NHS 111: London Winter Pilots Evaluation

Qualitative research exploring staff experiences of using and delivering new programmes in NHS 111

Executive Summary

A report prepared for Healthy London Partnership

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Authors

Sarah-Ann Burger

Cara Witwicki

Gill Goodall

www.picker.org

Picker

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Picker Institute Europe
Buxton Court
3 West Way
Oxford,
OX2 0JB
England

Tel: 01865 208100
Fax: 01865 208101

Email: info@pickereurope.ac.uk
Website: www.picker.org

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Executive Summary

The demand for urgent and emergency care (U&EC) services continues to grow. For many patients and care providers, the system is complex and difficult to navigate, meaning that many fail to access the most appropriate service for their specific need. The purpose of NHS 111 is to make it easier for the public to access the correct urgent healthcare service by serving as a first checkpoint to either provide immediate assistance where appropriate, or direct callers to services best suited to assist them.

To respond to the immense pressure on U&EC services, Healthy London Partnership (HLP) have been working with NHS 111 providers and Clinical Commissioning Groups (CCGs) to rapidly implement programmes across London, namely the London Winter Pilots, which aim to expand the capabilities of NHS 111. Included in this is the provision of dedicated telephony assistance to healthcare professionals (HCPs), 'no clinician alone', as well as expanding the resources available to NHS 111 staff to improve patient outcomes and improve flows. To operationalise these objectives, a range of pilots have been implemented.

To understand how these pilots are functioning, HLP commissioned Picker, a not-for-profit healthcare research organisation, to gather feedback from staff on three pilots being implemented in London. The pilots included:

- The GP Access pilot: HCPs can access a dedicated GP at NHS 111, 24/7, by dialling 111 and a specified PIN (*5 for paramedics; *6 for care home staff; *7 for rapid response nurses). Some providers also have access to video-conference consultation facilities.
- Mental health crises nurse pilot: Direct access to a mental health nurse who is available to take warm transfers (i.e. not a call back) from NHS 111 for patients who require this assistance.
- Rapid response nurse pilot: A dedicated rapid response nurse shift, 7 days a week, is embedded in the NHS 111 centre, to assist call handlers and clinicians to identify calls that could be directed to the community nursing team.

Aims & Methodology

The aim of this research was to gather feedback from frontline staff about the specific programme they were delivering or had access to. The overarching research questions were:

- What are staffs' views and experiences of how the new services being piloted are functioning?
- What are the implications for those delivering and using the service?
- What are staffs' perspectives of the implications for patients?
- What are staffs' perspectives of the implications for U&EC services?

The methodology involved researchers at Picker conducting 24, 45-minute to 1-hour telephone interviews with staff in the various roles:

- Six general practitioners who had provided clinical support to HCPs at NHS 111.
- Six London Ambulance Service paramedics who had used the star 5 function.
- Five care home staff who had used the star 6 function.

- Two NHS 111 supervisors.
- Two mental health crises nurses who had provided assistance to callers from NHS 111.
- Three rapid response nurses who had worked in the NHS 111 shift.

Key Findings

Overall

Overall, the staff interviewed across all groups had positive experiences of using or delivering the various features, and could see the benefit of these for providing high quality care to patients. Generally, all staff using the service felt that the access to GPs via NHS 111, as well as the additional resources such as mental health nurses, positively impacts patients and the U&EC system as a whole, reducing admissions to urgent and emergency care services, thereby meeting the aims of the pilots. Furthermore, they reported that they would continue to use the star function should it continue to be available, with the majority hoping that it would.

Uptake of service

The Winter Pilots were designed to be rapidly implemented and evaluated, and as such many staff reported lower usage, particularly at the start of the programmes. Almost none of the GPs or NHS 111 supervisors could recall providing assistance to rapid response nurses via the *7 routing. Similarly, there was a sense that there was a disappointingly low uptake of NHS 111 GP access from care home staff, who many felt would benefit greatly. Those care home staff who were interviewed rarely used the star function in-hours, as they generally had access to a dedicated GP to the care home. It was more frequently out-of-hours when this GP was not accessible that they would consider using the function.

Knowledge of process

Most staff felt they were sufficiently made aware of the service(s) through posters and advertising. However, there was some misunderstanding of how the features should operate, as it seemed the logistics and uses of the function were not consistently explained. Specifically, both the LAS paramedics and the care home staff felt misinformed by the information provided to them: that they would have instant access to the GP at NHS 111 via the star routing. The expectation that they would speak to a GP immediately rather than a call handler first, left many of the paramedics questioning whether they were in fact receiving expedited access to the GP.

Expedited service

There were contradicting views about the call back times among the different staff groups. Although LAS paramedics recognised that they did have more access to GPs and were being called back quicker than before, some still felt call back times should have been even quicker in order for it to be truly impactful for their work. Conversely, the NHS 111 supervisors and GPs felt that because of the low volume of calls from HCPs, particularly at the start of the pilots, GPs were able to respond to HCP calls relatively quickly, if not immediately.

Impact for staff

Working collaboratively, utilising the different skill sets, knowledge and access to the patients was recognised as invaluable by all the staff. For example, GPs found it immensely useful to have fellow HCPs be their eyes on the ground, speaking the same language. The HCPs could provide clinical details from their assessments which patients alone would normally not be able to provide. Furthermore, in the case of speaking with care home staff, they could receive a patient's medical history, including information about medications they are on.

HCPs found the support from the GPs at NHS 111 instrumental, when they were able to speak them. This could be through reassuring them of their decisions, providing clinical advice, prescribing medication, or taking over the case entirely. All staff noted the advantage of the GPs having access to primary care services when working in-hours, particularly the patient's own GP. GPs at NHS 111 are in many cases able to access the patient's own GP to get more information about the patient in order to assist the HCP calling NHS 111. In some cases, the GP is also able to make an appointment for that patient, as the GP practice is more likely to consider the case presented by a fellow clinician.

There were disparate perceptions of the sympathy for and respect of staff's roles from other staff. Particularly, how paramedics and rapid response nurses felt GPs viewed their capabilities, compared to how GPs reported their appreciation for their input. As noted above, GPs described feeling assured when working with HCPs, whereas the LAS paramedics felt that some GPs seemed unaware of the extent to which they could carry out a clinical assessment of a patient. For both GPs and LAS paramedics, some insight into what each staff group are trained and able to do would be valuable to manage expectations and reduce precious time spent on calls. Similarly, rapid response nurses often felt that they were stepping on the GPs toes and taking over their workload, which they didn't feel was well received. Clarity for rapid response nurses and GPs as to what their roles entailed could have avoided any animosity between these staff groups.

Rapid response nurses

The rapid response nurses raised the most concerns and challenges for them, and provided feedback on how their role and the service needs to be improved. While the rapid response nurses expressed that it was valuable to enlighten NHS 111 staff as to which calls could be transferred to their community teams, they highlighted challenges of how this worked in practice. For example, the process of identifying callers and subsequently intervening was viewed as clumsy. The nurses found it more difficult working at NHS 111 to their usual roles as they found the work tedious in comparison to being out on the road seeing patients. They felt that, should the pilot continue, rather than losing a rapid response nurse in the field to sit with call handlers and identifying appropriate calls, that they could instead run regular training, to highlight examples of the types of calls that would benefit from a referral to their team.

Mental health crisis nurses

Expanding resources for NHS 111 call handlers via access to dedicated mental health crisis nurses was viewed as incredibly necessary and useful. Previous research conducted by Picker[1] with NHS 111 call handlers and supervisors revealed a great need for additional support to patients experiencing a mental health crisis. Both NHS 111 supervisors who were interviewed saw the value in having this service available to them, however one noted that there are still occasions when the nurses are not readily available and they still need to arrange a call back for the patients. Both mental health nurses who were interviewed were positive about their role and providing the service.

Video-conference consultation

The video-conference consultation function revealed mixed feedback from both GPs delivering the service and care home staff using it. There was quite a stark difference between staff who had used the video-conferencing facilities and those who had not. Those who had, found it extremely advantageous and noted a variety of instances when it was appropriate. Conversely, those who had not used the service were asked to reflect on it hypothetically, and struggled to see the value or appropriateness of it, feeling apprehensive about the quality of the image, or uncomfortable viewing patients in this way. Those who had used the facilities successfully, offered insight into their colleagues' apprehension, noting that some might not have the technical expertise or confidence, and others may not be skilled in or comfortable with incorporating the video access into their medical assessment and to use it to their advantage. GPs were disappointed by the lack of uptake from care home staff and felt the biggest challenge was firstly, getting care home staff to utilise the service, and secondly, the logistics and time to set it up. GPs recommended that care home staff be sufficiently informed in how to set it up and have quick access to the necessary login details.

Impact for patients and U&EC

All staff recognised the benefit for patients. By working together as HCPs, patients receive quicker access to the most appropriate care, be it: receiving necessary medication; having an appointment scheduled at their own GP; being assessed in their own home (or care home), rather than being transported to accident and emergency; or reassigning the case to a more appropriate HCP or service.

Similarly, all staff recognised that by having access to GPs at NHS 111, and having the additional resources to support NHS 111, assists with the overflow from the overstretched primary care services, simultaneously ensuring patients don't attend U&EC services inappropriately.

[1] Burger, S.-A., & Witwicki, C. 2017. Chapter 5: Staff experiences of the PRM System. In, *The London NHS 111 Patient Relationship Manager (PRM) Evaluation.* A report prepared for HLP

Key Learnings & Recommendations

Raising awareness

Star routing: It is clear that uptake of the star routing feature could and should be improved in order to make it an impactful service. The reported low volume of calls from rapid response nurses and care home staff in particular was perceived as the greatest challenge to the service. Raising awareness of the service among these staff groups, including its benefits and when and how to use it, is vital.

Video-conference consultation: For care homes with video-conferencing facilities, it is important that staff are aware of the availability of this technology and that they have the necessary information and training to utilise the equipment confidently.

Accurate communications and managing expectations

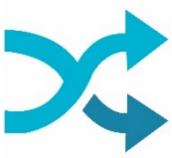
It is important that information about how the service works is clarified and communicated accurately. This includes the exact process of dialling NHS 111: how and when to select the *5, *6, or *7. As well as accurately describing who HCPs will speak to and how they will get access to the GPs to avoid any misunderstanding, and frustration owing to misplaced expectations.

Training

The findings identified a few areas that would benefit from staff receiving additional training.

Video-conference consultation: Both GPs and care home staff could benefit from receiving more training on how to use the video-conference facilities. This could be basic training in how to use the technology as well as when it might be appropriate to use. It was recommended that GPs who have had the opportunity to utilise the technology and feel more comfortable incorporating it into their clinical assessment, work with those who are less familiar.

Rapid response nurses: Training staff at NHS 111, be it call handlers, supervisors or other clinicians, to recognise calls that would be appropriate for the rapid response team would be beneficial. It was reported that currently, the rapid response nurses advise staff as and when calls come in. However, they felt it would be more beneficial to have dedicated training sessions delivered by themselves, to highlight examples of the types of calls that would benefit from a referral to their team.



Working together

Staff skill mix and capabilities: Making staff aware of each other's knowledge and skills was viewed as important. Knowing the remit and capabilities of the staff you are working with is important to deliver a coordinated service and to avoid unnecessary duplication of work. The LAS paramedics in particular felt it would be beneficial for GPs to have a better understanding of their abilities. Similarly, rapid response nurses would have liked their role in relation to other staff to be clarified and communicated to ensure each set of skills and specialist knowledge is being accessed.

Evaluating feasibility of rapid response nurse pilot

The interviews with NHS 111 supervisors and the rapid response nurses revealed a need to gain a deeper understanding of how having the rapid response nurses in the NHS 111 call centre could be better utilised. There were disparate accounts of how and when the rapid response nurses are accessed by staff in the centre. It seemed the NHS 111 supervisor thought of the rapid response nurse as an additional clinician working with and in the same way, as the existing clinicians in the centre. With the addition that they are able to liaise with and schedule appointments with the community team, however there was little knowledge of how this was done. Furthermore, the supervisors perceived the rapid response nurses are accessed more by GPs than call handlers. Rapid response nurses were also unclear of their remit and felt the practical process of identifying suitable calls to divert to the community team was lacking. It may be necessary to revisit how this service is being delivered and determining how what more should be put in place to improve it.

Making NHS 111 the norm

Care home staff: The staff interviewed, reported that care home staff mostly access the NHS 111 service when it is out-of-hours and they do not have access to the regular GPs: either the patient's own GP, or the GP dedicated to the care home. Furthermore, some noted that they use the service to request a home visit from a GP, rather than only requiring assistance over the telephone. It is thus important that effort is made to change the behaviour of care home staff, making NHS 111 their first point of call when appropriate both in-hours and out-of-hours.

LAS paramedics: Similarly, GPs felt that if LAS paramedics made it a habit to incorporate a call to NHS 111 into their assessment routine, it would mean they use the service more and it would be timesaving. In other words, as soon as they identify that they may require additional assistance they should be in the habit of calling NHS 111 and using the star function. That way, they can complete their usual assessment of the patient while waiting for the call back from the GP, rather than waiting until after the assessment is completed, resulting in them waiting idly.

Conclusion

On the whole, the winter pilots were viewed as a positive expansion to the NHS 111 service. The additional resources available to the various staff groups were seen as beneficial to both staff and patients. At this early stage, the longer-term impact of these services is yet to be seen, but most staff felt that with some tweaks the features were sustainable and were shifting NHS 111 in the right direction to being a valuable and viable service to assist with integrating U&EC services and ultimately reducing strain on the system as a whole.

Limitations and Context

The Winter Pilots were designed to be rapidly implemented and evaluated: most were launched at the end of January 2017. Although the pilots were extended, many of the interviewed staff did not have too much experience either using or delivering the service. This meant that a number of staff that were interviewed were asked to think about the service features hypothetically and subsequently may not be an accurate reflection on the service. This was particularly true when asking the GPs and care home staff to consider the usefulness of the video conferencing to assess patients.

The staff groups were outlined and agreed upon before the project began, including targeting a geographic spread: either from the different NHS 111 providers, or, in the case of care home staff, across London. Owing to difficulty recruiting some staff groups, this may not have been fully achieved in the case of care home staff.

Furthermore, as a range of pilots were implemented alongside each other, understandably many staff did not necessarily separate the functions and implications of the new features. That is, their accounts and experiences were intertwined with other pilots that were running concurrently.

Care home staff in particular had very little experience of using the star functions and this became apparent in the recruitment phase. Screening questions were implemented to determine eligibility to take part, following a number of interviewees having no experience or understanding of the star function, expecting the interview to be about NHS 111 in general.

Picker Institute Europe
Buxton Court
3 West Way
Oxford, OX2 0JB
England

Tel: 01865 208100
Fax: 01865 208101

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