

# **Urgent Community Response Learning Collaborative Webinar**

## **Urgent Community Response (UCR) Two-Hour Crisis Response and Ambulance Services: 100-day Challenge**

14<sup>th</sup> October 2021

NHS England and NHS Improvement



# What are we covering today?



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Discussion	Speaker
<b>Welcome and introduction</b>	<ul style="list-style-type: none"> <li>• Kathryn Evans – Deputy Director, Urgent Community Response, Community Services and Ageing Well, NHS England and Improvement</li> <li>• Sarah Whiterod – Delivery and Policy Senior Manager, Urgent Community Response, Community Services and Ageing Well, NHS England and Improvement</li> </ul>
<b>National perspectives on the importance of partnership working</b>	<ul style="list-style-type: none"> <li>• Professor Anthony Marsh – National Strategic Advisor of Ambulance Services, NHS England and Improvement</li> <li>• Dr Adrian Hayter – National Clinical Director for Older People and Integrated Person Centred Care, NHS England and Improvement</li> <li>• Dr Shelagh O’Riordan – Consultant Geriatrician and Chair, Community Geriatrics Special Interest Group for the British Geriatrics Society</li> </ul>
<b>Sharing local solutions and good practice examples.</b>	<ul style="list-style-type: none"> <li>• Caroline Williams – Associate Director – Integrated Care, Warrington</li> <li>• Rob Wood – Service Delivery Manager, Clinical Hub, North West Midlands Ambulance Service</li> <li>• Gary Lockley – Service Delivery Manager (Emergency Operations Centre Manager), East Midlands Ambulance Service</li> </ul>
<b>Question and answer session</b>	All speakers
<b>Break</b>	
<b>Interactive discussion using Mentimeter, including</b> <ul style="list-style-type: none"> <li>• overview of the 100-day project</li> <li>• pledges for the next 3 months</li> <li>• next steps</li> </ul>	<ul style="list-style-type: none"> <li>• Led by Rebecca Veazey – Delivery and Policy Lead, Urgent Community Response team, NHS England and Improvement.</li> </ul>
<b>Final reflections, next steps &amp; close</b>	<ul style="list-style-type: none"> <li>• Kath Evans, Deputy Director, Urgent Community Response, Community Services &amp; Ageing Well, NHS England and Improvement</li> </ul>

# Introduction

## What is a UCR 2-hr crisis response?

### Long Term Plan commitment:

- Community crisis response teams provide assessment, treatment and support (within two-hours) to people (over the age of 18) in their own home who are experiencing a health or social care crisis and who might otherwise be admitted to hospital.
- A multidisciplinary approach, with teams consisting of registered nurses, advanced clinical practitioners, physiotherapists, occupational therapists, support staff, social workers and paramedics and have support from other relevant professionals including GPs and geriatricians.
- Typical conditions suitable for a two-hour response, including but not limited to: fall, decompensation of frailty, reduced function/reduced mobility, urgent equipment provision, confusion/delirium, urgent catheter care, unpaid carer breakdown.

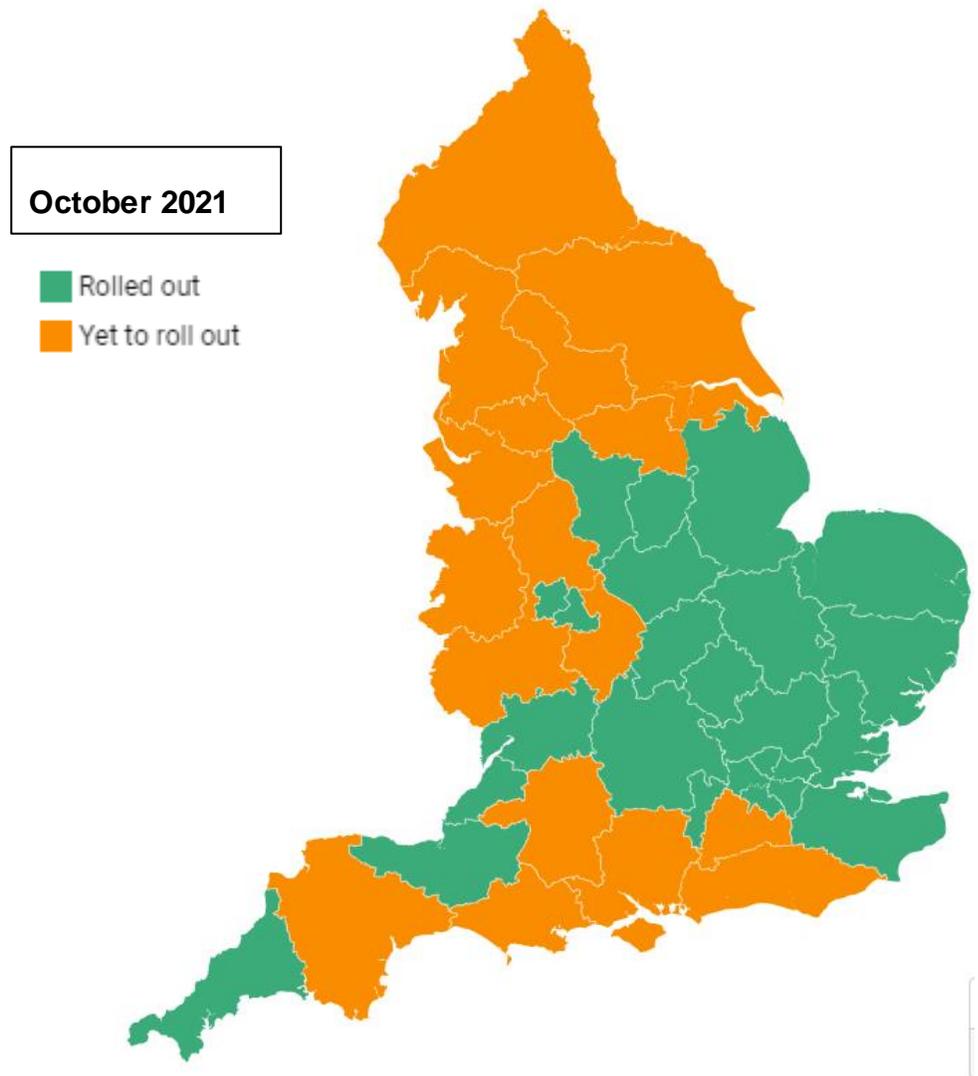
### Scale and coverage

- In line with [national guidance](#), ICSs must provide a two-hour community crisis response 8am-8pm (as a minimum), seven days a week across the full geography of an ICS by April 2022.
- There are 115 2 hr crisis response providers (approximately 213 services) across England.
- By the beginning of October 2021, 25 ICSs (out of 42) are reporting they now have full geographic coverage, with the remaining ICSs having a range of coverage in operational hours and geographically spread.

#### Jargon buster

- UCR – urgent community response
- EOC – Emergency Operations Centre
- CAD – Community Aided Dispatch System (within ambulance EOCs)
- Category 3 ambulance call – urgent, response within 120 mins
- Category 4 ambulance call – less urgent, response within 180 mins

# Geographical coverage, per ICS, as of October 2021: 8am until 8pm, 7 days a week



# Introduction to the webinar



## Webinar aim:

- To bring together urgent community response (UCR) teams and ambulance trusts to build networks and enable collaboration.
- To specifically launch a 100-day project encouraging ambulance and UCR teams to work together to help:
  - Manage ambulance demand and (where clinically appropriate) have UCR teams take on waiting category 3 and 4 calls.
  - Support work around the use of pendant alarms.

## Background to this work:

- In different parts of the country (e.g. East of England, the West Midlands and Warrington) UCR teams have been piloting work with ambulance staff to redirect waiting category 3 and 4 cases to UCR teams where appropriate.
- This has shown the potential to help manage demand for ambulance services and ensure that, when an ambulance response isn't appropriate, patients receive the right care at the right time.
- The Director of Community Health Services, Matthew Winn, has set a challenge to UCR teams nationally to work in partnership with ambulance trusts and develop rapid solutions around cat 3 and 4 waiting calls (that work for them locally).
- Lots of support from Ambulance and UCR colleagues to do further work in this space.

# An ambulance perspective on the importance of the 100-day challenge

**Professor Anthony Marsh**  
**National Strategic Advisor of Ambulance Services**  
**NHS England**

**Reminder:** please do pop any questions or comments in the Q&A box for the upcoming Q&A panel session. Or feel free to give a 'thumbs up' to questions from others you think we should prioritise

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# A community health services perspective on the importance of the 100-day challenge

**Dr Adrian Hayter**

**National Clinical Director for Older People and Integrated Person Centred Care**

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# A clinical perspective on the importance of the 100-day challenge

**Dr Shelagh O’Riordan**

**Consultant Geriatrician and Chair, Community Geriatrics Special Interest Group for  
the British Geriatrics Society**

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# **Q&A panel with speakers**

**Professor Anthony Marsh**

**Dr Adrian Hayter**

**Dr Shelagh O’Riordan**

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# North West Ambulance Service and Warrington UCR. Enabling referrals from 999 into two-hour crisis response services.

**Rob Wood, Service Delivery Manager, Clinical Hub, North West Ambulance  
Service**

**Caroline Williams, Associate Director, Integrated Care, Warrington**

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From our colleagues in **Emergency Departments**, we know that:

- category **3 & 4 patients** are experiencing **longer waits** for ambulance attendances and
- are arriving often **deconditioned** and having **experienced a long lie**
- supporting even **a small number of people** each day in the community would make a **big difference** to the work of the department and hospital flows

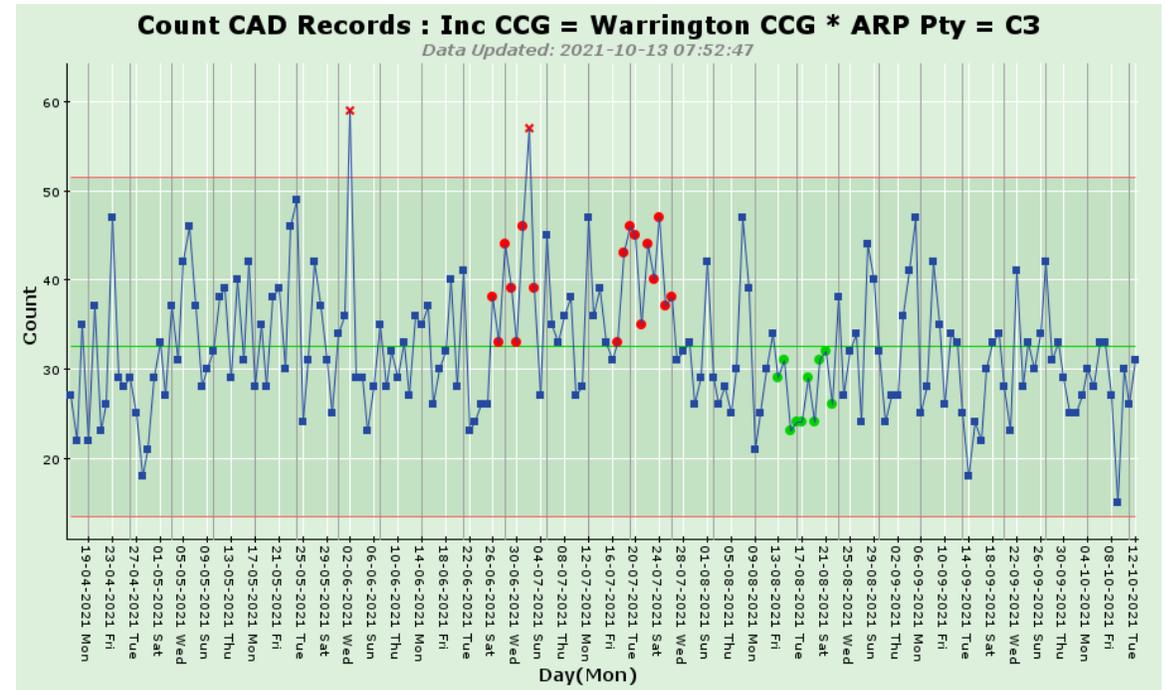
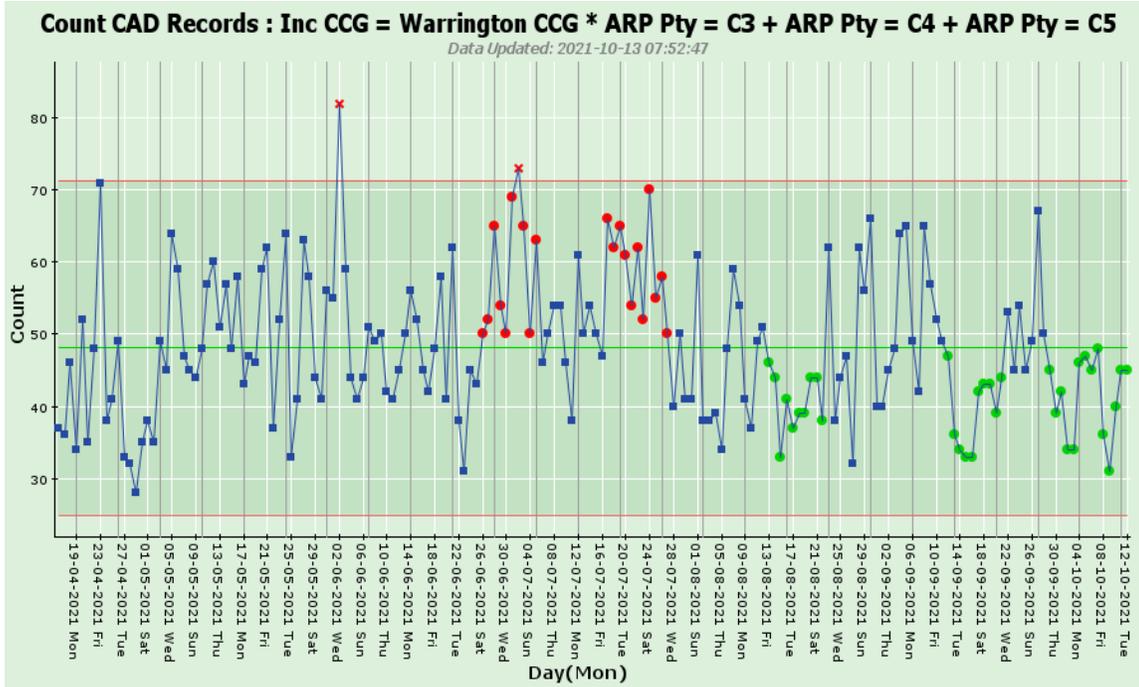
From **our own UCR team** locally we know that:

- they are proud of what they have achieved in 18 months and are eager to **build on their offer** extending support to **responder services** and **ambulance services**
- whilst a little in the community goes a long way in ED, small numbers make a big difference they are equally concerned that they will be able to **meet the demand** and
- they have the **skills, knowledge and competence** to respond to calls that would traditionally be taken by paramedic colleagues

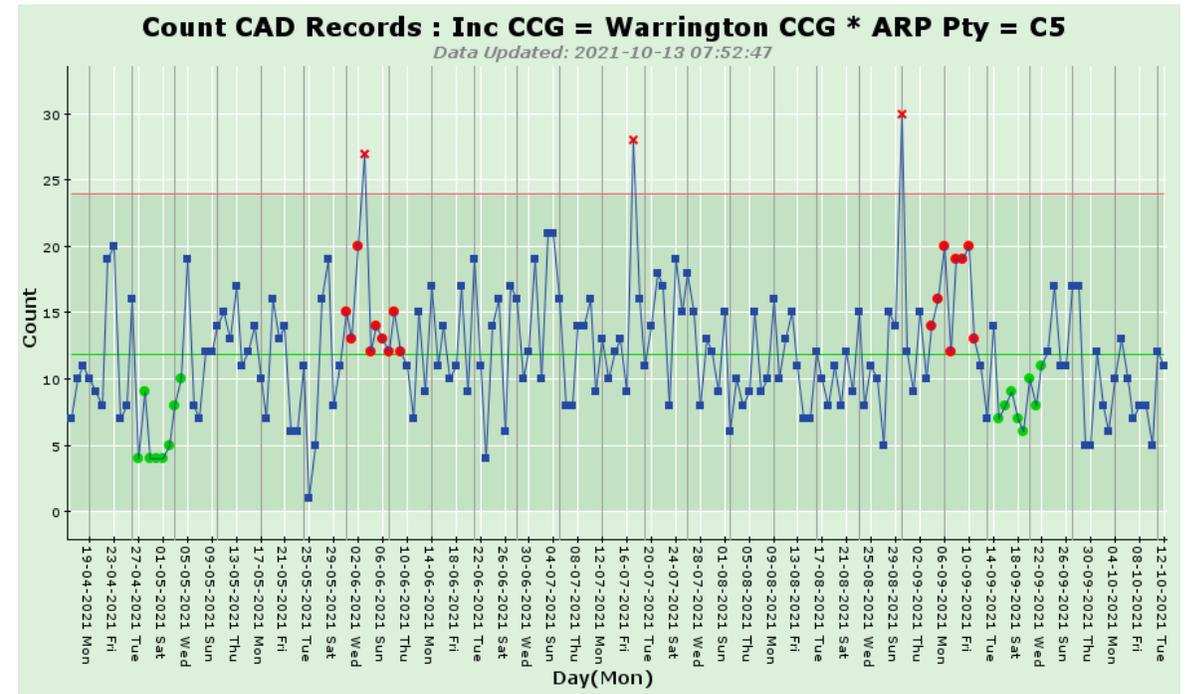
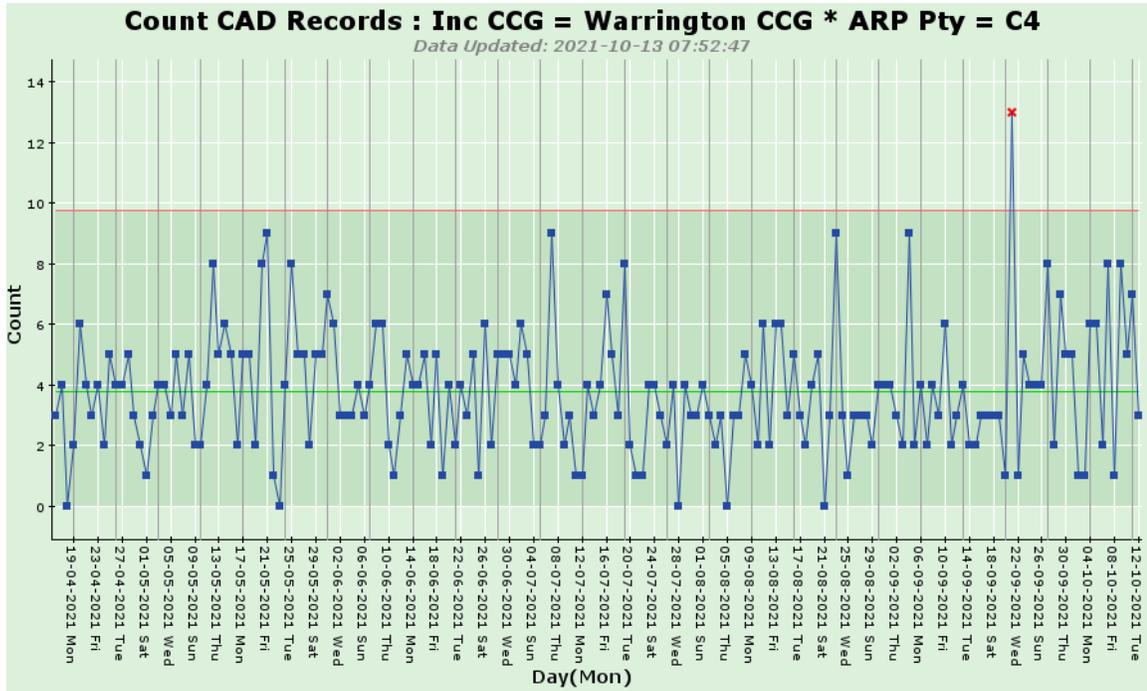
From our **NWAS colleagues regionally**, we know that:

- they are keen to enable **referrals from UCR's seven days per week** across Cheshire & Merseyside
- clear **process on the handover** of patients between services is a requirement
- even if UCR's are unable to avoid a conveyance, the **clinical information** they can provide to the CAS is invaluable

# Demand and Case Mix



# Demand and case mix



# Our Shared Philosophy

## **Improving Outcomes for People**

supporting people to remain at home where safe and possible

## **Working Together**

to match the person to the right service that meets their needs

## **Managing Demand**

supporting the system in a manageable way for the UCR service

## **Reflection & Learning**

sharing and learning together from practice events

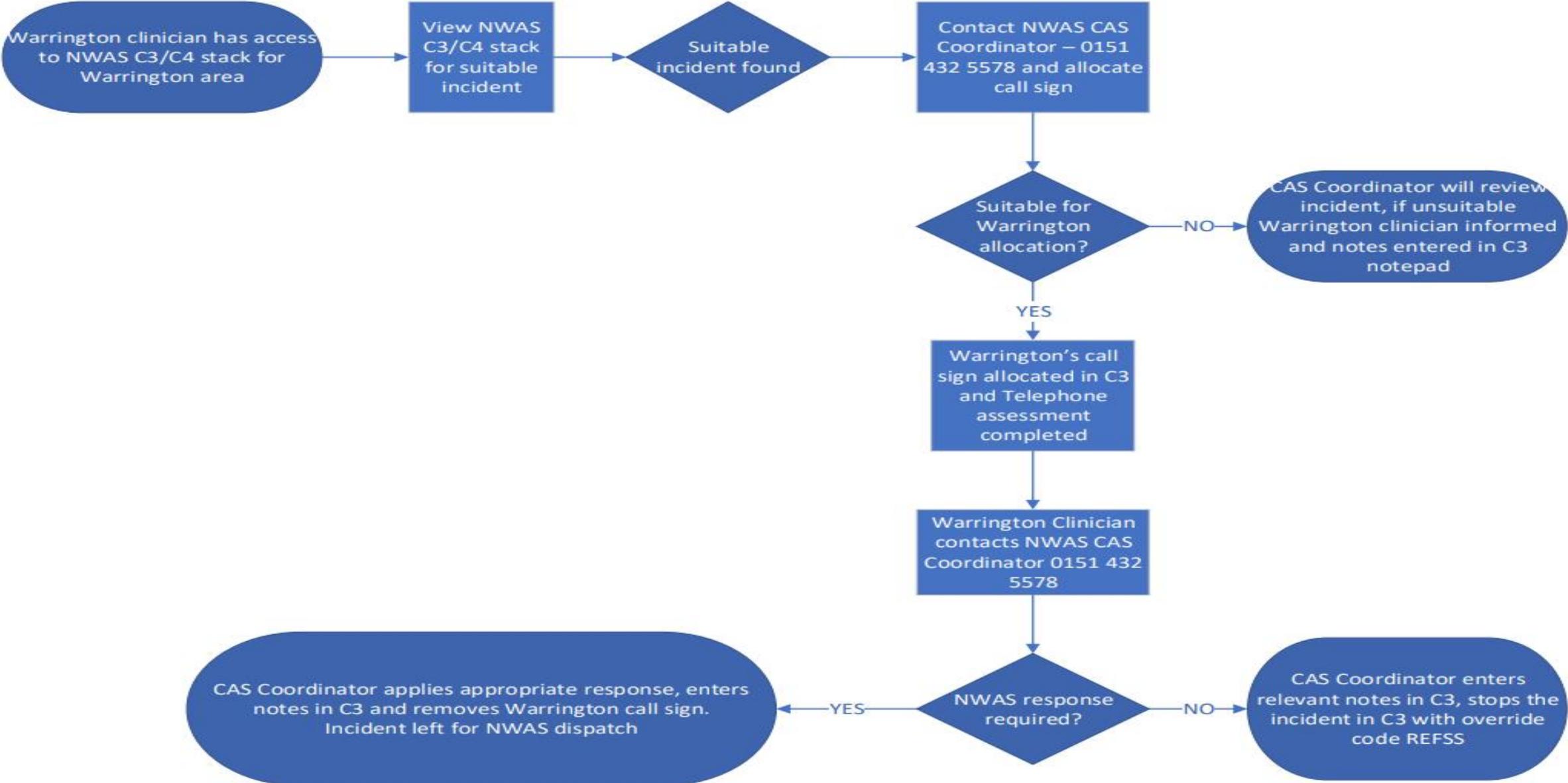
## **Challenge**

established practice and ways of working

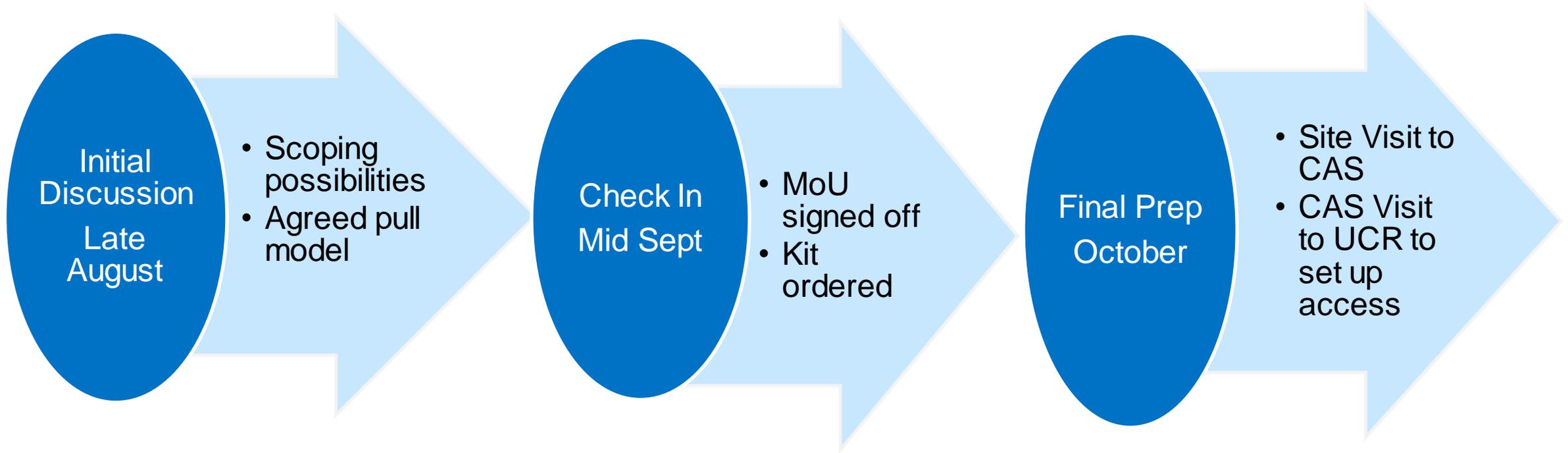
## **Identifying Opportunities**

to scale across Cheshire & Merseyside

# Our Proposed Pathway



## Our Road Map to Go Live



## Next Steps

- **Go Live** with our plans on 18<sup>th</sup> October 2021
- Evaluate **progress**, capturing **data**, **patient** and **staff feedback**
- Reflect, learn and **improve outcomes** for people
- Expand to other **pathways and diagnosis** codes to broaden our offer
- Move from a **pull to a push** model taking UCR amenable cat 3 & 4 calls consistently from 8am-8pm
- Support **regional developments** to **level up** the UCR offer across Cheshire & Merseyside
- Connect '**falls pick up service**' and NWAS to increase reach

# East Midlands Ambulance Service (EMAS)

Gary Lockley, Service Delivery Manager (Emergency Operations Centre)

Two Week Reporting period: 28/09/2021 to 11/10/2021

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# Workload

	In the two week reporting period	One year comparison	Two year comparison	From start of pilot phase 2	One year comparison	Two year comparison
Total Cat 3 999 * workload	3833	3096	3143	86963	84819	3747

In the two week reporting period	YES	NO
	Numbers and (%)	
1) Eligible for validation?	1952 (50.9%)	1881 (49.1%)
2) Accepted by clinical navigator?	1328 (68.0%)	624 (32.0%)
3) Received clinical validation?	1320 (99.4%)	8 (0.6%)
4) Closed as hear and treat?	905 (68.6%)	415 (31.4%)
	Returned as C3	Upgraded
OF those NOT closed as hear and treat (following clinical validation):	157 (37.8%)	258 (62.2%)

From start of Pilot Phase 2	YES	NO
	Numbers and (%)	
1) Eligible for validation?	46281 (53.2%)	40682 (46.8%)
2) Accepted by clinical navigator?	39349 (85.0%)	6932 (15.0%)
3) Received clinical validation?	38827 (98.7%)	522 (1.3%)
4) Closed as hear and treat?	17560 (45.2%)	21267 (54.8%)
	Returned as C3	Upgraded
OF those NOT closed as hear and treat (following clinical validation):	13096 (61.6%)	8171 (38.4%)

# Code Outcomes

	In the two week reporting period	One year comparison	Two year comparison	From start of pilot phase 2	One year comparison	Two year comparison
<b>Pilot code outcomes following full clinical validation (not just initial clinical review by navigator)</b>						
% Conveyed to ED	18.7%	36.7%	40.7%	30.1%	40.8%	40.6%
% Hear and Treat	68.6%	31.0%	30.5%	45.2%	23.6%	30.8%
% See and Treat	12.3%	30.1%	27.6%	23.3%	33.3%	27.4%
% Conveyed to non ED	0.5%	2.2%	1.2%	1.4%	2.3%	1.2%

	In the two week reporting period	One year comparison	Two year comparison	From start of pilot phase 2	One year comparison	Two year comparison
<b>Pilot code outcomes following full clinical validation (not just initial clinical review by navigator)</b>						
% See & Treat where DCA attended	69.75%	71.52%	69.33%	68.57%	74.53%	67.90%
% See & Treat RRV / Solo <b>only</b> attended	11.73%	12.45%	13.24%	13.16%	9.66%	14.64%
% H&T where video used	0.00%	N/A	N/A	0.7%	N/A	N/A

# Performance - Codes & Non Pilot Codes



Current period 60 Minute Auto timeout

TIME TO VALIDATION* START	In the two week reporting period	From start of pilot phase 2
Mean	00:12:56	00:16:47
90th centile	00:37:13	00:48:38

\* This is from clock start to the start of clinical validation ie the commencement of the clinical triage, **not** the time the call was initially reviewed by the navigator

PERFORMANCE	In the two week reporting period	One year comparison	Two year comparison	From start of pilot phase 2	One year comparison	Two year comparison
<b>For patients who were returned to dispatch for C3 response having <u>RECEIVED</u> clinical validation</b>						
C3 performance (mean)	03:26:58	00:59:55	01:31:17	01:39:00	00:47:23	01:32:14
C3 performance (90 <sup>th</sup> centile)	07:27:27	02:29:09	04:05:17	03:57:08	02:00:29	04:06:05
<b>For patients who were returned to dispatch for C3 response having <u>NOT RECEIVED</u> clinical validation (after sitting in the validation queue)</b>						
C3 performance (mean)	01:58:26	NULL	NULL	01:40:22	NULL	NULL
C3 performance (90 <sup>th</sup> centile)	05:55:19	NULL	NULL	05:41:09	NULL	NULL
<b>All 999 C3 emergency incidents that have <u>NOT GONE</u> for clinical review/ validation (exclude 111, HCP and IFT non emergencies)</b>						
C3 performance (mean)	03:21:17	01:15:33	01:10:10	01:41:31	00:48:49	01:10:17
C3 performance (90 <sup>th</sup> centile)	08:14:33	02:56:11	02:59:15	04:11:25	02:00:52	02:56:38

## Activity excluding 111 / HCP and IFT 1-4 hr



ACTIVITY	In the two week reporting period	One year comparison	Two year comparison	From start of pilot phase 2	One year comparison	Two year comparison
Total activity; all 999 incidents, including Pilot Codes and calls initially coded as C5	28091	24467	23520	586022	499335	28582
Total Category 3 incidents (A11)	3833	3096	3143	86963	84819	3747
C3 as % of total 999 incidents	13.6%	12.7%	13.4%	14.8%	17.0%	13.1%

## Activity including 111 (excluding HCP & IFT 1-4 hr)

ACTIVITY	In the two week reporting period	One year comparison	Two year comparison	From start of pilot phase 2	One year comparison	Two year comparison
Total activity; all 999 incidents, including Pilot Codes, calls initially coded as C5 and 111.	37323	31306	30830	767871	650034	37882
Total Category 3 incidents (A11)	4022	3182	2388	86549	85167	3009
C3 as % of total 999 and 111 incidents	10.8%	10.2%	7.7%	11.3%	13.1%	7.9%

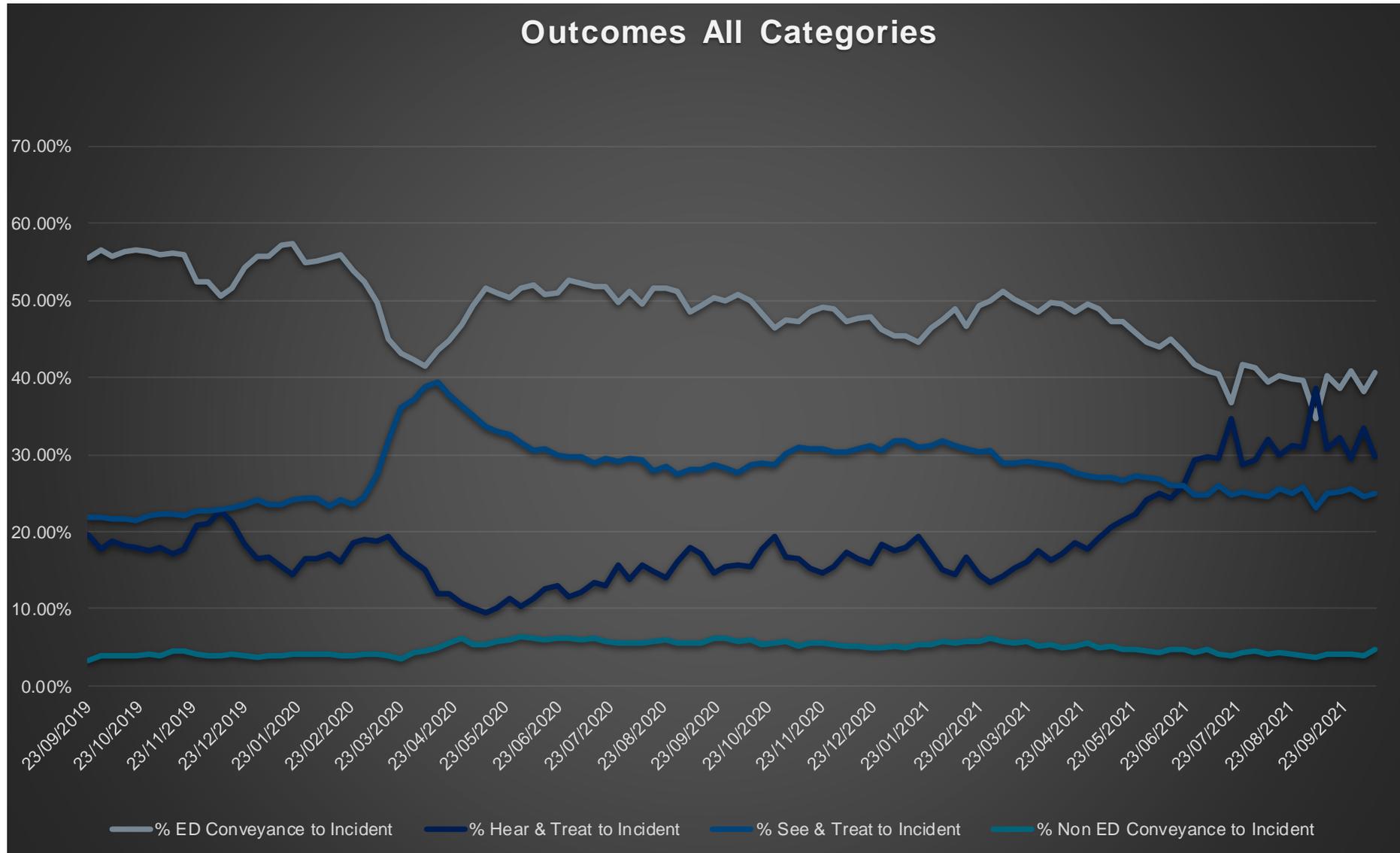
# Outcomes excluding 111 / HCP and IFT 1-4 hr

OUTCOMES (FROM TOTAL ACTIVITY)	In the two week reporting period	One year comparison	Two year comparison	From start of pilot phase 2	One year comparison	Two year comparison
% Conveyed to ED	43.1%	51.0%	57.4%	47.0%	51.1%	57.3%
% Hear and Treat	27.4%	15.5%	17.8%	20.6%	15.8%	17.9%
% See and Treat	24.6%	26.9%	22.2%	26.8%	29.4%	22.1%
% Conveyed to other	4.9%	6.6%	2.6%	5.5%	3.7%	2.7%

# Outcomes including 111

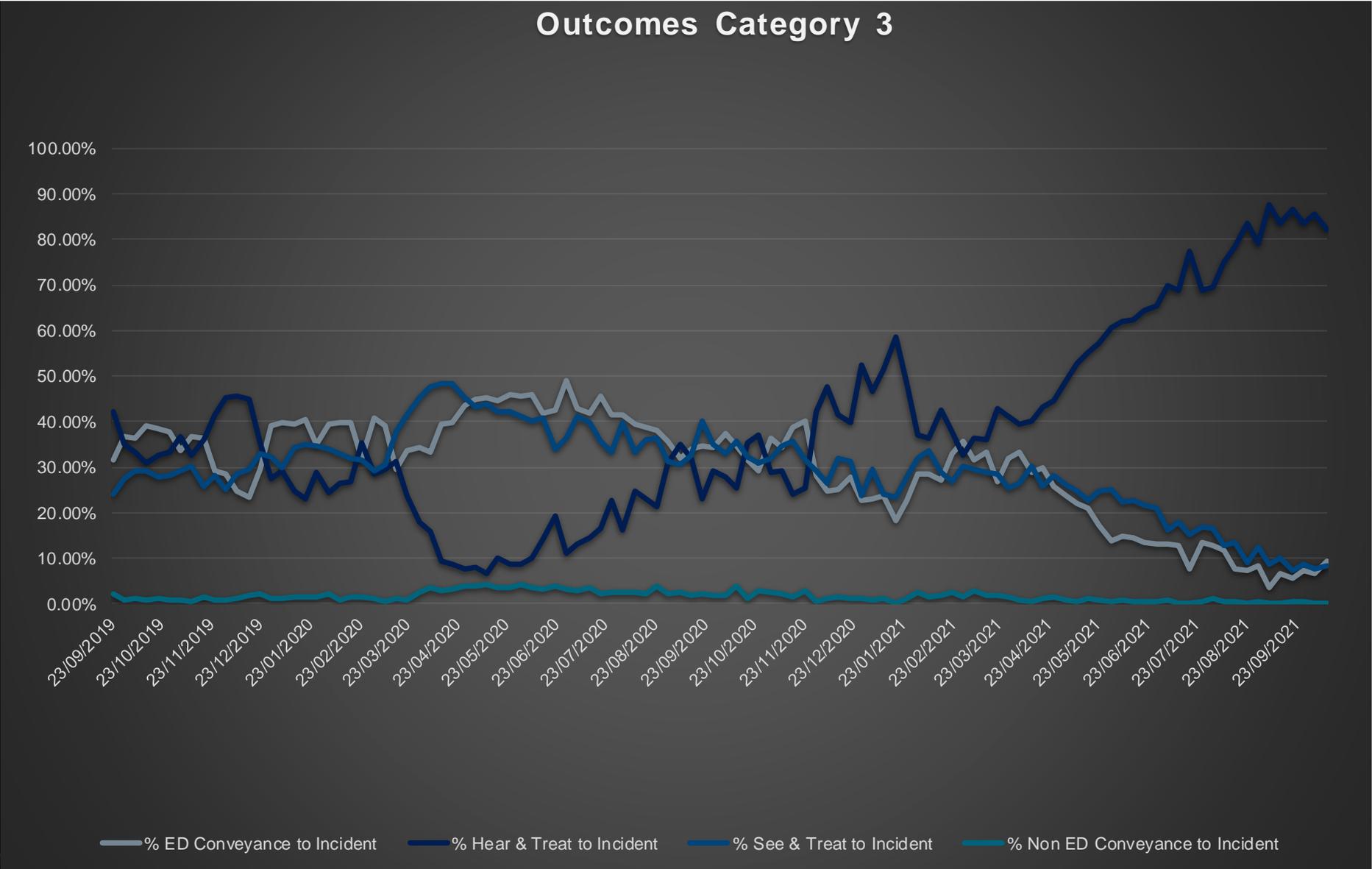
OUTCOMES (FROM TOTAL ACTIVITY)	In the two week reporting period	One year comparison	Two year comparison	From start of pilot phase 2	One year comparison	Two year comparison
% Conveyed to ED	40.9%	51.4%	57.0%	45.7%	51.4%	57.0%
% Hear and Treat	28.6%	13.9%	17.0%	20.7%	14.1%	17.0%
% See and Treat	26.2%	28.7%	23.4%	28.6%	30.8%	23.2%
% Conveyed to other	4.3%	6.1%	2.6%	4.9%	3.7%	2.8%

# Outcomes



# Outcomes

### Outcomes Category 3



# Clinical validation, ambulance clinical hub and UCR 2-hr crisis response services.



- Clinicians within ambulance clinical hubs work across multiple boundaries and have access to multiple services to support patients in the community.
- Often difficult to navigate the system and get access to the right care at the right time.
- Possibility of a clinician from UCR 2-hr service working within the emergency operations centre to pull suitable cat 3 and 4 calls for a 2-hr response by the UCR team.
- This could help to build relationships and increase the understanding of each others roles.
- Would need coordination across multiple community teams.
- Support the safe transfer of patient care for an appropriate response which may not be an emergency ambulance.
- Allow for the UCR service to 'pull' appropriate patients, while working within the existing ambulance governance.
- Requires further consideration and working through the exact process. .
  
- What's the art of possible? .... ITK's – Clinician handovers of complex patients that don't meet referral criteria
- Escalation level capacity changes?

# Recommendations

## MoSCoW Prioritization



Overall	To Operate at the “Gold Standard” to achieve consistent patient care across the whole of the EMAS Geographical area these recommendations should be achieved	
Code set	Review of partners on AMPDS code set and threshold for “auto Pass”	S
	Review the restrictions on patients in a public place and HCP referrals	C
IT/process	Invest in CAD Module which will identify and automatically transfer cases	M
	Identify a solution for PDS matches	S
	Identify a solution for management of cases where there are duplicates/upgrades	M
	Bring the service into BAU for all 2 hour UEC Crisis services across EMAS	M
Staffing/training	Continue to employ a wide skill mix in the management of Cat 3 & 4 cases including Triage Clinicians as the core staff role.	C

# Q&A panel with speakers

**Rob Wood**

**Caroline Williams**

**Gary Lockley**

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**Break**

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# About the 100-day project: collaborate and learn together



NHS England and Improvement is bringing together ambulance and UCR teams to rapidly work together to:

- Help manage ambulance demand and (where clinically appropriate) have UCR teams take on waiting cat 3 and 4 calls.
- Focus on the following solutions:

## Category 3 & 4 waiting ambulance calls

- **Pull solutions:**
  - Having remote access to the ambulance stack
  - UCR clinician working within an ambulance control room
- **Push solutions:**
  - Referrals from clinical validators or clinical navigators

Over the next three months we will:

- Measure impact and **make a difference to patients**
- Collaborate and learn together
- Try, test and scale work on these topics.

# About the 100-day project: our offer



## Monthly workshops which support participants to:

- Share learning, questions and do joint problem solving.
- Connect with and hear from other teams.
- Set goals for the next month or period.
- Reflect on progress and share successes.
- Discuss key topics or themes raised by the group.

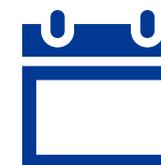
## Participants in the 100-day project will receive a joiner pack including:

- Invites to all events
- A planning template
- Access to the Futures Platform to collaborate, share and access documents



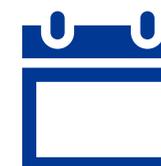
### Mon 8 Nov

- Local speakers and topic specific workshop on clinical and information governance
- *One representative from each team*



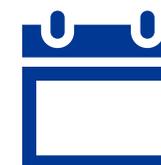
### Thu 2 Dec

- Local and national speakers
- *Multiple representatives from teams*



### Thur 16 Dec

- Local speakers and specific topic workshop
- *One representative from each team*



### Thur 20 Jan

- Celebration event with local and national speakers
- *Multiple representatives from teams*

## 100-day project: our ask of you

To take part in the 100-day project you will need to commit to the following actions:

- 1) Working together with partners to make this happen.
- 2) Setting smart goals.
- 3) Leading and contributing to work locally from within your organisation.
- 4) Participating and potentially presenting your work in the monthly workshops.
- 5) Sharing learning, data and good practice case studies/examples to demonstrate the positive impact of this work on patients and your organisations/systems.

# Take part – interactive session using mentimeter



Q: Based on the information that you've heard in the webinar today are you planning to participate in the 100-day project?

- If yes, tell us:
  - Your name and organisation
  - Email address
  - The region you're based in
  - If you would like to be connected to a UCR or ambulance team in your area (if known please say who they are)

*\*\* Please note that if you share your email address the UCR Team will:*

- *Send you a joiner pack to get your work on the 100-day project started*
- *Send a follow-up message to put you in contact with UCR or ambulance colleagues in your region where requested*

Q: What level of involvement or engagement have you had with this work to date?

- a. Already undertaking partnership work with UCR and ambulance teams
- b. At the beginning of planning partnership work with UCR and ambulance teams
- c. Interested in doing partnership work with UCR and ambulance teams in my area as part of the 100-day project and wish to be linked up

# Take part – interactive session using mentimeter



**Q. For participants who are already undertaking partnership work and at the beginning of planning work:**

**A) Ambitions:** what will you commit to doing in the 100 day project?

**B) Tools and enablers:** what do you need to do this? (e.g. tools, extra partners, practical asks)

**C) Support from partners:**

- What do you need from ambulance colleagues to start or further develop this work?
- What do you need from community services in order to start or further develop this work?
- What do you need from other partners in order to start or further develop this work (e.g. regional NHSE/I colleagues, ICS teams etc, please specify within your answer)?

**D) Metrics:** what outcomes and outputs will you expect to see?

(e.g. a positive increase in numbers of people who are seen and cared for in the community that would have previously been attended to by an ambulance)

At the next interactive workshop on 8 November we will have a focused discussion with peers and national partners on information governance and clinical governance.

Q: What are your questions on IG and clinical governance?

# Final reflections

**Kath Evans**  
Deputy Director  
Community Services & Ageing Well  
NHS England & Improvement

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# Closing comments and next steps



Join us on Mon 8 Nov, for the next interactive workshop in the 100-day project. Further updates and an invite will be shared, and you can check our Future NHS page for further updates.



If you have shared your email address you will receive a 100-day project joiner pack.



To continue conversations between workshops and access tools and resources visit the **Community Services and Ageing Well Future NHS platform**:

[Urgent Community Response - Discharge and Community Services - FutureNHS Collaboration Platform](#)



Connect with us on **Twitter** [@NHSEnglandCHS](#) #UCRwebinar #2hrcrisisresponse #UCR100days



For further information about the 100-day project email, [england.ageingwell@nhs.net](mailto:england.ageingwell@nhs.net)