The Strategy Unit.

2 Hour Urgent Community Response Evaluation

Qualitative Research: Round 1 Report

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Executive Summary

This report

This report presents the findings from the first round of qualitative research undertaken as part of the national evaluation of the delivery of the NHS England (NHSE) two-hour urgent community response (2-hour UCR) standard.

Evaluation activities

100 strategic, managerial and frontline staff from seven different 2-hour UCR services (one from each NHSE region) were interviewed between April and August 2022. Interviews explored operational learning and the key benefits and challenges for patients, carers, staff and the wider healthcare system. The next phase of the evaluation will include findings from more extensive patient and carer engagement.

Key findings

- Case study sites have interpreted the national 2-hour UCR guidance through a local lens, most often building on previous rapid response provision, resulting in significant variation in service design and delivery, and challenges for evaluating best practice
- Key areas in which sites have built on but gone further than the national guidance include:
    - Workforce and development (for example, unique or expanded job roles and duties or the introduction of specific UCR leadership roles and portfolios)
    - Introduction of new technical resources such as bespoke fully stocked service vehicles
    - Investment in technological solutions for tracking available staff and matching to patient need and enabling remote working and information sharing
- For four of the seven case study sites, physical co-location of teams has been a key success factor by enabling better communication and decision making between them
- Case study sites have had some success in overcoming widely-reported challenges of accessing social care, through the development of integrated health and social care teams or by working with the voluntary sector and other public sector teams to address wider wellbeing needs
- Common challenges with recruitment and retention (linked to geographic context, the increased cost of living and competition with other sectors) have hampered case study sites' ability to develop the service

- Case study sites have identified unanticipated rises in demand for 2-hour UCR services and increased levels of complexity in referrals so that refreshed or adjusted demand forecasting may be required
    - There is wide support for the 2-hour UCR standard's timeframe and service model due to its perceived benefits in preventing deterioration among patients, reducing pressures on other health services, providing care in the community and enhancing cross-system working
    - Some questions and concerns were raised by participants about whether the timeframe is appropriate for all referrals; whether more work is required locally to define the criteria for a two-hour response; and whether the overlap in the recruitment pool with other services may be creating new pressures elsewhere in the system
    - The most common areas for the case study sites to address in developing their 2-hour UCR services to meet the full requirements of the standard include:
        - Underdeveloped links with 111/999 services and working effectively with virtual wards, both of which have taken on more prominence as a priority for meeting winter pressures
        - Developing a consistent system-wide model at scale
        - Improving data quality at a local and national level in order to document progress on key performance measures for all case study sites.

Key recommendations

ICS leaders with responsibility for 2-hour UCR should:

- **Address gaps in their service models by regularly reviewing their delivery models against the requirements of the national guidance.** This should involve
    - Systematically and regularly mapping engagement activity and its results to date with relevant local partners, to identify targeted areas for further engagement
    - Requiring all partners to provide regular progress updates on their provision against national guidance requirements and agree their role in a system-wide approach
- **Explore solutions to shared workforce challenges including competing demands for staff across health and care services,** through exploring new blended roles across different services and extending the 2-hour UCR model through a wider network of provision. The

newly published Virtual Ward and Urgent Community Response Capabilities Framework[1] may provide one solution to a shared approach across these two key priorities for ICS planning

- **Identify additional capital or other system funding opportunities** to support the workforce with resources for an efficient UCR service such as equipped vehicles or technology for point of care testing
- **Invest resources in data collection and analysis** to drive improvement in CSDS submissions, link data to understand the patient pathways, develop shared definitions of requirements for a two-hour response, identify bottlenecks, inequities in patient provision and associated workforce requirements
- **Identify where there is ICS or external voluntary sector or public sector expertise for engaging patients (and their family/carers) accessing 2-hour UCR services.** 2-hour UCR teams can lack capacity – and expertise – to routinely collect feedback from patients and their family/carers following a two-hour response. 2-hour UCR leads should be supported by their ICS to identify and access and resource this expertise to embed this work in their provision

NHS regional leads should:

- **Continue to facilitate learning across their ICSs about particular shared challenges** including 'push' and 'pull' models for working with ambulance service; standardising and linking data collection; joint working with virtual wards; gathering patient feedback for learning; recruiting and training staff; and delivery across large rural or dense urban geographies

NHS national team should:

- Work with regional leads to **identify and review place-based variations in delivery models** which require targeted support to meet the guidance requirements
- **Continue to provide guidance and learning** on areas essential to understanding the impact of variations in service provision such as ensuring quality in CSDS submission and linking local datasets for performance monitoring and management.

[1] Skills for Health October 2022 https://www.skillsforhealth.org.uk/info-hub/virtual-wards-and-urgent-community-response-framework/

Purpose of this report

This report presents the findings from the first round of qualitative research for the national evaluation of the delivery of the two-hour urgent community response (2-hour UCR)[2] standard. The national evaluation was commissioned by NHS England (NHSE) following a scoping study completed by The Strategy Unit (part of NHS Midlands and Lancashire Commissioning Support Unit) in 2021. The scoping study identified key evaluation questions and a recommended mixed-method design. It will be delivered in stages, with final reporting in spring 2024.

This stage has involved qualitative research (fieldwork completed between April and August 2022) with seven 2-hour UCR services (both ICS and place-based), as case studies selected to reflect a range of approaches to delivery. There will be additional work to support the qualitative research, exploring implementation as it matures. National monitoring data from the Community Services Data Set (CSDS) is included in this report, but an impact and economic evaluation will be completed in the final stage of the evaluation (2024) to provide further detailed data analysis of outcomes.

[2] Acronyms will be used throughout this report after first definitions. A glossary is provided in Annex 1 to support understanding after terms are first introduced.

1. Introduction

This section provides an outline of the policy context for, and the development of, the 2-hour UCR standard, as well as a general overview of the evaluation.

1.1 Policy context

The NHS Long Term Plan (2019)[3] set out a new requirement for all Integrated Care Systems (ICSs) in England to provide crisis response care to people within their homes (or usual place of residence) within two hours. To support this, NHSE developed initial principles for a new two-hour urgent community response (2-hour UCR) standard to be provided nationwide.

In January 2020, seven accelerator sites were selected to rapidly implement the 2-hour UCR standard to provide learning for national roll-out. These sites were involved in co-developing tools and operational guidance (see detailed timeline for the accelerator site programme in Annex 2:. National guidance (2021),[4] informed by the experience of the accelerator sites, established a minimum standard for implementing 2-hour UCR services, for all ICSs to meet by April 2022. Each ICS received additional funding to support the delivery of the standard. The guidance was updated in March 2022[5] to identify key priorities for the year 2022/23, with 2022 winter priority letters[6,7] highlighting key community service and UCR-related requirements for tackling winter pressures.

1.2 What 2-hour UCR involves

The 2-hour UCR standard requires all systems to provide urgent community response (UCR) services within two hours, that assess, treat and support people aged over 18 experiencing health and/or social care crises, who are at risk of hospital admission within the next two to 24 hours. Services should be provided seven days a week from 8am to 8pm at a minimum, with full geographic coverage of a consistent service available across each ICS.

The standard requires systems to shift resources to home and community-based services. It reflects NHSE's commitment to transforming community health services and providing

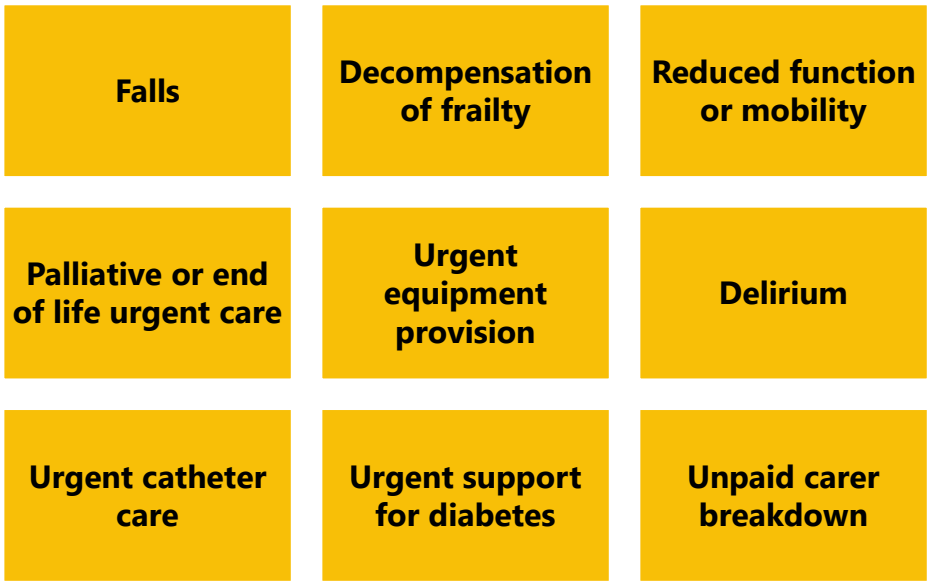
[3] https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/1-we-will-boost-out-of-hospital-care-and-finally-dissolve-the-historic-divide-between-primary-and-community-health-services
[4] NHSEI (2021) *Community health services two-hour crisis response standard guidance: Guidance for providers of care, integrated care systems and clinical commissioning groups*
[5] https://www.england.nhs.uk/publication/community-health-services-two-hour-urgent-community-response-standard-guidance
[6] https://www.england.nhs.uk/publication/next-steps-for-urgent-and-emergency-care/
[7] https://www.england.nhs.uk/long-read/going-further-on-winter-resilience-plans/

the right care, at the right time, to people closer to home. The programme is informed by National Institute of Health and Care Excellence (NICE) guidance[8] for intermediate care that crisis response should be started within two hours from receipt of referral.

2-hour UCR services are key to delivering the NHS strategic priorities and require partnership working across health and care. In some ICSs the service is entirely new, in others it builds upon existing provision (for part or all of the system).

The national guidance identifies nine common clinical conditions or needs that may lead to a patient requiring an urgent two-hour response (Figure 1.1, see Annex 2: for further details). Systems should respond to these nine conditions at a minimum, and it was not intended as an exhaustive list.

Figure 1.1 Nine common clinical conditions or needs requiring 2-hour UCR



The national guidance sets out the operational requirements for 2-hour UCR services, and how NHSE regional teams will support ICSs in both implementing the standard and monitoring their performance. Some of the core implementation and clinical operational elements required include:

- Access to 2-hour UCR should be provided through a single point of access (SPOA), operating on a 'no wrong door' ethos coordinating multidisciplinary clinical and non-clinical care
- An inter- and multi-disciplinary workforce should be involved, to match the professionals deployed to patient need. Exact roles and team composition to be

[8] NICE (2017) *Intermediate care including reablement: NICE guideline NG74*

determined locally but may 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
- Referrals into 2-hour UCR services should be accepted from all appropriate sources (including self-referrals)
- Complete performance monitoring data returns should be submitted regularly to the Community Services Data Set (CSDS), which should be regularly reviewed and include a focus on reducing health inequalities.

The updated national guidance in 2022 strengthened the requirements around referral routes to 2-hour UCR to include the requirement to work in partnership with: the local ambulance trust to ensure appropriate patients are redirected from 999; and technology enabled care (TEC) companies (providers of pendant alarms), local authorities, ICSs and place-based partnerships, to implement local pathways that provide a response as an alternative to urgent and emergency care (UEC).

2-hour UCR has been positioned as a core element of system operational planning and planning for winter pressures, with emphasis placed on the role of the service in working with ambulance services and other providers to reduce demand on UEC.[9] UEC systems have also been asked to ensure community-based falls response services were in place and that UCR services work more closely with ambulance services to take an increasing number of referrals for people who had fallen.[10]

1.3 2-hour UCR national evaluation

The NICE guidance[11] recommends a crisis response within two hours if: patients have experienced an urgent increase in health or social care needs; the cause of the deterioration has been identified; and their support can be safely managed in their own home or care home. However, there is a limited published evidence base for what works in UCR, and establishing a national two-hour standard is a global first. To further develop

[9] https://www.england.nhs.uk/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/
[10] NHS England, 2022, Going further on winter resilience plans https://www.england.nhs.uk/long-read/going-further-on-winter-resilience-plans/https://www.england.nhs.uk/long-read/going-further-on-winter-resilience-plans/
[11] NICE (2017) *Intermediate care including reablement: NICE guideline NG74*

the evidence base, and following the completion of a scoping study to identify principles of a robust approach, NHSE commissioned the NHS Strategy Unit (an independent specialist research, analysis and evaluation team within the NHS) and partners Ipsos to deliver an evaluation that provides:

- **Operational learning:** through a process evaluation evidencing the essential elements of a successful service at scale and maturity
- **Evidence of patient and carer/family impact:** exploring patients' health and wellbeing outcomes and experience, as well as the experience of carers
- **Evidence of healthcare system impact:** understanding the impact on admissions to acute care, the wider impacts for ICSs, and the economic impacts (costs and cost savings).

This work is shaped by the seven sites and supported by the **Evaluation Advisory Group** which brings together national, regional and local stakeholders with evaluation methods experts.

2. Methodology

This section provides a summary of the evaluation approach. A comprehensive description of the methodology is provided in Annex 5.

2.1 Summary of key stages

2.1.1 Developing the evaluation design

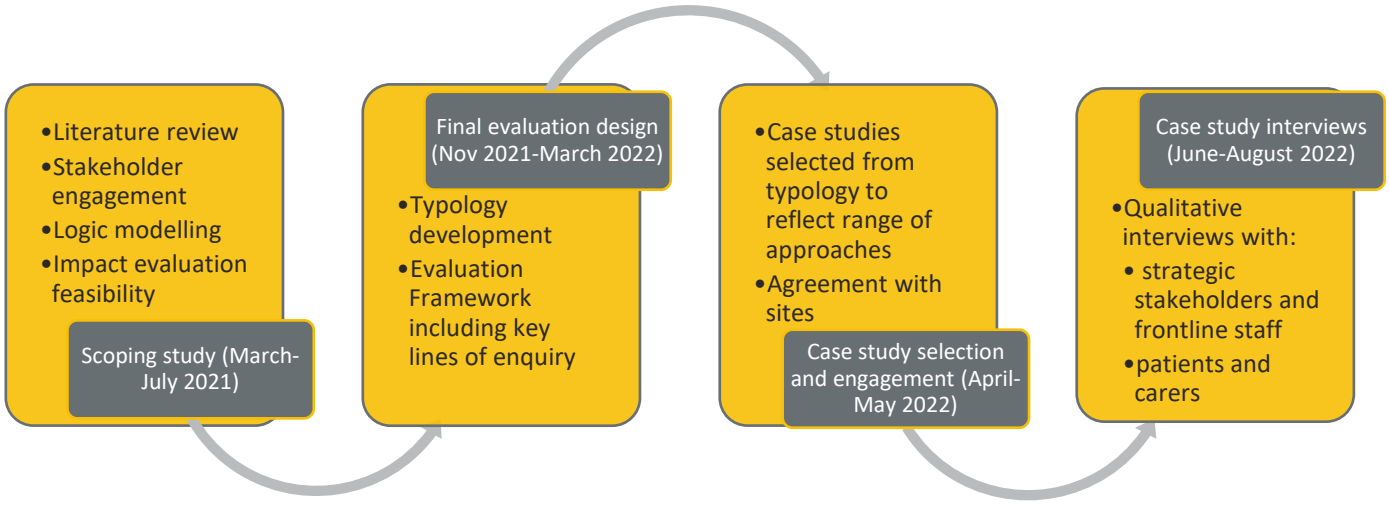
Informed by a previous scoping study undertaken by the Strategy Unit, the final evaluation design was developed through engagement with national, regional and 2-hour UCR service stakeholders setting out: a typology of service models and options for the case study sample; and key lines of enquiry for the qualitative, impact and economic evaluations.

Once the case study sample was finalised, the evaluation team and NHSE met with key stakeholders from each site to discuss the evaluation. When their involvement was agreed, the evaluation team worked with a nominated lead to plan the qualitative interviews.

The evaluation will have different phases of qualitative research exploring implementation over time, with an impact and economic evaluation reported at the final stage (2024).

These stages are summarised below in Figure 2.1.

Figure 2.1 Key stages in the evaluation



2.1.2 Case study interview participants

The evaluation is designed to include a range of perspectives within each case study. The aim for each case study was to include 15 semi-structured qualitative interviews across the partners involved in delivering 2-hour UCR:

- **Strategic stakeholders:** for example, commissioners and senior leads in community services, secondary/urgent care, and the local authority
- **Frontline staff:** operational and clinical leads, clinicians and staff delivering the service.

The evaluation also aimed to include three-five interviews with patients and family/carers. Securing this participation was challenging and further work with sites will explore how this can be developed for the final round of the qualitative research. Three sites provided the evaluation team with feedback that they had collected. A total of 100 staff interviews and 4 service user/carer interviews were completed and analysed using specialist NVivo software.

2.2 Limitations to the evaluation

The following limitations should be considered when reading this report:

- **Statistical significance:** this report is based on qualitative interviews and although a robust approach has been taken to the analysis of this data, it can only reflect the views, perspectives and experiences of these participants. This reflects a range of delivery models and stakeholders within them, but it is not statistically representative in the way that quantitative data analysis can be. These limitations apply to all qualitative data collection and analysis and should be borne in mind when reading this report.
- **Limited direct engagement with patients and family or carers:** the small number of patient and family/carer interviews completed in the first round of case study research reported here is a further limitation. Work with case study sites to explore how this can be improved and achieved in the final round will continue.

3. Case study sites: summary of delivery models

Table 3.1 Table 3.1across the following pages, provides an introductory summary of each of the seven case study sites participating in the evaluation. It highlights areas where sites have already made progress in priority areas for 22/23, including extended opening hours and dedicated additional work with 111/999 services to enable cross-referrals.

Table 3.1 Summary of case study site 2-hour UCR delivery models

Case study area	Providers (including remit)	Previous provision	Opening hours		SPOA & referral pathway	111/ 999 dedicated work	Staff involved
			8am-8pm	Extended			
Dorset (ICS)	• **Dorset HealthCare integrated urgent care (IUC) team** • Co-located with 111, SPOA, night nursing and out of hours	• Previous 4-hour rapid response team in East Dorset • PCN rapid response services	X		• Via 111, SPOA or 999 • Category 3 or 4 ambulance dispositions pushed or pulled from call stack	X	• Band 7 ACP and Band 6 occupational therapist or physiotherapist • 2-3 vehicles / teams available per day • 111, CAS and 999 call handlers.
Hull and East Riding (HER) (Place-based)	• **City Health Partnership** provides services in Hull and East Riding • Supports **Yorkshire Ambulance Service (YAS)**	• Previous frailty advice and guidance telephone line	X		• Same phoneline (recorded advice provided to direct callers) - referrals from practitioners	X	• Community geriatricians • Clinical support workers • Paramedic practitioners
Leicester, Leicestershire and Rutland (LLR) (ICS)	• **LLR local authorities** Home First social care teams (crisis response) • **Leicestershire Partnership Trust** (SPOA, therapy and nursing)	• Social care crisis response teams • LPT SPOA and overnight nursing assessment teams	X	X	• 24/7 social care response • 8am - 10pm SPOA for ICS-wide community health teams,	X	• Care workers • Call coordinators • Call handlers • Therapists • Nurses

Case study area	Providers (including remit)	Previous provision	Opening hours		SPOA & referral pathway	111/ 999 dedicated work	Staff involved
			8am-8pm	Extended			
	• **East Midlands Ambulance Service NHS Trust** (EMAS) and **DHU** (111 and OOH) support new Unscheduled Care Hub (UCH)	• LeicesterCare pendant alarm service (part of Leicester City Council)			• Overnight nursing assessment service 8am - 10pm • UCH- mostly professional except self-referral via LeicesterCare pendant alarm line		
Mid-and South Essex (MSE) (ICS)	• **Three providers**: Provide, NELFT, and EPUT providing services as part of **one single UCR model** • **Close-working with 111 and 999 providers** (IC24 and EEAST)	Four previous rapid response teams	X	8am – 10pm (8pm referral cut-off)	• One SPOA for all of ICS – only open to referrals from professionals and service users using pendant alarm	X	• Band 6 and Band 7 nurses (clinical triage) • Occupational therapists • Healthcare assistants • Social workers (in Thurrock only)

Case study area	Providers (including remit)	Previous provision	Opening hours		SPOA & referral pathway	111/ 999 dedicated work	Staff involved
			8am-8pm	Extended			
North West London (NWL) (ICS)	**Four providers across eight boroughs:** • **Central London Community Healthcare NHS Trust (CLCH)** • **Central and North West London NHS Foundation Trust (CNWL)** • **Hounslow and Richmond Community Healthcare NHS Trust (HRCH)** • **West London NHS Trust**	Rapid response teams – continuity with previous provision, developed to deliver a new, consistent model	X	8am - 10pm (8pm referral cut-off)	• SPOA for each of the eight areas		• Consultants • Nurses • Healthcare support workers • Advanced assessors • Pharmacists • Occupational therapists • Physiotherapists • Dietician • Paramedics
Warrington (Place-based)	• **Warrington Borough Council** • **Bridgewater Community Healthcare Trust** providing one 2-hour UCR multidisciplinary health and social care team	Elements of UCR design spread across multiple previous NHS and LA services	X	24/7 CareCall pendant alarm overnight provision)	• SPOA, referrals from professionals and self-referrals • Ambulance service able to push referrals	X	• Band 8 matron and • Band 7 and Band 6 nurses • Occupational therapists • Physiotherapists • Therapy assistants and assistant practitioners • Social care staff and call responders (manning CareCall)

Case study area	Providers (including remit)	Previous provision	Opening hours		SPOA & referral pathway	111/ 999 dedicated work	Staff involved
			8am-8pm	Extended			
West Kent (Place-based)	• **Kent Community Health NHS Foundation Trust (KCHFT) (covers both West Kent and East Kent) –** three teams: Home Treatment, Rapid Response and Hospital at Home.	All three teams existed, providing care within two hours prior to 2-hour UCR	X	24//7 Rapid Response team and Local Referral Unit (LRU)	• LRU acts as SPOA		• LRU call handlers (non-clinical triage) • Registered nurses, assistant practitioners, and health care assistants (Rapid Response and Hospital at Home) • Consultant geriatricians, speciality doctors, ACPs and HCAs (Home Treatment)

4. Operational Learning

Section summary

This section explores the operational learning across the seven case study sites implementing the national guidance, working toward a standard UCR offer. The operational learning section:

- Reports on the progress, key features, enablers and challenges in the design and implementation of 2-hour UCR
- Highlights challenges sites are facing in meeting ambitions set out in the guidance
- Explores features of a successful 2-hour UCR delivery model, including that which goes beyond the NHSE guidance for 2-hour UCR, to provide an advanced service for patients.

Each section first highlights key summary findings before discussing learning from the case study sites in more detail.

4.1 Progress with implementation

Key findings

- **Case study sites have interpreted the national 2-hour UCR guidance through a local lens resulting in significant variation in service design and delivery, which present challenges in evaluating best practice**
- **Previous experience of community-based rapid response or early involvement in 2-hour UCR implementation has both supported, and sometimes hindered, progress in design and implementation**
- **Key areas in which sites have made substantial changes to previous provision include workforce and development and the introduction of new vehicles and equipment**
- **While all sites enable self-referral through 111, a number of sites have enabled direct self-referral via multiple channels, including integrated pendant alarm services**
- **The extent to which sites have focused on data collection and modelling varied between them and remains an area for further future development**
- **Further progress is required in improving data quality at a local and national level in order to document progress on key performance measures for all case study sites**

4.1.1 Case study sites have interpreted the national 2-hour UCR guidance through a local lens resulting in significant variation in service design and delivery, which present challenges in evaluating best practice

The different 2-hour UCR models in the seven case study areas (as summarised in section 4) reflect design and implementation processes which primarily focused on adapting existing local provision to meet the core requirements of the guidance. This has resulted in a high level of variation between sites:

- All sites provide a 12-hour (8am-8pm) service, 7 days a week in line with national guidance
- Three of the seven sites (LLR, Warrington, West Kent) provide at least one element of the UCR service 24/7, with two other sites operating from 8am-10pm
- All seven of the sites have developed SPOAs but with a high level of variation in how these function
- While all seven of the 2-hour UCR services accept 111 and 999, referrals five of the seven case study sites so far have developed dedicated models for ensuring timely sharing of referrals – some with 'push', some with 'pull' models.

The high level of variation and complexity and issues with comparison data make it difficult at this stage of the evaluation to identify aspects of delivery models that might be considered as best practice or more effective – the final round of the evaluation will seek to build on the current picture to provide a clearer steer on this issue.

4.1.2 Previous experience of community-based rapid response or early involvement in 2-hour UCR implementation has both supported, and sometimes hindered, progress in design and implementation

Rather than creating new, single 2-hour UCR teams from scratch, the majority of sites worked to develop 2-hour UCR services from existing teams, sometimes spanning multiple providers, and building on existing resources. This process of adapting or restructuring existing services, as well as previous experience of delivering responses within two hours, or participating in early implementation efforts affected case study sites in the following ways:

- **Existing rapid response services:** each site already had community-based rapid response teams (varying in size and remit) with the majority adapting or making wider changes to these teams' delivery models in order to meet the standard. Box 1 below provides examples of the different ways case study sites have built on existing provision.[12] Many interviewees perceived a continuation between 2-hour UCR and these previous initiatives; this was described as both an enabler and barrier for multi-agency working and developing consistent service across the geography. Sites have been able to benefit from existing strong communication mechanisms, knowledge and experience in delivery. However, many have also faced challenges with integrating

[12] Boxes will be used throughout the report to provide focused reflection on particular examples from the case studies

different services (either within places or ICS-wide) due to these previously entrenched working cultures and historic relationships.

Box 1: Building on existing teams

Warrington has built their 2-hour UCR model around seven different services and initiatives in the community, including the intermediate care tier (ICT) services, which provide short-term support to help people recover, regain independence, and remain at home.

LLR have had rapid response teams within social care for many years and redesigned their services to integrate health and care in 2019, just before the 2-hour UCR programme was launched.

- **Delivering UCR within two hours**: a two-hour community response time was already in place in four of the seven case study sites: LLR (in Leicester City social care crisis response team), NWL, West Kent and Dorset. Other sites prioritised by assessment of patient need. Currently, all but one of the sites aim to provide an in-person response within two hours, as specified by the guidance.[13]

- **Early implementation:** some of the case study sites began implementation prior to publication of the national guidance in 2021, as chosen UCR accelerator sites. Warrington's 2-hour UCR service, co-located with existing intermediate care at home provision, went live in March 2020, and LLR started developing their Leicester City Home First model as an approach across the ICS in 2019:

"In terms of the accelerator site, we looked at where the actual gaps were… and used the Ageing Well money and the SDF money to improve our operational hours for those providers in a consistent way."

LLR | Role: Strategic

In Dorset, a three-month pilot of the 2-hour response service in 2020 was followed by a further pilot in 2021, linked to the 111 hub. A 12-week quality improvement project was then used to inform the implementation and development of the service launched at scale across the ICS.

[13] The exception is HER, who have built the 2-hour UCR service from an existing advice and guidance telephone line set-up during the COVID-19 pandemic by community geriatricians. They provide support to patients by offering clinical advice over the phone, and decision-making support to paramedics and other clinical responders. They plan to expand the urgent care response team and recruit skilled clinicians, such as ANPs and AMPs, who can conduct face-to-face clinical assessment, and the evaluation will explore these developments.

4.1.3 Key areas in which sites have made substantial changes to previous provision include workforce and development and the introduction of new vehicles and equipment

The national 2-hour UCR guidance makes recommendations regarding workforce and development, and resources for use during response and assessment, but does not mandate particular approaches. These were key areas where case study sites made changes from existing provision as part of their 2-hour UCR implementation:

- **Building capacity and expertise at different contact points:** West Kent increased capacity through new Advanced Clinical Practitioner (ACP) roles and trainee ACPs. MSE recruited Triage Clinicians to work within their Single Point of Access (SPOA)
- **Creating new leadership roles for integrating UCR provision:** Similar to the newly created MSE Head of 2-hour UCR role, in LLR the service manager from the Leicester City social care crisis response service moved to a strategic ICB role to drive implementation of the new model across the ICS
- **Investing in new vehicles and equipment to improve quality of response.** Case study sites described the technical changes (described in Box 2:) they have introduced for their 2-hour UCR teams to provide as comprehensive a response as possible and optimise patient care. Interviewees also described considerations relating to workforce development:

"[We thought about] what's the best vehicle for us? Do we have one that takes three so we can take students out to share what the service is doing? So, at the moment we've got three hire vans, like Transit vans, which are all kitted and branded, and we're taking the students out."

Dorset | Role: Strategic

Box 2: Using vehicles and equipment to support 2-hour UCR

Some case study sites have invested resources in vehicles and equipment to improve the effectiveness of contacts with patients:

- Dorset (in common with West Kent) introduced small vans (with enough space for three staff attendees) which enabled teams to transport larger equipment and provide treatment in patients' homes
- MSE have implemented a plan-do-study-act cycle to trial a 2-hour UCR car dispatched from the ambulance trust
- In LLR, one of the social care crisis services has a pool car which can be used by staff to respond to falls emergencies and has implemented a trial to test a robot (Cobot) that provides lumbar support for staff lifting patients who have fallen

- West Kent have point-of-care testing equipment which allows them to carry out diagnostic tests in patients' homes.

The benefits of these activities include:

- Larger capacity vehicles can support student learning opportunities
- Patients receive timely appropriate care as staff do not need to make onward referrals or multiple trips back to base.

4.1.4 While all sites enable self-referral through 111, a number of sites have enabled direct self-referral via multiple channels, including integrated pendant alarm services

Direct self-referral processes (as opposed to that via 111) have been introduced at four sites, which they described as particularly useful for responding to falls in known frailty patients. In LLR, Warrington and MSE, at-risk patients can use pendant alarms to self-refer. Box 3: describes case study examples of other key strategies for enabling and increasing self-referrals including:

- Promoting to those who have used 2-hour UCR services previously
- Promoting via different services (for example, community health services, GPs and social care)
- Making contact details available to public via web pages.

Box 3: Promoting self-referral to the patient cohort

In West Kent, patients who are known to the service are made aware that they can contact the Local Referral Unit (SPOA) if urgent care is needed. Patients living with frailty may also be told how to self-refer by their GP or social care provider. The SPOA number is available on their public website, meaning that anyone who is aware of the service can refer themselves.

In Warrington, self-referral has recently been promoted by 2-hour UCR staff when visiting patients by giving the SPOA number directly to patients and to their carers or relatives. During their operating hours, this ensures that the service is accessible and prevents the need for patients to contact a GP or emergency service before they receive a response.

4.1.5 The extent to which sites have focused on data collection and modelling varied between them and remains an area for further future development

A few case study sites described how they are using data and changes to data systems to support their implementation process and improve the quality of the data they are

submitting. However other sites identified particular challenges in this area (described in section 5.2), and this remains an area for further development for most case study sites:

- **Demand and capacity modelling:** MSE and West Kent estimated demand for 2-hour UCR using existing patient data and planned their workforce around this. Dorset carried out proof-of-concept work to assist with planning of implementation
- **Adaptations to patient record systems:** adapting patient record systems with changes necessary to record the new response for CSDS was key for some sites. Two of the sites (WK and Warrington) enabled better data recording through adaptations to their electronic patient record systems such as SystmOne and RiO. Warrington had previously used an internal spreadsheet to record relevant data and calculate whether the response was provided within two hours
- **Providing data collection training and shadowing for staff for improving individual recording:** in Dorset this focused on how to record 2-hour UCR data (including clock stops and urgency recording) to improve quality of data submitted to CSDS.

4.1.6 Further progress is required in improving data quality at a local and national level in order to document progress on key performance measures for all case study sites

One of the key CSDS performance measures for 2-hour UCR service delivery is the percentage of 2-hour standard UCR referrals seen within two hours. Table 4.1 provides data for three case study sites (with numbers of referrals received within the same period also included for reference)[14] which indicates that they have been successful in exceeding the minimum threshold of at least 70% calls seen within two hours. It was only possible to document the progress of a subset of case study sites (MSE, NWL, LLR), correct at time of analysis for July 2022, due to the following issues with data collection and data submission requirements:

- Data quality issues at time of analysis (Dorset, Warrington)
- Provider boundaries - West Kent's data refers to the whole area covered by the provider's (Kent Community Health Foundation Trust) remit, rather than West Kent alone

[14] Those accepted as appropriate 2-hour UCR referrals

- Fidelity with 2-hour UCR standard – HER are working with the CSDS data submission requirements, showing a 97% response rate but need to make further progress in implementing a face-to-face 2hr UCR response team before data is comparable.

Table 4.1 Key referral CSDS metrics for three case study sites

Site	Reporting period	Percentage of 2-hour standard UCR referrals seen within two hours at the end of the reporting period	Number of 2-hour standard UCR referrals received within reporting period
MSE	July 2022	91%	770
NWL	July 2022	84%	595
LLR	July 2022	78%	165

4.2 Features of a successful 2-hour UCR design process and delivery model

Key findings

- **An early focus on building relationships through stakeholder engagement was the key ingredient for success in service development and delivery**
- **Ongoing, targeted engagement and awareness-raising of referral processes across potential referral sources is key to ensuring effective referrals**
- **Case study sites are trialling both 'push' and 'pull' models for effective integration of 111, CAS and 999 referrals into 2-hour UCR service – co-location of staff is a key success factor for both models**
- **Case study sites had conflicting views on whether a single-stage or two-stage triage process is most effective**
- **Digital tools and protocols to aid triage decisions are particularly useful for supporting non-clinical or less senior clinical staff to provide an effective triage process**

Key findings

- **Some sites consider senior staff as more likely to have the skills and knowledge necessary for the pressures of effective triage**
- **Staff skills and use of technology enables effective and appropriate prioritisation to ensure that the most urgent patients are met within two hours**
- **Among a range of factors, remote access to digital solutions can be particularly important for enabling 2-hour UCR teams to provide an effective response within two hours**
- **Effective follow-up response is shaped by available local resources, but can be provided by a wide range of organisations and is potentially important to provide beyond 48 hours after a 2-hour UCR referral**
- **The voluntary and other public sector teams beyond health services can be key partners in providing effective follow-up responses which prevent crisis by addressing wider wellbeing needs**
- **Multi-disciplinary team (MDT) meetings are a key enabler of effective follow-up support**

4.2.1 An early focus on building and maintaining relationships through stakeholder engagement was the key ingredient for success in service development and delivery

Engagement across providers to design the model and agree core elements (referral criteria, patient pathway, promotion activities) were carried out by all sites. Interviewees felt that this was key to providing a foundation for progress with effective implementation. Some particular examples of engagement processes conducted by sites include:

- In NWL, stakeholders from four providers across eight different rapid response teams (one for each borough), worked together to identify their main differences and principles for standardised provision
- In MSE, a Memorandum of Understanding (MoU) for a newly integrated service, led by a new Head of UCR, was signed by the three providers providing four community rapid response services
- In Dorset, a task and finish group for the pilot was put in place, attended by key stakeholders including social care and PCNs, to complete process mapping and understand any gaps in the 2-hour UCR response
- Participants in West Kent described a programme of stakeholder engagement with PCNs, urgent and emergency care, the local authority and others.

4.2.2 Ongoing, targeted engagement and awareness-raising of referral processes across potential referral sources is key to ensuring effective referrals

Referrals into 2-hour UCR were described as effective when they are both appropriate for a two-hour response and provide the clinical assessor with the essential information required for triage, such as patient history.

Although nationally the main three sources of referrals across the country are self/care/relative-referrals (35%), GPs (17%) and community health services (15%)[15], across the case study sites, the most common referral sources varied, often depending on the existing service provision and how development and promotion of 2-hour UCR had built on this.

All case study sites highlighted the importance of engaging and raising awareness of referral processes across potential referral sources. This has involved:

- **Targeting services to increase referrals:** such as local hospices (West Kent and MSE), social care (MSE and NWL) and care homes (NWL, MSE, LLR, HER and West Kent). Conversely, Warrington has not actively promoted referrals from care homes due to concerns about their current capacity to respond
- **Providing materials to aid referral decisions:** HER provide patient vignette examples to referral sources which are aligned to the nine conditions, to promote appropriate referrals.

4.2.3 Case study sites are trialling both 'push' and 'pull' models for effective integration of 111, CAS and 999 referrals into 2-hour UCR services – co-location of staff is a key success factor for both models

Five of the seven case study sites had already made progress in meeting the 2022/23 national requirements for 2-hour UCR teams to work more closely with 111, CAS and 999 services, accept patients who have fallen and help to divert patients from urgent and emergency care. This has been achieved through the introduction of either 'push' or 'pull' models.

- The **push model** enables 111 or the ambulance service to send or 'push' patients from 111 or the ambulance call stack to the 2-hour UCR service. This has been enabled in Dorset, Warrington and HER through:

[15] According to CSDS data from July 2022

- **Co-location of teams:** Dorset have made the most progress with implementing primarily a push model with 111 and the ambulance service, enabled by co-location at the 111 hub building and hosting the 2-hour UCR in the integrated urgent care service
- **Shared information systems:** Warrington's 111 service is currently able to 'push' patients to the 2-hour UCR team using SystmOne, with further plans to expand this to 999 and potentially more elements of a 'pull' model (following a pilot)
- **Existing provision and partner relationships:** reflecting its origins as a frailty advice and guidance line for paramedics, as part of their 2-hour UCR team development, HER are working with Yorkshire Ambulance Service to develop a trial of a 'push' model, which will automatically refer cases with a pre-defined code to the 2-hour UCR team

- The **pull model** involves 2-hour UCR teams accessing 111 and 999 call queues and identifying and 'pulling' out cases which may be more suitable for their team. For the sites providing this kind of model (MSE, LLR and Dorset), the factors which have supported it include:
  - **Training:** in MSE, the highest number of referrals come from the ambulance service and they have built strong relationships. To further support referrals from the ambulance service, 2-hour UCR clinical triage staff are now undertaking training to enable them to 'pull' referrals from the ambulance stack
  - **Hub coordination of services:** LLR have recently introduced an unscheduled care hub which involves practitioners from all three areas (city, county and Rutland), working with the ambulance service and the out-of-hours GP/111 provider to pull calls from their call queue
  - **Co-location:** the co-location of the Dorset team means they can also sometimes 'pull' cases from 111 or the ambulance stack, where 2-hour UCR capacity allows. They are currently considering how to expand this way of working.

4.2.4 Case study sites had conflicting views on whether a single-stage or two-stage triage process is most effective

The case study models have developed different processes for triage, which align with the staff and clinical assessment skills available within the team, resulting in opposing views on the most effective model.

Sites with clinicians providing single-stage triage via the SPOA (MSE, NWL and Warrington) felt that this was important for improving patient experience, ensuring people do not have to speak to multiple people before receiving a response.

Conversely, to provide an efficient use of resources, other sites (West Kent, Dorset, HER) have introduced a non-clinical call handler basic triage step prior to additional clinical triage, ensuring that 2-hour UCR teams are responding to appropriate referrals only.

4.2.5 Digital tools and protocols to aid triage decisions are particularly useful for supporting non-clinical or less senior clinical staff to provide an effective triage process

While some sites enable staff to use clinical judgement to provide effective triage (for example, LLR), others (particularly, but not exclusively, those where non-clinical or fewer senior staff are involved in triage) described the benefits of using a range of different tools for guiding staff through triage including:

- Forms which guide the person triaging through the decision making (for example the General Adults Additional Response Information form in West Kent)
- Standardised triage protocols and guidance (for example in Warrington, where they have streamlined their triage guidance to make it more efficient for referrers and to encourage referrals)
- A basic triage algorithm to determine urgency of the response (HER).

4.2.6 Some sites consider senior staff as more likely to have the skills and knowledge necessary for the pressures of effective triage

All sites agreed that effective triage professionals need to have a good understanding of the skill mix within the 2-hour UCR team, the level of care that can be provided, and knowledge of potentially more suitable alternative provision.

At some sites (for example, Dorset, West Kent, LLR) interviewees felt that seniority (staff of Band 6 and above) can be important for most effective triage due to senior staff's likely higher levels of comfort with risk and experience of quick decision making.

"That triage [clinician] tends to be one of the most senior clinicians that we have on shift that day because there is a lot of decision making and risk taking that's held there."
West Kent | Role: Frontline

4.2.7 Staff skills and use of technology enables effective and appropriate prioritisation to ensure that the most urgent patients are met within two hours

Sites described that in circumstances where referrals need to be prioritised by need, staff skill and knowledge are important but can also be best facilitated by digital solutions:

- MSE have a case manager who reviews referrals from the SPOA and prioritises patients based on service capacity
- In West Kent, prioritisation is managed by the triage clinician who tracks the location of responding staff to send the closest and most appropriate responders to priority patients (see Box 4: below for further details)
- Warrington reported that they use labels to prioritise cases in their record system and that lower priority referrals may be responded to within four hours.

"We will put red and a P for priority, so we know we are hitting that two-hour standard, [but]if we know it's [just] safety netting for the hospital, and [it's] safe, then that [referral] can be lower down in the priority. So, we always make sure [for] the ones that are [[more urgent],] the two-hours are being met."

Warrington | Role: Frontline

4.2.8 Among a range of factors, remote access to digital solutions can be particularly important for enabling 2-hour UCR teams to provide an effective response within two hours

As there is variation across the sites regarding the ability of teams to treat the nine clinical conditions without the need for onward referral, it is difficult to identify the features of effective response. This may be influenced by the maturity of teams that work across the system to coordinate a response in adhering to the guidance. Future work in the evaluation will focus on the impact of this variation and seek to understand which factors have the most impact.

Nevertheless, current findings from this round of the evaluation suggest that in order to provide an effective response, the teams must have:

- **Use of technological solutions** to optimise travel time, support virtual working and provide remote access to patient records or information, and social care records (See Box 4:)
- **Access to comprehensive resources** (e.g. supplies, equipment, staff competencies) through 2-hour UCR vehicles which are stocked with medical supplies and equipment

- **Quick and direct access to disciplines beyond UCR teams** including coordination with other community services (for example, established catheter or palliative care teams) to provide a holistic response.

Box 4: Technological solutions that support effective response

- In Dorset and West Kent, staff carry laptops with SIM cards which are used to access patient records and **track their location**. This ensures that:
  - Frontline clinicians do not have to return to the main hub after seeing each patient and call handlers are able to match the closest responders to incoming referrals
  - Call handlers can match the most appropriate responders (based on clinical skills) to patient need
- In MSE, responders have the **(specialist, secure) Pando app** on their mobile phones, which allows them to send photos of the patient to the clinical coordinator to support clinical decision-making
- West Kent and MSE have an **encrypted WhatsApp group** for providers which ensures quick communication to support responders.

4.2.9 Effective follow-up response is shaped by available local resources, but can be provided by a wide range of organisations and is potentially important to provide beyond 48 hours after a 2-hour UCR referral

The follow-up support provided by case study sites, designed to confirm the patient is having their needs met and prevent further crisis, was dependent on the existing services available locally, staff capacity and the skill mix within the teams.

A core thread among the range of follow up responses provided was that even in sites where 2-hour UCR staff provide a direct follow-up response, rather than staff from partner teams or organisations responding, this was sometimes provided beyond 48 hours after the initial 2-hour UCR referral. Future work of the evaluation will further explore the importance of the timeframe of follow-up support.

Effective follow-up support provided by 2-hour UCR teams is provided either **in-person or by telephone** (neither method was highlighted as better than the other)) and is important reassurance for both patients and 2-hour UCR staff. MSE reported that in South East Essex, approximately 75% of patients are seen by a nurse in person the day following their referral. The Warrington team reported that they will follow-up with patients on an ad-hoc basis with a telephone call to check on their condition and whether they have been contacted by any services they have been referred into by 2-hour UCR staff.

Beyond the 2-hour UCR team, therapy (particularly **therapy staff based in reablement teams**) and **intermediate care teams** were identified as key and common sources of follow up support sites have been effective in engaging:

- In LLR, HER and Warrington patients with additional therapy needs can be referred to a two-day reablement service which will support rehabilitation, for example after a fall. The integration of health and care in LLR (to varying extents across the ICS) means that this kind of follow-up support is easily accessed- reablement teams work closely with urgent community response as part of the Home First model
- Participants in MSE and HER reported that when a 2-hour UCR response can't keep patients at home, to prevent admission into acute care they will refer into intermediate care beds, where the necessary follow-up support can be provided.

"If you can't keep a patient at home, the only other choice is [often] to send them into hospital. So that is why intermediate care is a foundation for [2-hour UCR]."

HER | Role: Strategic

Box 5: highlights less common or emerging sources of health service follow-up support described by the case study sites.

Box 5: Promising practice in follow-up response

Four case study sites described particularly effective options for follow-up response involving in-person follow up and onward referral. This includes:

- **Case management referrals:** in NWL 2-hour UCR staff make home visits between three to seven days after the initial assessment of a patient. If the patient is stable during the home visit, they can be discharged from 2-hour UCR. Sometimes they are signposted to other services, such as support in the community. However, if the patient is not stable within five days, they are referred to the case management teams which are able to provide more holistic support for up to six weeks. The case management team can conduct further investigations and refer the patient into services which meet complex needs, which might not have been possible under the initial rapid response. This follow-up support ensures that patients with complex needs are cared for following a rapid response, which prevents future hospital admissions
- **Virtual wards:** in MSE, if the patient needs treatment and care beyond 48 hours, the patient will be referred to the virtual ward service for up to 14 days (depending on capacity). Newly introduced virtual ward services have also been used for follow-up care by Dorset and HER. The virtual ward service was described as an effective way of monitoring patients who no longer need an acute intervention.

4.2.10 The voluntary and other public sector teams beyond health services can be key partners in providing effective follow-up responses which prevent crisis by addressing wider wellbeing needs

Multiple sites described partnerships with other public and voluntary sector organisations who can provide follow up support. Dorset, Warrington and West Kent identified support provided by food banks or the fire and rescue service for home checks. Box 6: describes the experience of two case study sites with the most mature relationships with the voluntary sector.

Box 6: Promising practice in working with the voluntary sector

Dorset are working with a voluntary partner PramaLife who provide a telephone welfare check and onward referral for patients for up to seven days after initial contact. This aims to identify any further support needs, such as being able to look after themselves, manage the home and cooking, and whether they are being visited by friends or family.

Warrington is supported by a Healthy and Home coordinator, who can identify and facilitate referrals to appropriate voluntary services, and the Good Neighbour scheme which provides volunteers to support people at home. This ensures that more holistic support is provided if social care needs are identified during a response.

4.2.11 Multi-disciplinary team (MDT) meetings are a key enabler of effective follow-up support

Three case study sites described different types of MDT discussions that they have found essential for coordinating effective follow up support:

- In LLR, the Leicester City Home First health and social care teams have daily MDTs but can also discuss cases outside of this. In the county, community health teams and reablement have a weekly MDT
- In the MSE South East Essex team, they meet with other services (social care, hospital, community occupational therapy (OT) team, respiratory team, and specialist dementia service) to discuss specific patient cases and support identified follow up needs
- West Kent reported meetings with PCNs to discuss patients who may have needed a two-hour response multiple times, to identify if referral to another service would be beneficial.

4.3 Additional factors supporting or hindering effective implementation

While particular factors supporting or hindering particular elements of the 2-hour UCR delivery models have been identified throughout, a number of cross-cutting factors were identified that influenced delivery as a whole which are described below.

Key findings

- **For four of the seven case sites, physical co-location of teams has been a key success factor by enabling better communication and decision making between teams**
- **Geography can prohibit consistent provision of 2-hour UCR responses within 2-hours and cause issues for recruitment and retainment of staff – providing service specific vehicles are a potential key element of a mitigation strategy**
- **The wider challenges of integrating health and social care impacts capacity and the conducting of holistic assessments and comprehensive follow-up support – sites which have enabled information sharing have important learning to share**
- **Additional recruitment and retention challenges are a significant concern for case study sites requiring solutions focusing on organisational development, job role re-evaluations and use of external resources**
- **Case study sites have identified unanticipated rises in demand for 2-hour UCR services and increased levels of complexity in referrals so that refreshed or adjusted demand forecasting may be required**

4.3.1 For four of the seven case study sites, physical co-location of teams has been a key success factor by enabling better communication and decision making between teams

Four case study sites (WK, Dorset, Warrington and LLR) have physically co-located teams. This includes in West Kent, the Urgent Care and Home Treatment services, while in Dorset the co-location of the 2-hour UCR team within the 111 hub.

In an example of promising practice, two of the four sites have co-located both health and social care services:

- In Warrington, clinical staff, social care staff and responders from the different organisations delivering 2-hour UCR are co-located
- Similarly, in LLR, Leicester City crisis response staff, reablement staff, and healthcare staff (nursing, therapy) work together in the same building.

Overall, across the sites, physical co-location with other services and being able to have weekly discussions to escalate cases was highlighted as a key facilitator of an integrated service. The benefits include:

- Enabling and facilitating joint-working
- Shared caseloads and shared patient information
- Direct handover
- Building better relationships between staff and smoother, integrated follow-on care.

"As much as you can try new technology it is better if you're having a corridor conversation or literally popping your head through a door and saying…I'm concerned about this patient that I've just been to see, can you go and see them."

LLR | Role: Frontline

4.3.2 Geography can prohibit consistent provision of 2-hour UCR responses within 2-hours and cause issues for recruitment and retainment of staff – providing service specific vehicles are a potential key element of a mitigation strategy

One common challenge across several sites was the difficulties caused by the geographical context of their 2-hour UCR services, which has the potential to contribute to health inequalities. This was experienced in the following ways:

- **Longer travel distances with less direct transport infrastructure:** Dorset, LLR and West Kent reported that the large, rural geography covered by their UCR services makes it challenging to respond to some referrals within the 2-hour standard
- **Rising fuel costs and cost of living are hindering recruitment:** staff from LLR suggested that recruitment for the county service may be negatively impacted by rising fuel costs (applicable to both pool cars and their own vehicles) and increased cost of living which make longer travel distances less palatable for many staff
- **Reduced ability to use public transport options:** In NWL staff have historically relied on public transport, particularly bicycles, as an effective way of navigating a busy and congested city. In developing a service to respond to the nine conditions, they are now becoming less suitable due to the requirement for responders to carry bulky and heavy medical equipment (for example: raiser chairs, intravenous equipment, and Automated External Defibrillators).

"We've got cars [and] the London bikes. A lot of clinicians cycle but the ability to cycle is actually starting to reduce as we're having to carry more equipment. [For instance,] an

ECG [and] raiser chair, which is what we use to get people up off the floor, is two bags worth … probably about eleven, twelve kilograms."

NWL | Role: Frontline

To respond to this challenge, Dorset has introduced a model of vehicle-based mobile provision (which provides a response coordinated by a central hub) and NWL is increasing the use of cars. Nonetheless, in all these settings vehicles are required to drive either long distances or through congested traffic between referred patients, and geography continues to present a challenge in meeting the two-hour standard.

4.3.3 The wider challenges of integrating health and social care impacts capacity and the conducting of holistic assessments and comprehensive follow-up support – sites which have enabled information sharing have important learning to share

Most case study sites (with the exception of Warrington and LLR) reported challenges for 2-hour UCR services working with social care, including integrating social care support into the 2-hour UCR response. This includes the challenges of:

- **Limited availability of follow-up support from social care due to a lack of capacity:** this can often result in health care staff from 2-hour UCR services having to provide bridging care or referring patients to other health services until a social care package can be arranged. This can have implications for the capacity of the 2-hour UCR team
- **Lack of access to shared patient records:** while the majority of 2-hour UCR delivery teams have access to patient medical records, only two (Warrington and LLR) have gone further and enabled teams to have access to both health and social care records. For those sites without access to both, this can prevent a completely holistic assessment of the patient. Box 7: describes the approach taken by Warrington to address this.

Box 7: Access to health and social care records

In Warrington, 2-hour UCR was developed as an accelerator site by strategic leads for existing services (with SPOAs) in both health and social care. Despite some early challenges with interoperability between systems, now patient records on SystmOne (NHS system) and Mosaic (local authority system) can be accessed on the same laptop. Whilst this supports a holistic view of the patient, it is however, reported to be time consuming to manage records on two systems – this is a potential area for future improvement.

4.3.4 Recruitment and retention challenges are a significant concern for case study sites requiring solutions focusing on organisational development, job role re-evaluations and use of external resources

Recruitment and retention challenges were described by all case study sites, whether these were due to working hours, sector competition, or skills gaps. They presented a key initial barrier for sites trying to extend existing operating hours to meet the seven-day a week requirement set out by the national guidance in 2021. For some sites, operating hours and referral routes have therefore been (and continue to be) extended incrementally in line with services increasing their workforce:

- In Warrington, it took 18 months to provide a seven-day service due to the difficulties in recruiting a sufficient workforce
- Dorset, being a small team, reported impacts on the service from staff absences due to annual leave or sickness.

Several reasons for recruitment difficulties were identified:

- **Requirement for staff to work non-traditional, unsocial hours including evening and weekend shifts**
- **Higher salaries being offered in other sectors**
- **Challenges with recruiting overseas nurses** (linked to changes following Brexit) were reported in NWL
- **Rising fuel costs and cost of living:** staff from LLR suggested that recruitment for the county service may be negatively impacted by its size, due to 2-hour UCR responses requiring lengthy daily travel distances. Rising fuel costs (applicable to both pool cars and their own vehicles) and increased cost of living make these distances less palatable for many staff
- **Skills gap in staff with specialist skills required** (for instance working in the community, working across multi-disciplinary teams and supporting varied clinical conditions). The roles highlighted by sites as particularly challenging to recruit for include:
  - Advanced clinical practitioners and Advanced approved medical practitioners (HER)
  - Social workers, physiotherapists and occupational therapists with experience in urgent care (Warrington)

- Integrated crisis response staff and crisis response service social care staff skilled and experienced in providing effective response (LLR)
- Domiciliary care workers (West Kent).

"[There is limited] availability of staff that are equipped to do this is very specialist community role, [who can] manage uncertainty and have all the competencies, skills and the training to be able to do that. We have our internal programmes for growing our own, developing our own staff, [but] we really are finding recruitment really challenging."

NWL | Role: Frontline

Some sites described steps they have taken to mitigate these challenges:

- **Providing effective development opportunities for existing staff:** Dorset has developed a blended, shared role across the 2-hour UCR service and 111, with time protected for continuing professional development (CPD). This is intended to make the role more attractive to applicants, and to solve recruitment challenges for both services
- **Amending pay scales to correspond with job responsibilities:** LLR's Leicester-based ICRS service promoted their care workers to a higher grade to recognise the specialist skills and competencies required for the role and to improve staff retention
- **Drawing on short-term external resources:** MSE use bank staff to respond at weekends due to staff shortages.

4.3.5 Case study sites have identified unanticipated rises in demand for 2-hour UCR services and increased levels of complexity in referrals so that refreshed or adjusted demand forecasting may be required

Some sites described challenges for provision as demand for their 2-hour UCR service increases. In NWL, it was reported that demand for 2-hour UCR had increased beyond that expected after the onset of the COVID-19 pandemic, as patients developed more complex needs following lack of engagement with services. Staff from HER noted that demand for the service is high and remain concerned about their ability to maintain high compliance with the two-hour response standard as they progress in implementing a face-to-face response. Additional or adjusted demand forecasting will therefore be needed and is already underway across some case study sites.

4.4 Workforce and organisational requirements for effective rapid response

Key findings

- **The team composition and skill mix of a multidisciplinary 2-hour UCR team is a key area of variation between case study sites, which illustrates the breadth of response underpinning the 2-hour UCR approach**
- **Clinical leadership of 2-hour UCR teams is most commonly provided by nursing staff**
- **Integrating social care roles or response into 2-hour UCR teams has been a struggle and remains a key area for future development for the majority of case study sites**
- **Therapy professionals are an essential part of the 2-hour UCR team, but some sites have struggled to appoint them consistently across the full geography**
- **Clinical support staff enable the provision of more holistic care**
- **Appointing dedicated resource for 2-hour UCR data analysis is important for performance management driving improvement**
- **Unique roles represented in case study sites include ICS strategic roles, pharmacists, dietitians and care worker response staff**
- **Upskilling existing staff in areas such as clinical skills or decision-making can reduce the need to recruit additional specialist roles**
- **Additional local funding has been important for addressing skills gaps in their teams**
- **Specific strategic roles and operational meetings involving all relevant 2-hour UCR meetings are key governance arrangements which support effective system working**

4.4.1 The team composition and skill mix of a multidisciplinary 2-hour UCR team is a key area of variation between case study sites, which illustrates the breadth of response underpinning the 2-hour UCR approach

The variation in team roles and skill mix within 2-hour UCR teams in the case study sites was often shaped by any previous services the current teams were built upon. However, other interviewees highlighted that the range and complexity of issues that can require a 2-hour UCR response has shaped which disciplines they have included in their skill mix. Among the case study sites, NWL currently brings together the largest range of professionals to provide a 2-hour UCR response. Table 4.2 summarises the different roles across the case study teams at the time of the research, with cells shaded to indicate those senior clinicians who are leading the team.

Table 4.2 Summary of roles within 2-hr UCR services for each case study site

	MSE	NWL	LLR	Warrington	HER	West Kent	Dorset
Call handlers	X		X	X	X	X	X
Social care	X		X	X			
Advanced Clinical Practitioners	X						
Therapists (OT/PT)	X	X	X	X			X
Clinical support workers		X			X		
Nurses	X	X	X	X		X	
Consultant/ geriatrician		X			X	X	
Paramedic practitioners		X			X		
Healthcare assistants	X	X	X			X	
Pharmacists		X					
Dietitians		X					
Assistant practitioners	X		X	X			

4.4.2 Clinical leadership of 2-hour UCR teams is most commonly provided by nursing staff

As highlighted in Table 4.2, for most case study sites nurses are leading the 2-hour UCR teams particularly in those case study areas where 2-hour UCR is provided by discrete teams (for example MSE). For those areas where 2-hour UCR involves multiple different services working together (for example, LLR) leadership input can also be provided by staff leading those core teams. This includes:

- **Nurses:** the Urgent Care Team in West Kent is a nurse-led service, with nurses clinically trained in the needs of the community. Similarly, Warrington has a Band 8 clinical lead matron who manages the clinical work of the team. MSE have a Band 8a clinical operational lead who is responsible for team management, coordinating triage, responding to more complex cases, and collating data
- **Geriatricians** lead 2-hour UCR services in HER and the other teams in West Kent;the majority of referrals for these services are from elderly patients
- **Social care:** only LLR has a core leadership role for social care professionals who oversee the Home First social care crisis response teams.

4.4.3 Integrating social care roles or response into 2-hour UCR teams has been a struggle and remains a key area for future development for the majority of case study sites

Among the case study sites, only LLR and Warrington, and one area in MSE (Thurrock) have made significant progress in integrating social care roles into the 2-hour UCR delivery model. Apart from LLR, other examples of the social care roles provided in these case study areas include:

- MSE have two social workers and a community care worker based in their Thurrock 2-hour UCR team
- Warrington have social workers, but the social care response is provided on the same day and is not prioritised for a two-hour urgent response. The social workers largely focus on arranging emergency respite, giving advice to 2-hour UCR staff, or arranging referrals to social care services for further packages of care.

Some sites described their plans to improve integration between health and social care. For example, Warrington described planned recruitment to grow the social work team, and NWL described plans to build partnerships with adult social care and other services.

4.4.4 Therapy professionals are an essential part of the 2-hour UCR team, but some sites have struggled to appoint them consistently across the full geography

The majority of sites reported that they have therapy staff within the team and identified the vital role they play in 2-hour UCR (and follow-up response) in assessing what the patient needs to help them to remain at home, supporting reablement and providing a link across different roles in the wider multidisciplinary team. The different ways therapy staff are included in 2-hour UCR teams include:

- Warrington, NWL and Dorset have both occupational therapists and physiotherapists; Warrington also have therapy assistants
- For other case study sites (West Kent, MSE and LLR) therapy staff are a skills gap in at least part of their area – with recruitment still required to ensure consistent provision across the full geography.

4.4.5 Clinical support staff enable the provision of more holistic care

Multiple sites described the benefits of having clinical support workers or healthcare assistants (HCAs) who can support the clinical staff – the different roles and responsibilities are further described in Box 8:.

Box 8: Responsibilities of clinical support staff

- In MSE, HCAs perform clinical observations and urgent bloods
- West Kent reported that HCAs provide valuable support such as reorientating the patient, helping them to the toilet, providing food and hydration and other personal care. They described how pairing an advanced care practitioner (ACP) with an HCA from a different background can enable a more rounded response to the needs of the patient
- In LLR, once a patient has been triaged by senior Band 7 staff in the SPOA provided by Leicestershire Partnership Trust, visits can be conducted either in pairs (for example nurse and physiotherapist) or by the Band 4 healthcare staff who have been trained to respond to particular 2-hour UCR calls without supervision.

4.4.6 Appointing dedicated resource for 2-hour UCR data analysis is important for performance management and driving improvement

Sites also described roles that are dedicated to or supporting data analytics, driving improvement in submission to CSDS and local performance analysis for learning, primarily accessing existing system expertise and capacity to support service performance management:

- West Kent have a Programme and Performance Lead who gathers data on the 2-hour UCR, with a dashboard comparing performance with East Kent
- In LLR senior strategic staff have created a local dashboard to collate and analyse data from their health and care services, with support from either business intelligence staff (from the local authorities) or in some cases, frontline staff with particular responsibility for data collection
- At HER, an information analyst team co-designed a dashboard with clinical and operational leads to optimise its use for integrating with integrated services and understanding pressures across the wider local health system
- Dorset have a lead for Business Intelligence Development and Data Architecture who was involved in the implementation phase and supported services in recording and processing relevant information that could be submitted to CSDS in a consistent way
- Warrington have recruited to a data analyst role, due to be in place October 2022, to address identified challenges of clinical governance and interoperability associated with running an integrated service.

4.4.7 Unique roles represented in case study site 2-hour UCR teams include ICS strategic roles, pharmacists, dietitians and care worker response staff

Some case study sites described roles in their teams which were not replicated in other sites. These are highlighted in Box 9:

Box 9: Unique workforce roles

- MSE have a 'Head of 2-hour UCR' role within the ICS, a strategic leadership position, building a consistent 2-hour UCR offer across its different services
- NWL have pharmacists and dieticians as part of the 2-hour UCR team, reflecting the staff mix of the services their model has built upon
- LLR are the only model which have care workers who respond directly to 2-hour UCR referrals (rather than advise healthcare staff or provide follow up support).

4.4.8 Upskilling existing staff in particular clinical skills or decision-making can reduce the need to recruit additional specialist roles

Although case study sites had recruited staff (or built from existing teams) with the skills required for 2-hour UCR delivery, training staff was also identified as important for service effectiveness and efficiency. Overall, sites described a breadth of training covering clinical skills and competencies relevant to 2-hour UCR, delivered via a variety of methods, described in **Error! Reference source not found.**, including the cascading of training by other colleagues. Upskilling existing staff through training enables a more comprehensive response to be provided by a wide range of roles.

Box 10: Training provided to 2-hour UCR staff

- Dorset provide extensive training opportunities to new staff, including independent prescribing and ACP qualifications
- HER provide phlebotomy training for new Clinical Support Workers and training on how to perform observations, for example, blood pressure and ECGs. They also have good links with universities that can offer continuing professional development (CPD) for staff
- In Warrington, all responders receive one week of tailored training
- Triage staff from West Kent's home treatment service receive training to ensure that triaging is completed to a high standard
- MSE provide workshops and training about 2-hour UCR and clinical decision-making in relation to the typical patient cohorts within the 2-hour UCR remit, as well as training on specific competencies such as phlebotomy, falls, and non-medical prescribing
- LLR, Dorset, West Kent and MSE provide on-the-job training for their staff including shadowing and observation. For example, In LLR, Leicester's integrated crisis response (ICRS) service, newly recruited ICRS staff shadow existing staff to learn about their delivery of 2-hour UCR, how to take referrals, and how to do assessments.

4.4.9 Additional local funding has been important for sites addressing skills gaps in their teams

Some sites described how additional local funding had been identified to support recruitment:

- In Warrington, the System Sustainability Group has allocated some funding to support the Warrington Together workforce group and Adult Social Care to develop a multi-agency strategy for recruitment and retention, particularly in the care sector
- In West Kent, Service Development Funding (SDF) from the wider Ageing Well programme is being used to recruit therapy staff within the rapid response team.

4.4.10 Specific strategic roles and operational meetings involving all relevant 2-hour UCR meetings are key governance arrangements which support effective system working

Participants also described governance arrangements which have been put into place to support safe, high-quality system-wide delivery. Overall, sites described governance arrangements as helpful for providing clear direction in following the national guidance, facilitating engagement from delivery staff, and problem-solving barriers in implementation and delivery.

Particular aspects of governance arrangements identified as supporting effective system working include:

- Some sites described having strategic staff with responsibility for providing leadership and oversight on key areas of 2-hour UCR delivery and implementation, such as integration between health and social care, supporting transformational work, and evaluation of 2-hour UCR services.
- Several sites also described the benefits of operational and strategic meetings for performance management and problem solving:
  - LLR reported on the importance of operational meetings with key stakeholders as well as strategic meetings in order to address any issues arising from different services working together under a 2-hour UCR umbrella
  - MSE have a programme board that includes leads from each locality, the three providers, and other stakeholders such as NHSE which they felt were essential for standardising care across these partners
  - In addition, participants from West Kent described existing urgent care meetings involving all of the provider organisations in order to discuss 2-hour UCR performance and service improvements, as well as internal focused UCR meetings to review performance and compare it against national data and data from East Kent.

"[At] our UCR Team programme board… all different partners and providers [give] updates, [support] decision-making, and [push] the UCR Team forward… We also have some sub meetings [such as the] improvement cycle meetings where we look at data, system pressures, what can we do; the clinical ops meeting, or [meetings where] senior clinicians from each locality come together."

MSE | Role: Strategic

5. Patient and carer experience and outcomes

Section summary

This section provides a summary of findings for patient and family/carer experiences of, and outcomes from, 2-hour UCR services. Data for this section is limited as there were challenges for evaluation team and case study sites in engaging patients and their families/carers with providing feedback. This section therefore draws on findings from a small number of qualitative interviews[16], intelligence provided by two case study sites[17] and staff perceptions of benefits for patients and family/carers.[18]

Key findings

- **Patients and carers were positive about the care received and the avoidance of a hospital admission**
- **Patients and carers were mostly happy with the access routes and timing of the response received with some concerns raised relating to accessing the team via 111 and lack of direct care home referral routes**
- **Staff highlighted that receiving 2-hour UCR at home is particularly beneficial for preventing deterioration among a range of different patient groups and providing reassurance and respect to end-of-life patients**
- **The multi-disciplinary, holistic approach of 2-hour UCR enables patients and carers to be more involved in, and make decisions about, their care**
- **Staff raised concerns about access challenges for patients without care support or for whom English is not a first language**
- **The involvement of a range of professionals as part of a 2-hour UCR response can risk overwhelming some patients**
- **Social care resource limitations and low awareness of 2-hour UCR services among the general public may still be leading to emergency or hospital admissions.**
- **Case study sites described a range of different patient feedback mechanisms, that they use for continuous learning but overall reported this as particularly challenging**

[16] Two patients from HER and Dorset, one family carer (NWL) reporting on the experience of a family member they care for and one care home manager discussing two residents' experience (West Kent).
[17] A patient case study provided by MSE, and an unpublished survey report from Healthwatch Warrington
[18] Because of this limited evidence base (see also 2.2.2 and 2.5) the findings cannot be generalised, and the case study descriptions are used for illustrative purposes only. Similarly, staff members' perspectives on patient/carer experiences are not intended to represent the experience of patients and carers themselves.

5.1 Patient/carer experiences of the pathway

5.1.1 Patients and carers were positive about the care received and the avoidance of a hospital admission

Interviews were conducted with the following:

- One patient in Dorset (with osteoarthritis, vertigo and a history of falls) was referred due to a fall
- One patient from HER, (an elderly resident from Hull with COPD) was referred for a chest infection
- In NWL, a carer discussed the experiences of a patient (a woman in her 80s) who had experienced a fall while attending a hospital appointment and who had received support from one of NWL's 2-hour UCR (borough rapid response) services soon after returning home after being referred by the hospital.
- In West Kent, a care home manager discussed the 2-hour UCR service in relation to two residents: one who had caught a COVID-19 infection and then became suddenly unwell; and another with respiratory difficulties who had a sudden deterioration in their health, which led their GP to suspect that they may have had a stroke.

All the patients and carers were happy with the assessment and treatment provided by the 2-hour UCR team and both patients felt happier and/or safer for not having to attend hospital. This mirrors a patient case study collected by MSE (see Box 11:) and survey feedback collected by Healthwatch Warrington (see Box 12:).

The main thing is [the 2-hour UCR team] were very well-prepared and they knew exactly what they were doing, [they found it] easy to diagnose, easy to assess the situation of the residents and there was no confusion."

West Kent | Carer

Box 11: Patient case study provided by MSE – Mr A

- Mr A is a resident of South Essex. Despite ongoing health problems, he describes himself as independent and active. After being discharged from a recent trip to the hospital, Mr A experienced some issues with a catheter while at home and had to call for an ambulance.

On receiving Mr A's call, the ambulance control centre ascertained he had all the classic symptoms of a urine infection or UTI. They were able to contact the 2-hour UCR team who visited him in his house and were able to meet his individual needs based on his history. A medicine review was undertaken, and they planned arrangements for him to see a catheter expert; Mr A was monitored for the following days to make sure he was improving.

"They treated me as a human being, they were kind and supportive, and just wonderful. I know what sitting in A&E is like and they were sensational; experts in care and going above and beyond for me. They stayed with me to make sure I received the right medication for my needs."

Box 12: Warrington's survey of patient experience

Healthwatch Warrington carried out an independent telephone survey which obtained feedback from 79 service users who had used Warrington's 2-hour UCR service. As with the patients and carers interviewed, the vast majority of the feedback was overwhelmingly positive:

- 92% of respondents said that the service was 'very good' and 7% said the service was 'good'
- 99% of respondents said that staff were professional
- 99% of respondents said that staff were compassionate.

5.1.2 Patients and carers were mostly happy with the access routes and timing of the response received with some concerns raised relating to accessing the team via 111 and lack of direct care home referral routes

In terms of access to the 2-hour UCR service, both carers were happy with the timing of the response from the 2-hour UCR team and in HER, the patient's relative spoke to a 2-hour UCR doctor after only a short wait. 97% of respondents from Warrington's Healthwatch survey agreed that the service responded in a timely way.

"They arrived on time. I didn't have to wait for them…My nurses and my carers felt like they'd been very much supported. Really, I was very grateful for what they have done on that day, and within minutes.

West Kent | Carer

However, the patient in Dorset reported that their neighbour, who had called 111 on their behalf, had waited four hours to get through (the referral route to UCR). The long wait caused concern for the patient due to the inconvenience to their neighbour. There is a national ambition to optimise referral routes through a SPOA and learning from sites on how improving referral pathways will be explored throughout the evaluation.

Both the care home manager from West Kent and carer from NWL reported that they would like easier access to the 2-hour UCR team to enable them to contact the 2-hour UCR team directly (as both first contacted primary care). Healthwatch Warrington survey respondents also indicated that they would have liked to know about the service beforehand to assist with self-referral. The carer in NWL also suggested that it would have been useful if the responding team had provided them with advice in a written format.

5.2 Staff views of the benefits and challenges for patients and carers

Staff who participated in the case study research reported additional benefits and challenges for patients and their carers.

5.2.1 Receiving care at home is particularly beneficial for preventing deterioration among a range of different patient groups and providing reassurance and respect to end-of-life patients

Staff agreed that, as envisioned by the national guidance, providing high quality care and treatment at home does prevent deterioration by preventing admissions - particularly beneficial for dementia patients, patients with complex needs, patients with mobility problems and elderly patients who may be concerned about hospital-acquired infection.

There was a shared view that being able to stay at home was particularly beneficial for end-of-life patients, enabling them to spend their last hours with their family at home. In addition, staff highlighted the reassurance that 2-hour UCR services provide for patients and carers, knowing that they will be able to receive medical help in their home.

5.2.2 The multi-disciplinary, holistic approach of 2-hour UCR is enables patients and carers to be more involved in, and make decisions about, their care

By providing access to a multidisciplinary team, but at home (as opposed to within a more specialist acute setting) interviewees felt that patients have more agency to make decisions about their care, while carers can also have more involvement and influence. Staff felt that it is beneficial for carers that they can also get support for their own needs.

> *"Being able to be around their patient, their relative who they're living with, to be able to be involved in and support their treatment and care, be part of the conversation, to have some support and influence over what is happening to their loved one."*
>
> **West Kent | Role: Strategic**

5.2.3 Staff raised concerns about access challenges for patients without care support or for whom English is not a first language

Some participants were concerned about the accessibility of 2-hour UCR services for patients who do not have carer support; or who may not want to be a burden on services. In LLR, participants reported that the diversity of Leicester City's communities means that language can be a barrier where the patient (and or their family/carer) does not have English as a home language. To mitigate this, responders use translation apps on their smart phones. However, these challenges may result in inequalities in access to 2-hour UCR services (health inequalities are discussed further in section 6.4).

5.2.4 The involvement of a range of professionals as part of a 2-hour UCR response can risk overwhelming some patients

Some staff highlighted the possibility that patients may feel overwhelmed when having lots of health and social care professionals visiting their home in a short period of time.

"[The service] almost overload[s] people because we … need to be done and dusted within forty-eight [hours]. Sometimes people are [a] bit overwhelmed, because [we're saying] "…[I'll] come see you now, do the assessment, one of my colleagues will be back in a couple of hours to deliver the equipment, somebody else will be out probably tomorrow to set up your falls pendant [alarm], somebody else is going to come out a day after to come and put [a second stair] rail up"

Warrington: | Role: Frontline

5.2.5 Social care resource limitations and low awareness of 2-hour UCR services among the general public may still be leading to emergency or hospital admissions.

Staff also reported that the challenges in providing bridging support for patients who require urgent social care support (described in 4.2.9) are sometimes leading to hospital admission until a care packages can be arranged.

Staff from across the case study sites also shared a concern that at times, patients and carers did not know about the service until the 2-hour UCR responders arrived in the patient's home. It was suggested that wider promotion is needed to ensure the service is providing appropriate support including for carers where unmet need could drive admissions to emergency care – or lead to UCR referrals for problems that could have been identified earlier elsewhere in local systems.

"Carers [and] a lot of relatives of the patients don't know our service until we go out. [We rely] on the healthcare professional that's spoken with that patient or seen that patient [to communicate about UCR]… we go out [and] they go 'Oh, we didn't know you existed'… they're probably not aware of us until they get referred in by someone else."

MSE: | Role: Frontline

5.3 Collecting 2-hour UCR patient and carer feedback

5.3.1 Case study sites described a range of different patient feedback mechanisms but overall reported this as particularly challenging

Patient and carer feedback is collected by several methods, including written feedback, surveys and a text message system (see Box 13:). However, collecting feedback was often described by interviewees as particularly challenging for 2-hour UCR services. One key reason given was that by nature, the patient cohort served by 2-hour UCR are often living with frailty and long-term conditions; at the time of, or shortly after their response support they may be acutely unwell and therefore it may be deemed inappropriate to ask for

feedback. Alternatively, patients may not be mentally capable of giving informed consent or have carers available to provide feedback on their behalf.

Strategic interviewees across case study sites identified that in their experience patients who have a negative experience may not give consent to be contacted, introducing bias into feedback reporting. They also described issues accessing the information governance expertise and resources required to collect and analyse patient feedback.

Where mechanisms are in place, sites described ways of using feedback for continuous learning or service improvement. For example, Dorset, NWL, LLR and West Kent participants described how patient feedback is discussed with colleagues or in team meetings to identify ways of improving patient experience or changing the service.

We wouldn't just sit on our laurels and let that [patient feedback] go by. We will talk to all our colleagues and make sure we revisit the situation and take whatever action is necessary to make sure we provide the right level of service."

LLR | Role: Strategic

Box 13: Patient feedback mechanisms

- Responders in Dorset, LLR and West Kent take feedback forms to patients when they visit
- Surveys are used in Warrington and Dorset, via a text message system after their contact with patients
- NWL and LLR gather feedback through post-discharge phone calls. In West Kent patients are supported to complete the feedback form via telephone
- In Dorset, volunteers from PramaLife (Dorset 2-hour UCR's voluntary sector partner) call patients a week after the response to establish whether further support is needed, and to complete a feedback questionnaire
- Warrington commissioned Healthwatch to conduct an independent assessment of patient satisfaction (see Box 12:).

6. Impact on local health and care systems

Section summary

This section explores the impact of 2-hour UCR on the local health and care system, related to: the benefits and challenges of the 2-hour standard; how data is being used to monitor service provision; the impact on health and system outcomes; and future discusses the changes case study sites planned to develop their service at scale.

Key findings

- **2-hour UCR is removing pressure from key health and social care services, including reducing emergency admissions**
- **For some case study sites though overlaps in remit with other services have created pressure points elsewhere**
- **The majority of interviewees felt that the two-hour timeframe is an appropriate standard due to the benefits it has for patients and other health services**
- **Some interviewees were keener to see the service focus on clinical need and keeping people out of hospital**
- **Developing a local dashboard or other data analysis tools has driven quality improvement by enabling analysis of the patient pathway for the majority of case study sites**
- **Sites are working with external providers of training to improve the quality of the data they submit to CSDS**
- **There were mixed views on whether 2-hour UCR services are providing equitable access to services**
- **The data available at a local and national level makes it currently difficult to establish the impact of 2-hour UCR on health inequalities**
- **Expanding referral routes into 2-hour UCR services is key priority focus area for service development, particularly in relation to 111 and 999 and self-referral**
- **Other key areas for development include introducing additional support services to reduce inappropriate referrals; workforce development, relationships with virtual wards and IT solutions**

6.1 Benefits and challenges of the 2-hour UCR standard for health and care services

6.1.1 2-hour UCR is removing pressure from key health and social care services, including reducing emergency admissions

There is consensus across the case studies that 2-hour UCR is having a positive impact on their wider health system, particularly in relation to removing pressure from other health and social care services (for example, accident and emergency, ambulance, hospital, GPs, social care, care agencies) by reducing unplanned admissions and providing care in the community setting. For example, in HER and West Kent, stakeholders described local data analysis which demonstrates that 2-hour UCR reduces accident and emergency attendances for patients who do not require critical secondary care as paramedics are provided with clinical support at the point of referral, which subsequently reduces pressure felt by accident and emergency staff. In LLR, one 2-hour UCR team evaluation participant described that out of 1500 calls for falls, only 5% needed to go on to require admission.

6.1.2 For some case study sites though overlaps in remit with other services have created pressure points elsewhere

Whilst relieving pressure on a range of key services some case study sites raised concerns about overlaps with other services in terms of the recruitment pools and where they have continued to run in parallel with 2-hour UCR services. For example, in Dorset, participants described how 2-hour UCR staff have been recruited from other parts of the health system, such as urgent care, which is reported to have created staff shortages in those services. This is largely due to the difficulties in recruiting new healthcare staff that have the required skill set for the response role – developed in providing other, related, services.

"We're all fishing in the same pool, aren't we? So, you take people with more of an urgent care background from urgent care services, and you leave a vacancy there by moving somebody over."
HER I Role: Clinical

Issues arising from service overlap was reported most often in sites where 2-hour UCR staff do not have access to patient health and social care records, making it difficult for 2-hour UCR staff to know of other services a patient may be receiving or awaiting a package of care from. Staff in HER and Dorset also identified how 2-hour UCR has unintentionally created demand pressures on community and social care providers (such as community-based rehabilitation teams through onward referrals for follow-up care).

6.2 Views on the two-hour response time

6.2.1 The majority of interviewees felt that the two-hour timeframe is an appropriate standard due to the benefits it has for patients and other health services

Sites identified that the two-hour response time allows patients to receive timely urgent care frees-up other health services such as ambulance response; and reduces the likelihood of patients deteriorating whilst waiting for an ambulance response and therefore reducing their admission to hospital. The two-hour UCR standard is seen to be particularly relevant for non-emergency referrals such as requests for diagnostic blood tests from a GP, or onward referrals to social care provision.

6.2.2 Some interviewees were keener to see the service focus on clinical need and keeping people out of hospital

However, there were examples of some participants questioning whether the two-hour standard is appropriate. Although not described as targets by the national guidance, one interviewee described their concerns that a misconception of the standard as a target may unintentionally lead to some staff prioritising response times over the clinical needs of a patient. Other interviewees argued that response time should match the patient and, instead of strictly focusing on the time of response, the sole focus should be on keeping people out of hospital. There were examples of some participants considering further work necessary to agree system-wide what requires a two-hour response and what can be responded to safely outside of this timeframe while retaining the focus on preventing admission. The clinical conditions and situations which warrant a 2-hour response will be a key issue further explored by the evaluation.

"One of my frustrations is people describe them as targets, and they're not targets, they're standards of care. I think target implies it's almost like a sales target. Whereas actually this is a standard of care. I think it's really helpful having that standard. It's focussed people's minds and it's made us go off and do some of those changes to pathways, re-look at some of the resources, re-allocate resources and just re-design."

West Kent I Role: Strategic

6.3 Using data to monitor service provision

6.3.1 Developing a local dashboard or other data analysis tools has driven quality improvement by enabling analysis of the patient pathway for the majority of case study sites

Six of the seven sites have developed dashboards or other local data tools to monitor their local data and analyse specific parts of the patient pathway. This is particularly important

for the sites who have struggled to submit CSDS returns or with interoperability of health and social care systems.

These sites are also using local data to explore the impact of 2-hour UCR on other parts of the healthcare system, for example the avoidance of hospital admissions, and have invested in improving the quality of data collection both for national reporting through CSDS and for local learning.

For example, to support their social care teams to collect relevant 2-hour UCR performance data, LLR ICB have developed bespoke data collection tools for local authority staff to mitigate challenges related to interoperability, and to ensure that data can be submitted to CSDS on their behalf.

Other benefits of good quality data collection and reporting identified were enabling internal auditing; providing understand workforce capacity and demand; and supporting future business cases.

6.3.2 Sites are working with external providers of training to improve the quality of the data they submit to CSDS

Some sites described training activities established to ensure the data they input into CSDS is to a high standard. For example, Dorset have worked with Wessex Academic Health Science Network (AHSN) to develop 2-hour UCR education toolkits for staff. In West Kent, staff received training from the providers of their data inputting system to improve their knowledge on how the system works, and how to enter data correctly.

"We gave ourselves enough time to really support the team and monitor their data, so that we could regularly update them, we wanted the data on a weekly basis…So we can bolster them and give them the support that they needed, or training, or the information perhaps, because they've missed it."

***West Kent* | Role: Strategic**

6.4 Impact on health and system outcomes

6.4.1 There were mixed views on whether 2-hour UCR services are providing equitable access to services

Across the sites, many participants agree that 2-hour UCR is having a positive impact on health inequalities. For most, this centres on how they perceive the accessibility of 2-hour UCR to an all-adult patient cohort. It may also identify early treatment needs through the crisis response that prevent longer-term problems developing. However, some described how the 2-hour UCR service may not meet the needs of patients equitably. For example, participants across different case study sites highlighted how the service may not reach all

patients, especially those from ethnic minority backgrounds who do not speak English or those who are not registered with a GP. The rural location of some services, such as Dorset and MSE, means that patients may also have unequal access to services compared to patients in urban locations with more available provision. Further work will be needed by case study sites to understand equalities impacts.

"I'm not an expert on who is around but I would say it is difficult when you do get somebody who doesn't speak English. I would say it's very difficult. I would wonder whether there are people who don't speak English very well that can't access our service for whatever reason and probably might get sent straight into hospital."

HER | Role: Clinical

6.4.2 The data available at a local and national level makes it currently difficult to establish the impact of 2-hour UCR on health inequalities

Some participants identified the need for more local service user data to determine who is receiving a response from 2-hour UCR compared with other services, in order to identify potential barriers patients may still be facing. As data quality at a local level improves this will be a key area for case study sites (and all 2-hour UCR services) to explore.

The national and localised CSDS data also provides a mixed picture (see Table 6.1): [19]

- 28% of all submitted 2-hour UCR referrals nationally come from the three most deprived deciles and 30% from the three least deprived deciles
- 61% of all national referrals are from the White ethnic group with 10% not recorded (percentages rounded, July 2022)
- Most sites have a majority of referrals from the White Ethnic Group although HER, MSE and Warrington have high levels of missing data. The exceptions are LLR and NWL, reflecting their diverse communities
- LLR, MSE and Warrington all had a greater proportion of referrals from the most deprived areas (although Warrington has a high level of missing data); HER had more referrals from least deprived areas.

Given the data quality issues and the current lack of disaggregated service usage data at a local level available from case study sites it is not possible to make firm conclusions on what difference 2-hour UCR is making to health inequalities. However as delivery matures,

[19] Note that at the time of analysis Dorset and Warrington had only recently begun submitting data.

it will be increasingly possible for the evaluation to draw conclusions from trends in the data; and to conduct the evaluation impact analysis in 2024.

Table 6.1 CSDS data on deprivation and ethnicity, by case study site

Site	Number of referrals	% Referrals from the three most deprived deciles	% Referrals from the three least deprived deciles	Referrals from White Ethnic Group	Referrals from other ethnic groups[20]
National data	*44.465*	*28%*	*30%*	*61%*	*30% (10% not recorded)*
Dorset	5	Data not available at this level		100%	0%
HER	195	44%	25%	44%	3% (54% not recorded)
LLR	580	22%	36%	83%	16%
MSE	1,610	11%	36%	21%	2% (26% not recorded)
NWL	965	23%	23%	53%	46% (0.5% not recorded)
Warrington	80	15% (35% not recorded)	35%	47%	23.5% (29% not recorded)
West Kent	Data only available for Kent (East and West Kent)				

6.5 Looking ahead

Sites identified a range of future initiatives in the short and medium term to develop the service at scale from the current provision.

6.5.1 Expanding referral routes into 2-hour UCR services is key priority focus area for service development, particularly in relation to 111 and 999 and self-referral

Five of seven case study areas described the changes they intend to implement to increase and improve 2-hour UCR referral processes. Warrington, West Kent and HER are all aiming to increase the number of referrals routes as a priority for the future (essential for HER as

[20] For this calculation all non-white ethnic groups have been grouped together. The 2-hour UCR dashboard providers a breakdown across all of these groups, and includes 'Other Ethnic Groups' which is not the category reported here

they develop the face-to-face team). HER plan to first expand the urgent care response team and then its referral base to other sources, for example, working closely with the ambulance service to develop a 'pull' or 'push' model. Similarly, MSE are planning to train clinical staff to be based in EEAST and 111 so they can 'pull' referrals directly from the stack in order to develop a pre-clinical triage SOP to 'push' calls from the 999 stack.

Warrington plan to build a direct online referral system for GPs in SystmOne, as well and take referrals directly from residential and nursing homes. In MSE, staff are planning a phased opening of the SPA referrals from care homes to manage expected increases in service demand.

Across the case studies the plans to widen referral, including self-referral, were planned in conjunction with growing the service capacity to respond, building their workforce, partnerships and securing high quality, clinically safe provision.

6.5.2 Other key areas for development include introducing additional support services to reduce inappropriate referrals, workforce development, relationships with virtual wards and IT solutions

Some of the other key areas for future development include:

- **Service redesign initiatives to support appropriate referrals:** for example, Dorset are planning to develop a 48-hour response service for patients with less acute needs, and for those with an urgent need for rehabilitation and/or reablement. Warrington plan to introduce a 'One Front Door' designed to act as SPOA for all services at place level to ensure only patients in need of urgent care are referred to 2-hour UCR
- **Workforce development:** most sites are planning to recruit staff to increase the capacity of their services, and to expand their team skills so that they can respond to complex cases. This includes pharmacists to help nursing staff to review and manage medications for patients with comorbidities (Warrington) and Physician Associates and therapy staff who can support the management of patients (West Kent).). Dorset plan to train care home staff to assist patients following a fall, to reduce the need for an ambulance response
- **Developing integration with virtual wards and other partner services:** case study sites identified the need to improve integration with other services, particularly related to social care, mental health, intermediate care and specialist care. Participants in HER, Hull, Warrington and West Kent identified future plans to integrate with virtual wards in order to improve follow-up support for patients and reduce admissions to hospital. For example, participants in HER highlighted that collaborative working with virtual wards will allow 2-hour UCR teams to help identify patients who would benefit from

clinical care at home, such as IV antibiotics and fluids, aiding planned and unplanned care flows and reduce reliance on district nurses and bedded units

- **IT systems:** Dorset are developing an interoperability toolkit to enable referrals to be sent automatically to the 2-hour UCR service from 111 and 999. In Warrington, staff plan to build a direct online referral system for GPs in SystmOne.

7. Conclusions and recommendations

Section summary

This section provides a short summary of the data collection and analysis that forms the basis of the report, the key findings from the first round of qualitative research and the evaluation team recommendations. It also provides an outline of the next steps for the evaluation.

Conclusions

- Almost all of the sites are meeting the minimum standard, with a variety of models developed from local provision. The exception is HER which meets the core of the standard but does not yet provide a multi-disciplinary in-person response team
- Some key developments are required in HER to move beyond a virtual service for patients and support for paramedics and other clinicians in the community
- There are common workforce challenges across the case studies, with recruitment and retention impacted by the requirements of 2-hour UCR roles and wider issues linked to the cost of living
- The ability to provide a comprehensive service, including follow-on holistic support is impacted by the capacity of partners (sometimes limited to those engaged to date
- There is wide support for the service model and two-hour standard, seen to bring benefits for both health and care systems and patients
- Key areas for development include establishing push/pull models with 111/999 services, effective delivery with virtual wards, and improving data collection and tools for analysis.

Recommendations

- **For ICSs and 2-hour UCR services** include: developing effective mechanisms for collecting patient/carer feedback; mapping local provision to inform a programme of partner and stakeholder engagement; exploring creative solutions for shared workforce challenges, invest in data collection and analysis – to develop plans for provision at scale
- **For NHSE and the regions** include continuing to facilitate learning (regions, NHSE), and providing additional guidance on effective working with 111/999 and virtual wards (NHSE).

7.1 National evaluation of 2-hour UCR

This evaluation report presents findings from the first round of qualitative research with seven case study 2-hour UCR services. The case study sites were selected to reflect a range of different delivery models and include both ICS and place-based approaches, across rural

and urban geographies in England. Impact and economic analysis will take place at the end of the evaluation period (2024).

The research took place from June-August 2022 and involved 100 qualitative interviews (c15 per case study site) with a range of stakeholders from strategic to front-line roles. There were challenges engaging with patients and carers and few case studies had routine mechanisms in place for collecting patient feedback. Two patients and two carers participated in qualitative interviews as part of the research and two case study sites provided feedback that they had collected. This is a limitation of this report.

Although a robust approach has been taken to the analysis of the qualitative data collected, it can only reflect the views, perspectives and experiences of the participants – it is not statistically representative in the way that quantitative data analysis, including surveys, can be. These limitations apply to all qualitative data collection and analysis and should be borne in mind when reading this report.

7.2 Conclusions

Six of the case study sites have developed a service that meets the minimum standard detailed in the 2021 NHSE guidance. The seventh, HER, has a telephone-based service providing advice to paramedics and other practitioners in the community with a more limited face-to-face UCR response. All have seven-day provision, 8am-8pm and five go beyond this. There have been two core approaches (sometimes blended): bringing different services together to provide a new, consistent model; or taking an existing service to scale across a new geography. As a result, there is a range of different delivery models, with different workforce characteristics and different modes of response, reflecting their previous prevision and development of a service appropriate to local context. There is a unique approach in Dorset, which has a mobile service with equipped vans providing coverage of this large rural area, away from but coordinated by the service hub.

The majority of models bring together a multi-disciplinary team to provide a face-to-face response within two hours. Again, the exception is HER where the service primarily provides telephone and virtual support to patients, and advice and guidance to paramedics and clinicians in the community. This site meets the core of the minimum standard, but some key developments are required to provide a model that responds to patients with in-person support. Although the service makes use of existing responder capacity across the system and has used 2-hour UCR funding to increase the number of therapy nurses to support more equitable provision across the geography, the model

requires further development to expand provision to provide a service which reduces existing system demands and meet the aims of the 2-hour UCR standard.

Across the different service models, there are common workforce challenges. Sites reported that challenges with recruitment and retention hampered their ability to develop the service and were barriers to delivery at scale. There are two key components: 2-hour UCR requires out-of-hours working, making other roles with more standard hours more attractive; and the shortage of staff with the combination of necessary specialist (for example therapy) and more general (for example multi-disciplinary working) skills. Concerns about the impact on other local services where staff left to join UCR were also raised. Some sites have developed innovative schemes such as blended roles to aid recruitment, aiming to make them more attractive. There were also issues around pay and other features impacting health and care workforce that are not unique to 2-hour UCR (cost of living).

Another common challenge is providing follow-on, holistic support, which is impacted by the capacity of other partners, and particularly social care. A minority of the case studies have social care services embedded within their delivery model. The limited capacity of social care was reported as a common issue across sites and this can cause delays in putting care packages in place where these are identified through the two-hour response. Some teams have access to voluntary and community sector provision. Some are able to provide bridging or follow-on care; for others, this impacts on their capacity for new referrals.

There is wide support for the 2-hour UCR standard and service model. It is understood to be removing pressure in health and social care by reducing unplanned admissions, providing care in the community and enhancing cross-system working. There is broad support for the two-hour standard, described as driving a rapid response that avoids admissions, bringing benefits for patients in being treated at home and preventing deterioration. Nonetheless, some questions were raised about whether the timeframe is appropriate for all referrals and whether more work is required locally to define the criteria for a two-hour response.

There are some key common areas for the case study sites to address in developing their 2-hour UCR services to meet the full requirements of the standard:

- Links with 111/999 services are underdeveloped, with limited push/pull models in place across the case study sites. The importance of establishing this element of the service has been further emphasised in additional guidance 2022 and is essential for meeting the ambitions of the standard

- Working effectively with virtual wards is another key area for development, which has taken on more prominence as a priority for meeting winter pressures
- Most sites have further work to do in developing a system-wide model at scale, working with complementary provision in partnership to provide holistic, follow-on support and to meet, and go beyond, the nine conditions – including exploring solutions to workforce challenges
- Ensuring high quality CSDS submission is a challenge across several sites. There are issues for place-based models in using CSDS because it is collected and reported at a system level. Nonetheless some case studies have invested in dashboards and other tools for local performance management.

7.3 Recommendations

From the analysis presented in this report, and drawing on the reflections of participants at a national evaluation learning event in presenting the key findings in October 2022, the evaluation team make the following recommendations, to address the key common area identified above:

7.3.1 Recommendations for ICSs and 2-hour UCR services

- **Map local partners and their provision to inform a programme of engagement**. 2-hour UCR works best when referral criteria into – and the role of – the service is widely known and understood, and the landscape of local provision (both statutory services and those provided by the voluntary and community sectors) that can support the service works in partnership to provide follow-on and other care to support UCR response. ICS leaders with responsibility for 2-hour UCR should ensure that their local service:
  - Systematically maps relevant local partners and their engagement to date; and
  - Engage all partners to both understand their provision and agree their role in a system-wide approach.
- As services explore how they can develop at scale, effective stakeholder engagement will provide the necessary foundations of shared understandings (including definitions of appropriate referrals) and agreed ways of working to deliver shared goals for ICS and patient outcomes. ICS leaders with responsibility for 2-hour UCR should facilitate and support this across their system.
- **Explore solutions to shared workforce challenges.** To address competing demands for staff across health and care services, ICS should explore how shared solutions

might be found to ensure a sufficient workforce for 2-hour UCR. For instance, through new blended roles across different services and extending the 2-hour UCR model through a wider network of provision. The newly published Virtual Ward and Urgent Community Response Capabilities Framework21 may provide one solution to a shared approach across these two key priorities for ICS planning. ICSs should also explore use of capital or other system funding to support the workforce with resources for an efficient UCR service such as equipped vehicles or technology for point of care testing

- **Invest resources in data collection and analysis.** High quality CSDS data is essential for national and local performance monitoring and learning. Dashboards enable ICS and 2-hour UCR services to explore patterns in and outcomes from provision. ICSs should invest in ensuring data can be recorded (and shared) across partners for UCR monitoring, reporting and in support of joint working. Alongside driving improvements in CSDS, ICSs should explore how data from different sources can be linked to understand the patient journey. It will support reviews to refine which patients require a two-hour response, and which are appropriate for a different timeframe as well as identify bottlenecks, patient needs and associated workforce requirements and other key features for an effective system-wide response. It will also enable ICSs and their UCR services to understand ethnicity and other potential inequalities in their provision, and to take evidence informed steps to ensure an equitable service that meets the needs of all groups in their local communities
- **Identify where there is expertise for engaging patients (and their family/carers) accessing 2-hour UCR services.** 2-hour UCR teams can lack capacity – and expertise – to routinely collect feedback from patients and their family/carers following a two-hour response. Local voluntary and community sector partners, other health and care services working with this patient group, local Healthwatch organisations or other independent organisations can take on this role. Feedback should be collected regularly and used alongside performance data to evidence what works and why, and inform service improvement. 2-hour UCR leads should be supported by their ICS to identify and access and resource this expertise to embed this work in their provision
- **Develop plans for provision at scale.** Partner engagement to develop shared understandings and a network of provision, learning through a systematic approach to patient/carer feedback, addressing workforce challenges and investing in data collection and analysis will support planning for provision at scale. This includes

[21] Skills for Health October 2022 https://www.skillsforhealth.org.uk/info-hub/virtual-wards-and-urgent-community-response-framework/

extending operating hours (including through work with partner provision), expanding referral routes, and developing work with 111/999 and virtual wards.

7.3.2 Recommendations for NHSE and the regions

- **Regional leads should continue to facilitate learning across their ICSs.** There is an appetite from 2-hour UCR services to share their learning and to learn from others, as well as to explore solutions to shared challenges. Ambulance trusts span multiple ICS and a common approach to push and pull would bring benefits: for them in terms of a consistent way of working; and for 2-hour UCR in learning from what works where one or more services have developed a solution, or in working together to pilot, test and implement at scale. Other shared challenges for 2-hour UCR services include: standardising and linking data collection; joint working with virtual wards; gathering patient feedback for learning; recruiting and training staff; and delivery across large rural or dense urban geographies
- **NHSE should continue to provide guidance and learning.** Guidance about working with 111/999 and virtual wards are two important areas where practical learning would be of benefit to ICSs in meeting the standard. Two similarly important, inter-related, areas are ensuring quality in CSDS submission and linking local datasets for performance monitoring and management. Examples for these areas could be identified through the mechanisms in place for regional learning, with guidance provided on principles for effective practice in meeting national requirements. NHSE could identify good practice in addressing challenges with CSDS, and examples of effective data integration, to share as guidance. In addition, national learning events will have an important role alongside regional forums to share practice and drive service improvements.

8. Next steps for the evaluation

The final round of qualitative research will take place in autumn 2023, establishing learning from the further development of 2-hour UCR services in the seven case study sites. In addition to exploring how the features of each model have been developed since round 1 as services mature and are taken to scale, a key focus will be learning from work to address the key issues reflected in the recommendations in this report and plans for winter pressures, learning from 2022/2023:

- Working with 111/999 services
- Working with virtual wards
- Addressing workforce challenges
- Improving CSDS data collection and data linkage
- Working with the voluntary and community sector, including for patient engagement.

The findings from the research and analysis will become available in spring 2024. That will include the impact and economic analysis, which will be further developed and tested during 2023.

Annex 1: Glossary

111 – The national NHS telephone and online service for support with an urgent healthcare need that is not life threatening.

2-hour UCR – 2-hour urgent community response.

999 – The national telephone number for emergency response.

A & E – Accident and Emergency.

Accelerator programme – NHS England 2-year programme launched with 7 sites in 2020 to inform national roll-out of urgent community response and the operating guidance. Sites worked towards meeting the minimal requirements, including achieving the 2-hour standard for at least 80% or more of referrals by October 2021.

ACP – Advanced Clinical Practitioner – a healthcare professional (for example a nurse, pharmacist, paramedic or occupational therapist) who has undertaken Master's level training to allow them to take on expanded roles and scope of practice caring for patients.

Category 3 and Category 4 calls[22] (Cat 3/4) – Ambulance response categories used for each call from a patient to the service. The category of the call determines the type of treatment and response time:

- Category 3 ambulance calls are classified as urgent, not immediately life-threatening but that need treatment to relieve suffering (for example., pain control) and transport or clinical assessment and management at the scene
- Category 4 ambulance calls are for incidents that are not urgent but need assessment (face-to-face or telephone), and possibly transport, within a clinically appropriate timeframe

Clock start – the start time of an urgent community response referral, which is recorded and used as the starting point to measure whether the 2-hour response time has been met. More specific information can be found in the NHS Technical guidance on 2-hour UCR.

Clock stop – 'For all referral routes, the clock stop is the time at which crisis response is delivered by the appropriate health or social care worker' (NHS England, 2020). This time is recorded and

[22] The Nuffield Trust (2022), Ambulance response times, Available online at: https://www.nuffieldtrust.org.uk/resource/ambulance-response-times#background

used as the ending point when measuring whether the 2-hour response time standard has been met. More specific information can be found in the NHS Technical guidance on 2-hour UCR.

Coding – To classify data by a set of themes/topics to help organise and make sense of the data.

CSDS – Community Services Data Set – a secondary uses dataset containing patient-level information about people who are in contact with NHS-funded community health services.

HER – Hull and East Riding – one of the case-study sites included in this evaluation, providing 2-hour UCR services at a place-based level

ICB – Integrated Care Board – ICBs are statutory organisations that bring NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.

ICS – Integrated Care System – a geographically-based partnership of health and care organisations.

LLR – Leicester, Leicestershire and Rutland – one of the case study sites included in this evaluation, providing 2-hour UCR services at an ICS level.

MDT – Multi-disciplinary team (composed of professionals from different clinical and non-clinical backgrounds), required to deliver 2-hour UCR services.

MSE – Mid and South Essex – one of the case study sites included in this evaluation, providing 2-hour UCR services at an ICS level.

NHSE – NHS England.

NICE – The National Institute for Health and Care Excellence provides national guidance and advice to improve health and social care.

NWL – North West London – one of the case study sites included in this evaluation, providing 2-hour UCR services at an ICS level.

Palliative – Care and support offered to patients with a terminal illness to make them more comfortable and manage pain. May be referred to as end-of-life care.

PCN – Primary Care Network.

Phlebotomy – The procedure of taking blood samples for blood tests, carried out by phlebotomists.

Plan-do-study-act cycle – This is a way to test, change or implement a new service such as a UCR. This is done by planning the service, trying it out, evaluating it and using what has been learned to improve or inform the service.

Push/pull model- description of model for diverting referrals from the 111/999 call queue to 2-hour UCR either coming from 111/999 (push) or being identified and reallocated by 2-hour UCR staff (pull).

Reablement – Assisting people to re-learn skills needed for an independent lifestyle, for example cooking, to help people to continue living as they wish to. This includes brief interventions and home-based methods.

SOP – Standard operating procedures – a list of instructions for workers to carry out routine tasks in their organisation.

SPOA – Single point of access – team who review cases and decide best treatment pathway, for example whether the 2-hour UCR is an appropriate service for the patient. Referrals through the SPOA can usually be made by GPs, hospital staff, ambulance crews, nursing or residential homes etc.

Stack – Usually referred to as 999, 111 or ambulance call stack. This is a list of calls for the ambulance service. It has details about the patients and why they have called for urgent help. It is used to prioritise and determine what help patients need.

SystmOne – Internal data monitoring/recording system used by many healthcare services. It contains information about individual patients on (electronic healthcare records) and can be shared across services.

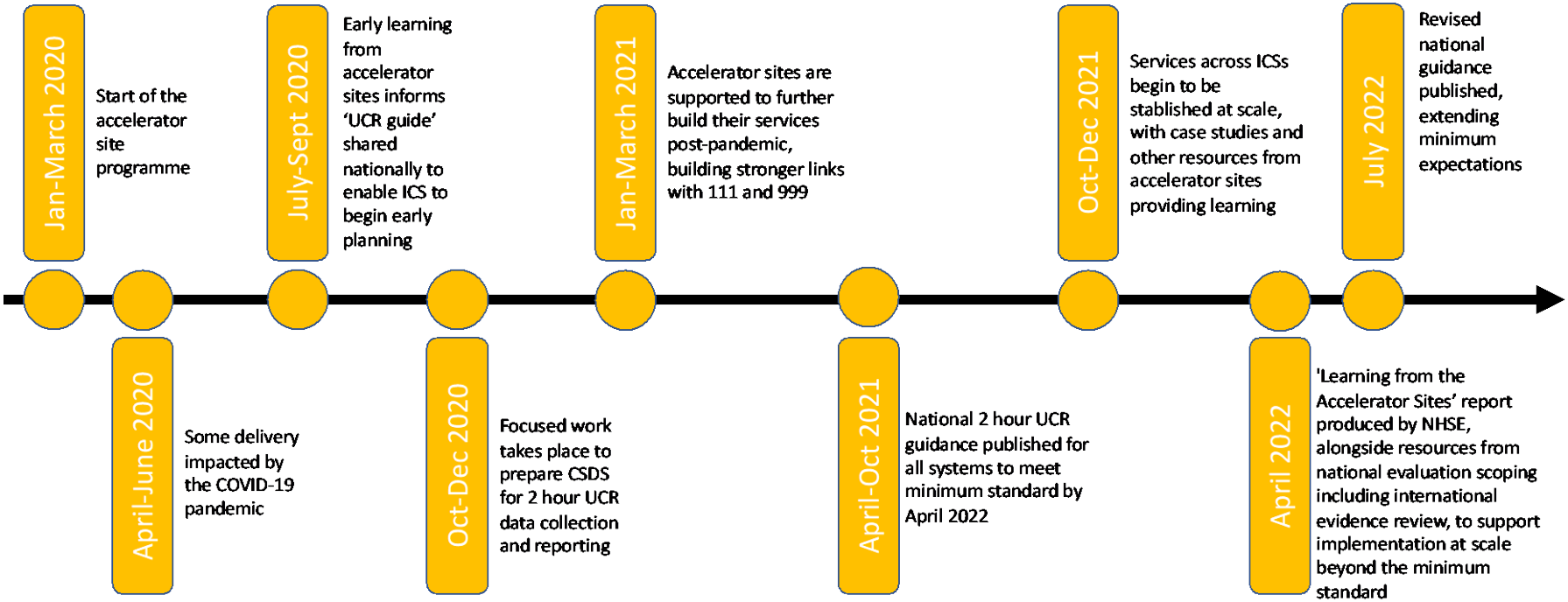
UCR – Urgent Community Response – a service that provides assessment, treatment and support to people over the age 18 in their own home or usual place of residence, who are experiencing a health or social care crisis (a sudden deterioration in their health and wellbeing) and are at risk of hospital admission within 2 to 24 hours. The care need requires urgent treatment or support within two hours and can be safely delivered in the home setting by multidisciplinary clinical and non-clinical teams.

West Kent – One of the case study sites included in this evaluation, providing 2-hour UCR services at a place-based level.

Annex 2: Timeline of 2-hour UCR implementation

Seven UCR accelerator sites were established in early 2020, one in each NSHE region, to provide early learning for national roll-out (as part of the Ageing Well programme). NHSE undertook a range of development activities with these sites to shape the 2021 guidance and provide learning resources for ICS. 0 presents a summary timeline of the accelerator site programme.

Figure A2.1 Timeline of 2-hour UCR development and implementation as part of the UCR accelerator site programme



Annex 3: Evaluation key lines of enquiry

Focus area	Evaluation questions
Operational learning	What are the features of a successful 2-hour UCR delivery model? To consider: • Geography • Patient populations • Existing service population • Patient pathway • Local Service provision (typology of model)
	What is considered a high quality 2-hour UCR service?
	What progress have sites made with implementation?
	Which process/other factors enable or block the achievement of: • Services which align with NSHEI guidance? • Provision that goes beyond the NHSEI guidance?
	What has been required in different sites to meet the national service requirements after April 2022?
	Which patients or conditions do sites consider require a two-hour response rather than a different level of response?
	How are patients' needs assessed, monitored and responded to and what are the reasons for these approaches?
	What do effective triage and referrals look like and what supports them? To consider: • Professional knowledge and confidence • Changes in patient behaviour
	Which (strategic and clinical) governance structures support system-wide delivery?
	What are the workforce requirements (roles, skills and knowledge, configurations and scale per head of population) for rapid response teams which meet community needs?
	What training does the workforce require to enable them to deliver this service and why?
Patient/carer outcomes	What are patients'/carers' experiences of the pathway from 111/referral to treatment? To consider: • Confidence in treatment experience • Views on effectiveness of triage and assessment at home • Experience of holistic approach • Perceptions of integration of services

	How are patients empowered to self-manage their conditions?
	What are the outcomes as a result of the programme for patients and/or carers? To consider: • Views of patients • Views of carers/families • Hospital admissions for individual 2-hour UCR teams • Impact of different implementation models • Impact of different timescales – is two hours correct? (to consider if different outcomes/impact for different times, for example 30 minutes, 4 hours)
	How are patients/carers involved in evaluation and system learning?
Healthcare service impact	What is the benefit or impact of two hours in particular as a waiting time? To consider: • Different contexts • Issues with measurement • Benefits for different stakeholder groups • Benefits for system as whole • Multidisciplinary working in particular • Local alternatives
	How is the CSDS used to drive and monitor service provision?
	What lessons have been learnt from delivering services which meet the NHSEI guidance?
	How did the introduction of additional requirements change which benefits are realised?
	What facilitates or acts as a barrier to: • Reallocation of resources to community provision • Shared understanding of risk • Integrated approach to delivery?
	How are health inequalities monitored and reviewed?
	What is the impact of the service on health inequalities? Consider barriers to access in particular.
	What infrastructure is required for effective system wide approaches?
	How effective has national support been and what could be improved?
	What impact has the 2-hour UCR programme had on emergency admissions to hospital and other agreed outcomes?
	Has the 2-hour UCR programme delivered a return on investment?

Annex 4: The nine conditions[23]

The national guidance identifies nine common clinical conditions or needs that may lead to a patient requiring an urgent two-hour response. Systems should respond to these nine conditions at a minimum, and it was not intended as an exhaustive list.

Condition/need	Supportive definition
Fall	With no apparent serious injury, including to the head, back, hip, or where able to rule out a fracture, and where there has been no loss of consciousness but where care/support is required within two hours to prevent hospital admission. 'Level 2' patients as defined in the Falls Response Governance Framework for NHS Ambulance Trusts falls response model should be responded to and supported by UCR teams. Lifting equipment and manual handling aids should be available to UCR teams to help a person who has fallen and needs support to get up from the floor.
Decompensation of frailty	A frailty-related condition which may result in loss of strength, speed, energy, activity, muscle mass, resilience to minor health strains and subsequent loss of independence. • Decompensation caused by a minor stressor event, such as a urinary tract infection (UTI), which can cause a sudden or disproportionate decline in function
Reduced function/ deconditioning/ reduced mobility	• The person may have a gradual change in functional ability or ability to manage at home and with activities of daily living. Mobility loss can also be sudden, leading to an acute need.
Palliative/end-of-life crisis support	If core palliative/end-of-life care services are not available to respond, a two-hour UCR service will help maintain a person close to the end of their life at home, offering symptom control/pain relief in line with a person's wishes.
Urgent equipment provision to support a person experiencing a crisis/at risk of hospital admission	Alongside an assessment, makes a person safe and optimises functional ability to support prevention of admission. A person should be made safe and ongoing care provided where appropriate by reablement or rehabilitation services

[23] NHSEI (2022) *Community health services two-hour crisis response standard: Guidance for providers of care, integrated care systems and clinical commissioning groups Version 2*

Confusion/delirium	Increased or new confusion, acute worsening of dementia and/or delirium (excluding sepsis requiring hospital admission13,14). The patient should be assessed, and physical health needs managed to establish the cause (e.g. UTI, cellulitis, pneumonia) so that their needs are managed safety at home.
Urgent catheter care	Where a person has a blocked catheter and/or pain from a catheter-related issue and is at risk of harm and has a very high risk of admission to hospital. Where a district nurse service does not have the capacity to respond or is part of the explicit function of the two-hour UCR team.
Urgent support for diabetes	Examples of this include urgent injections and where the person has experienced a hypoglycaemic episode (now resolved) or where blood sugar management is a concern, and the person is at risk of hospital admission as a result (excluding sepsis requiring hospital admission hyperglycaemia/ketoacidosis).
Unpaid carer breakdown which, if not resolved, will result in a healthcare crisis for the person they care for	Provide healthcare where a carer who meets a person's healthcare needs is no longer able to do this and the person they care for now requires a two-hour UCR. Where two-hour UCR teams identify social care needs rather than healthcare needs – for example, where carer stress means a carer is unable to provide safe care or where either the carer or cared for person is experiencing abuse or neglect – they should: • make an urgent referral to the relevant service where the two-hour UCR team does not have Care Act 2014 responsibilities • provide care in line with the Care Act 2014 where the two-hour UCR team does have Care Act responsibilities • work jointly with local authorities or care providers.

Annex 5: Evaluation methodology

Evaluation scoping

The evaluation was developed through two phases of scoping activity: an initial scoping study to explore options for a national evaluation of the 2-hour UCR standard; and then further work to refine the design within the option commissioned by NHSE.

Scoping study

NHSE commissioned the 2-hour Community Response Evaluation Scoping Study in early 2021, in preparation for the publication of national guidance and the minimum standard for all ICS to meet by March 2022.

The study aimed to identify key issues and challenges for the national evaluation and how these could be addressed for the three defined objectives for the evaluation, to provide: operational learning; evidence of patient and carer/family impact; and evidence of healthcare impact.

To explore the options for the national evaluation The Strategy Unit team:

- Carried out a rapid review of literature relating to urgent community response services with an aim of avoiding admission or ambulance conveyance, and produced a summary of key findings
- Held two participatory workshops with national and regional NHSE stakeholders, and leads from accelerator sites, to develop a set of logic models summarising key features of the programme[24] and the outputs and outcomes that will be delivered – leading to the identification of suggested evaluation questions
- Held telephone interviews with leads from two of the accelerator sites, to discuss the service model in their ICS and explore their perspectives on priorities and challenges for the evaluation
- Reviewed available datasets including CSDS fields to explore potential metrics for the impact evaluation of the national evaluation (and local performance management), and assessed the feasibility of different design options

[24] Three strands of activity were identified for successful implementation of the standard at scale, with a logic model developed for each: system development, workforce development, and service delivery

- Considered key aspects for the process strands to address within a mixed-method evaluation (section 5)
- Made recommendations about the final evaluation that should be commissioned.

On the basis of the report and recommendations, NHSE commissioned The Strategy Unit and partners Ipsos to provide a long-term (2022-2024), mixed method evaluation of the 2-hour UCR standard:

- With in-depth qualitative (process) evaluation with a sample of case studies across each of the seven NHSE regions to reflect different approaches
- Where development and delivery is followed over-time through ongoing qualitative data collection and analysis
- With formative reporting for learning during national implementation
- Including impact and economic evaluations, dependent on further work to establish what is feasible.

Main evaluation scoping activities

Further scoping activities were undertaken from November 2021 to March 2022 to further refine and develop the approach to the evaluation, through engagement with stakeholders at national, regional and local levels. Key activities are described in Table A5.1 below.

Table A5.1 Summary of main evaluation scoping activities

Activity	Detail
Key informant interviews	Interviews with key members of the national programme team, regional leads and three ICSs to explore progress with the implementation of the standard to date and priorities for the evaluation to address
Typology discussions and development of framework	Interviews with the seven regional leads to explore the approaches being taken by ICS across their geography The development of a typology of approaches, across key organising features: • Geography – to ensure a spread of different demographic contexts (large urban, suburban, coastal and majority rural) • Maturity in provision of services aligned with core aspects of UCR guidance: • 2-hour response times • 8am-8pm, seven days a week or extended hours • Single points of access • Single ICS or place-based models (different approaches within an ICS)

Activity	Detail
	• Particular progress in aspects of delivery including work with 111.
Evaluation framework development	An **Evaluation Framework** was developed, detailing the **key lines of enquiry** for each of the three identified objectives (**operational learning**; **evidence of patient and carer/family impact**; and **evidence of healthcare impact**) for the evaluation across the process (qualitative) and impact (quantitative) strands.

Process evaluation case studies

The Evaluation Framework established a process evaluation that would include three rounds of qualitative work with a sample of seven case studies, exploring implementation over time. This was then revised to:

- **Round 1:** May-July 2022, exploring early implementation (delayed and was conducted from June-August 2022)
- **Round 2:** September-November 2023, exploring learning from delivery at scale.

The evaluation was reduced to two rounds to allow sites to work through 2022/2023 winter pressures and to complete the final round before winter pressures 2023/2024, for spring 2024 final reporting.

Sampling

Through discussion with NHSE national and regional 2-hour UCR leads, the sample of seven case studies was agreed against the typology developed to include both ICS-wide and place-based (within an ICS) delivery models.

The lead at each ICS was contacted for an initial discussion about involvement in the evaluation, and then a meeting was held bringing together stakeholders from across that system with the evaluation team, NHSE and the regional lead.

These discussions confirmed the detail of the delivery model in that system, explored what participation would involve, identified an ICS lead for the evaluation, and agreed the focus of the evaluation at that ICS (ICS-wide or place-based).

Interview participants

The evaluation is designed to include a range of perspectives within each case study. The aim for each case study was to include 15 semi-structured qualitative interviews across the partners involved in delivering 2-hour UCR:

- **Strategic stakeholders:** for example, commissioners and senior leads in community services, secondary/urgent care, and the local authority
- **Frontline staff:** operational and clinical leads, clinicians and staff delivering the service.

The evaluation also aimed to include three-five interviews with patients and family/carer. Case study sites have found engaging patients and families/carers routinely difficult due to their frailty and health condition and these challenges have been mirrored in the evaluation (discussed in more detail in section 5.) A small number of interviews were achieved and this has been supplemented by some secondary materials provided by case study sites. Further work to explore how this element of the evaluation can be developed will continue so that more of these perspectives can be included in future findings.

Table A5.2 below lists the seven case study sites and the number of interviews completed including data included for patient and family/carer perspectives.

Table A5.2 Case study site details

Region	Site	Staff interviews completed	Service user/carer perspective
East	Mid- and South Essex (ICS)	15	1 patient case study *(provided by service)*
London	North West London (ICS)	13	1 family carer interview
Midlands	Leicester, Leicestershire and Rutland (ICS)	17	1 patient case study *(provided by service)*
North West	Warrington (place-based)	14	Healthwatch survey report *(provided by service)*
North East and Yorkshire	Hull and East Riding (place-based)	13	1 service user interview
South East	West Kent (place-based)	15	1 interview with care home worker re: 2 patients Service user survey data *(provided by service)*
South West	Dorset (ICS)	13	1 service user interview
Total		**100**	**4**
Aim		***105***	***21-35***

Analysis methodology

The qualitative data has been analysed using specialist NVivo software. The process followed established best practice[25] in involving a group of researchers to develop the coding framework, to include both deductive (codes developed to reflect the key line of enquiry) and inductive codes (codes developed through reading a sample of the data to reflect emerging themes). The methodology was peer-reviewed by internal experts at NHSE. In summary the process involved:

- Verbatim transcripts produced for each interview from audio recording were uploaded into NVivo
- A coding framework was developed by one of the Strategy Unit researchers to reflect deductive codes (for example, 'barriers' and 'enablers')
- The coding framework was applied to a sample of the transcripts by them and two other Strategy Unit researchers as a test
- The three researchers noted new codes (inductive coding) to reflect themes emerging in the data
- The researchers met to discuss the inductive codes identified and agreed a common set
- Researchers from the Strategy Unit and Ipsos then applied the codes to a new sample of transcripts, identifying any new codes required
- The researchers from both organisations met and agreed a final common set of codes – detailed in a code book with notes to support consistent application
- Researchers from both organisations involved in the evaluation applied codes to the full dataset.

The coded data was then used to write case study reports, which were structured by the deductive codes. These were shared with site leads for agreement (over points of accuracy) and to provide them with a resource for local learning.

Once the case study reports were agreed, they were imported into NVivo, and the coding frame applied using NVivo auto-coding function. This enabled the software to organise the content of the case studies as a dataset under the deductive coding headings (each deductive code including a number of thematic codes identified through the inductive process outlined above).

A researcher then organised this coded data from case study reports under the headings and subheadings of the report structure agreed with NHSE, which reflected the key lines of enquiry

[25] Bryman, A. and Burgess, B (Eds) (1994) *Analysing Qualitative Data,* London: Taylor & Francis

(operationalised through the deductive codes). The report authors then used this data to write the narrative of the report findings, returning to the coded transcripts dataset where necessary to provide more detail.

The headline findings to emerge from the analysis of case study reports were shared with the Evaluation Advisory Group and at a national learning event for 2-hour UCR leads from across each ICS in England, prior to the completion of this report.

The learning event was held to discuss the findings with stakeholders beyond the participating case study sites. They confirmed the key themes and provided suggestions for recommendations based on the analysis as well as identifying additional themes for exploration in year two of the qualitative work.

Economic modelling

It was agreed during the scoping stage that the evaluation team would develop an economic modelling tool to support local systems implementing the 2-hour UCR standard.

Two economic modelling tools have been developed:

- An **Excel tool** for operational managers (available here [link to be added]), which allows users to test different local scenarios using nationally held (CSDS and SUS) data and includes the option of uploading local data for more granular analysis
- A **system dynamics model** for expert users (ICS analysts), that allows all a more complex, nuanced analysis using specialist, open-source, software (Silco – available here). *[link to be added]*
- The tools enable different scenarios for patient flow across the 2-hour UCR pathway against a modelled counterfactual. The tools, with user guides and detailed discussion of the methodology for each, are available here. [link to be added]

Impact assessment: looking ahead

The scoping work for the evaluation (2.1.1) included an impact evaluation feasibility study. Establishing impacts is necessary for an economic evaluation, which explores costs and cost consequences. The feasibility study explored the availability of data for the programme outcomes, as established in the logic models and associated metrics framework. The most robust impact evaluation designs include a counterfactual (control group) – enabling the analysis to compare the outcomes achieved with what would have happened without the intervention (an experimental design).

Because the standard has been introduced across all systems at the same time, it is not possible to compare areas with the intervention (treatment group) with areas without it (control group). Therefore, historic data is required to compare trends in outcomes before and after the introduction of the standard, using quasi-experimental methods. However, the CSDS used to capture data for the standard has not collected high quality data consistently (with one aim for the implementation of the standard being to improve the quality of CSDS). The combination of historical data quality issues and the national implementation of the standard makes it difficult to identify suitable controls, at an individual person or provider level, who are not exposed to a 2-hour UCR service.

The study concluded that the most feasible method for addressing the impact evaluation question "*Have individual UCR Teams had any impact on emergency admissions to hospital and other outcomes?*" is likely to be an Interrupted Times Series (ITS) design. This projects the expected trend with actual trend following implementation.

Further work was required following this scoping stage to explore the availability of historical data with a subset of providers. The economic modelling work (2.3) has required detailed interrogation of the availability of data and options for data linkage (CSDS with admissions and other data held in the Secondary Uses Service (SUS) dataset). The final stage feasibility work will be completed before the end of 2022, for agreement with the Evaluation Advisory Group and developmental work including testing during 2023 and reported in the year 2 evaluation report.

Limitations

This report is based on qualitative interviews with a sample of 100 stakeholders at strategic and operational levels in sample of seven ICS delivering 2-hour UCR services. Although a robust approach has been taken to the analysis of this data, it can only reflect the views, perspectives and experiences of these participants. While samples were selected to reflect a range of delivery models and stakeholders within them – and the findings shared at a national learning event where they were confirmed as reflective of the key issues across systems – it is not statistically representative in the way that quantitative data analysis including surveys can be.

These limitations apply to all qualitative data collection and analysis and should be borne in mind when reading this report.

A further limitation is the small number of patient and family/carer interviews completed in the first round of case study research reported here. Work with case study sites to explore how this can be achieved in future rounds will continue, including learning from sites where engagement has begun, continuing that engagement on an ongoing basis rather than linking it to the wider stakeholder fieldwork at defined periods of time, learning from other evaluation teams working with similar patient groups, and building on local engagement where this is put in place.

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