
Outcomes
Increased care for people in crisis at home
Influence investment and support for wider CHS
Increased: professional knowledge and confidence in 2HCR, improved access to care
Ability to monitor activity, outcomes, health inequalities and design support
Ability to target improvement w imp directorate
Understanding of intended and unintended impact, patients shaping service
Accountability and assurance reduces risk and improves performance and integration
Volume of activity increasing over time, the right workforce in place for local communities
Skill and capability support for systems and providers
Improved handover, shared culture/trust, high workforce satisfaction, system capability increased
Improved experience of care, reduced pain/distress, improved clinical outcomes
Improved caseload management, patient at home matched with the right clinician
Patients treated at home, appropriate referrals to UEC and care
NHSX support and funding, WF exp, outcomes
NHSX support and funding, WF exp, outcomes, productivity
High Level Summary
Impacts
Improved patient outcomes and experience in a crisis
Reduced/changed demand for some UEC and acute services
Increased/changed demand for social care, primary and CHS
Increased profile and knowledge of CHS and 2H
Increased sophistication of crisis services and local integration
Improved understanding of optimum service model and costs
Better use of resources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Inputs
Funding – new and existing
Expertise, knowledge, good practice
Strategic ambition & policy guidance
IT infrastructure
Current rapid / crisis services
Activities
CSDSD: submit complete data returns; local codes aligned to national requirements/requirements
Local case management data systems in place
Learning & improvement: National evaluation commissioned
Systems develop local monitoring and evaluation plan
Ongoing data reviews: to improve waiting times and outcomes including health inequalities
Systematic local collection of patient feedback
Multi-agency review of good practice and incidents
Review hospital attendance and admission to identify patients that could have benefited from crisis response but did not do so; learn lessons
Consistent model: All systems use guidance and support offer to deliver consistent model & approach
Align crisis response and other urgent care services, other planned care teams and primary care
Market capacity building to address gaps in provision
Establish shared care approaches with Same Day Emergency Care Teams
Governance: each region and system establishes governance and performance management
Outputs
Large scale data available, monthly dashboard reporting at local, regional & national levels
Consistent data collection and reporting
Evidence of learning applied
Regular data reviews to performance manage and support quality improvement
Assessment of possible unmet need
Interventions target those most at risk
Improved response times
Minimum level of provision 2021/22 – 8-8, 7 days
Clear and agreed inclusion / exclusion criteria
Agreed clinical models/SOPs and care pathways
A consistent community offer that includes care home residents
Increased scale of delivery
Capacity and capability of rehabilitation services and other pathways enhanced and strengthened to support increased referrals
Demand and capacity plan; gaps in provision identified and addressed
Joint commissioning of community services
Oversight and assurance structures in place to identity risks and monitor performance
Outcomes
Ability to monitor activity, outcomes, health inequalities and design support
Data supports ongoing quality improvement
Understanding of intended and unintended impact, patients shaping service
National, regional, local view of delivery and impact on patients
Reduced health inequalities
Monitoring of achievement, effectiveness and quality 2022 onwards
Increased access to care for people in crisis at home
Professional confidence in 2HCR
Timely flow into and out of UCR
Clarity on model and national requirements, national coverage of consistent model
Locally tailored models delivering national guidance
Enhanced and strengthened community health services crisis capacity
Shift in resources to home and community based resources aligned with adult social care
Acute/community and wider stakeholders have shared expectation of acceptable risk
Accountability and assurance reduces risk and improves performance and integration
System development
Impacts
Improved patient outcomes and experience in a crisis
Reduced/changed demand for some UEC and acute services
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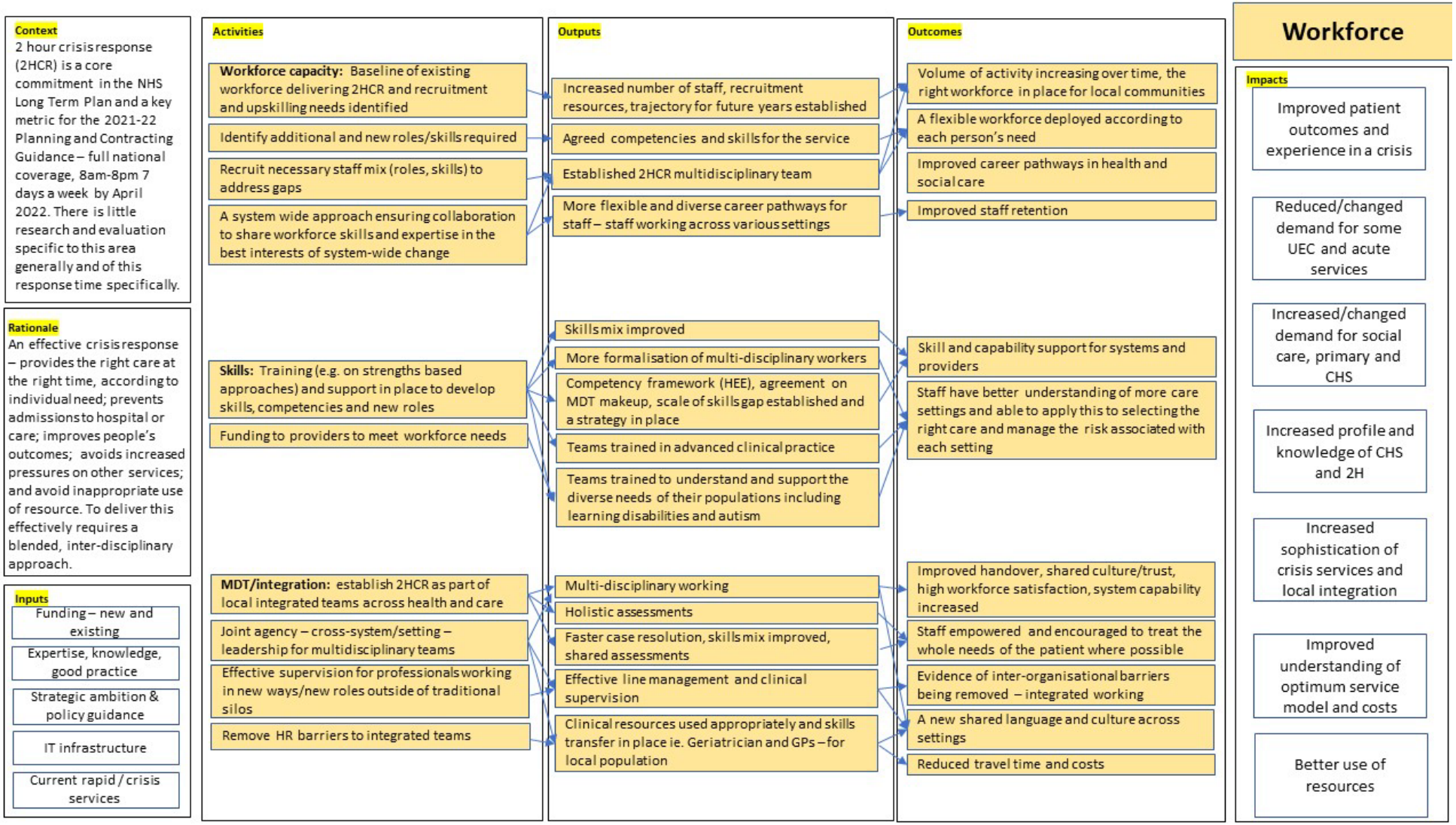
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Inputs
Funding – new and existing
Expertise, knowledge, good practice
Strategic ambition & policy guidance
IT infrastructure
Current rapid / crisis services
Activities
Workforce capacity: Baseline of existing workforce delivering 2HCR and recruitment and upskilling needs identified
Identify additional and new roles/skills required
Recruit necessary staff mix (roles, skills) to address gaps
A system wide approach ensuring collaboration to share workforce skills and expertise in the best interests of system-wide change
Skills: Training (e.g. on strengths based approaches) and support in place to develop skills, competencies and new roles
Funding to providers to meet workforce needs
MDT/integration: establish 2HCR as part of local integrated teams across health and care
Joint agency – cross-system/setting – leadership for multidisciplinary teams
Effective supervision for professionals working in new ways/new roles outside of traditional silos
Remove HR barriers to integrated teams
Outputs
Increased number of staff, recruitment resources, trajectory for future years established
Agreed competencies and skills for the service
Established 2HCR multidisciplinary team
More flexible and diverse career pathways for staff – staff working across various settings
Skills mix improved
More formalisation of multi-disciplinary workers
Competency framework (HEE), agreement on MDT makeup, scale of skills gap established and a strategy in place
Teams trained in advanced clinical practice
Teams trained to understand and support the diverse needs of their populations including learning disabilities and autism
Multi-disciplinary working
Holistic assessments
Faster case resolution, skills mix improved, shared assessments
Effective line management and clinical supervision
Clinical resources used appropriately and skills transfer in place ie. Geriatrician and GPs – for local population
Outcomes
Volume of activity increasing over time, the right workforce in place for local communities
A flexible workforce deployed according to each person's need
Improved career pathways in health and social care
Improved staff retention
Skill and capability support for systems and providers
Staff have better understanding of more care settings and able to apply this to selecting the right care and manage the risk associated with each setting
Improved handover, shared culture/trust, high workforce satisfaction, system capability increased
Staff empowered and encouraged to treat the whole needs of the patient where possible
Evidence of inter-organisational barriers being removed – integrated working
A new shared language and culture across settings
Reduced travel time and costs
Workforce
Impacts
Improved patient outcomes and experience in a crisis
Reduced/changed demand for some UEC and acute services
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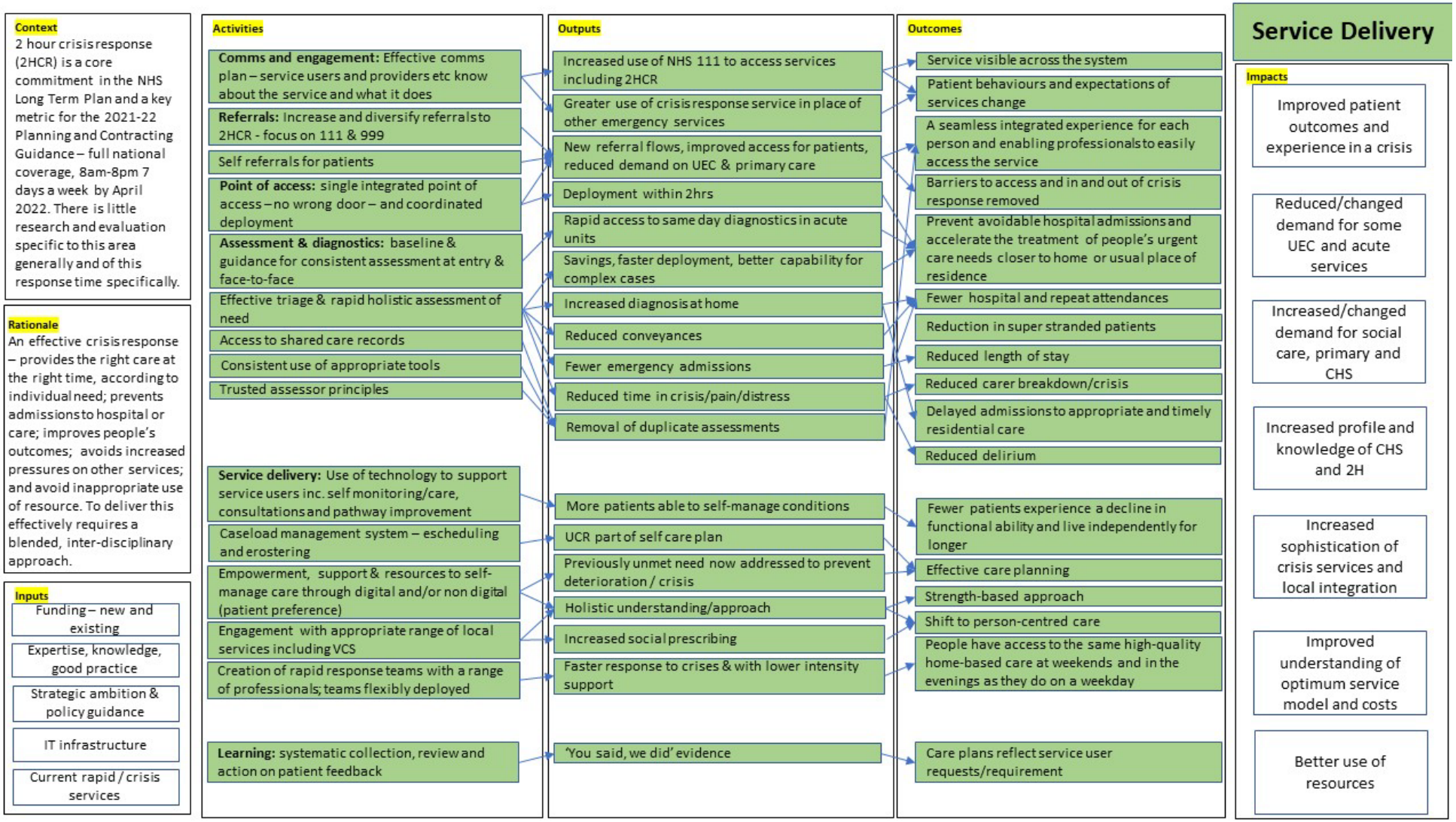
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Inputs
Funding – new and existing
Expertise, knowledge, good practice
Strategic ambition & policy guidance
IT infrastructure
Current rapid / crisis services
Activities
Comms and engagement: Effective comms plan – service users and providers etc know about the service and what it does
Referrals: Increase and diversify referrals to 2HCR - focus on 111 & 999
Self referrals for patients
Point of access: single integrated point of access – no wrong door – and coordinated deployment
Assessment & diagnostics: baseline & guidance for consistent assessment at entry & face-to-face
Effective triage & rapid holistic assessment of need
Access to shared care records
Consistent use of appropriate tools
Trusted assessor principles
Service delivery: Use of technology to support service users inc. self monitoring/care, consultations and pathway improvement
Caseload management system – escheduling and erostering
Empowerment, support & resources to self-manage care through digital and/or non digital (patient preference)
Engagement with appropriate range of local services including VCS
Creation of rapid response teams with a range of professionals; teams flexibly deployed
Learning: systematic collection, review and action on patient feedback
Outputs
Increased use of NHS 111 to access services including 2HCR
Greater use of crisis response service in place of other emergency services
New referral flows, improved access for patients, reduced demand on UEC & primary care
Deployment within 2hrs
Rapid access to same day diagnostics in acute units
Savings, faster deployment, better capability for complex cases
Increased diagnosis at home
Reduced conveyances
Fewer emergency admissions
Reduced time in crisis/pain/distress
Removal of duplicate assessments
More patients able to self-manage conditions
UCR part of self care plan
Previously unmet need now addressed to prevent deterioration / crisis
Holistic understanding/approach
Increased social prescribing
Faster response to crises & with lower intensity support
'You said, we did' evidence
Outcomes
Service visible across the system
Patient behaviours and expectations of services change
A seamless integrated experience for each person and enabling professionals to easily access the service
Barriers to access and in and out of crisis response removed
Prevent avoidable hospital admissions and accelerate the treatment of people's urgent care needs closer to home or usual place of residence
Fewer hospital and repeat attendances
Reduction in super stranded patients
Reduced length of stay
Reduced carer breakdown/crisis
Delayed admissions to appropriate and timely residential care
Reduced delirium
Fewer patients experience a decline in functional ability and live independently for longer
Effective care planning
Strength-based approach
Shift to person-centred care
People have access to the same high-quality home-based care at weekends and in the evenings as they do on a weekday
Care plans reflect service user requests/requirement
Service Delivery
Impacts
Improved patient outcomes and experience in a crisis
Reduced/changed demand for some UEC and acute services
Increased/changed demand for social care, primary and CHS
Increased profile and knowledge of CHS and 2H
Increased sophistication of crisis services and local integration
Improved understanding of optimum service model and costs
Better use of resources

Evaluation next steps

The outcome of the national evaluation scoping stage was an Evaluation Framework. The programme logic models here were used, alongside engagement with key programme stakeholders, to develop key lines of enquiry and associated design of a mixed method evaluation with process and impact strands:

- **Operational learning:** process evaluation to understand the essential elements of a successful service at scale and maturity
- **Patient and carer/family impact:** evaluation of health and wellbeing outcomes and experience
- **Healthcare system impact:** flow, health economics (including return on investment (ROI)) and presentations and admissions to acute care.

As well as the Evaluation Framework, this report is published alongside an evidence scan drawing out learning for the programme from an international literature review and an NHSEI report on learning from the accelerator sites (available to those with access to FutureNHS).[8]

The national evaluation data collection begins in Spring 2022, continuing until 2024 with regular reporting to support implementation and evidence what works.

[8] If you're not a member of FutureNHS and would like to join, please email communityhealthservices-manager@future.nhs.uk to request access.

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