Healthcare Improvement Scotland

Rethinking Unscheduled Care Insights for Decision Makers

Findings from interviews with decision makers

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Introduction

Rethinking Unscheduled Care Strategic Planning Considerations argued that health and social care decision makers needed to look outside of unscheduled care to find a sustainable solution to the pressure faced by unscheduled care. It articulated that a key way to create long-term sustainability in unscheduled care is to better address demand drivers through investing well in services outside unscheduled care. This means how we arrange the services outside the box in Figure 1 drives the demand for unscheduled care services within the box.

Figure 1

To do this, we need to provide decision makers with better information on the causal links between the care and support provided by services outside the box and the impact this has on demand for unscheduled care. Decision-making on unscheduled care still largely relies on output and throughput figures on various parts of the unscheduled care system. We need to see a shift to greater reliance on qualitative and quantitative insight within the national and local decision-making to see a change in how decisions are made.

Through our work at Healthcare Improvement Scotland (HIS), we seek to develop an alternative set of insights to inform decision makers of quantitative data, patient experience and their journeys, staff insight, and evidence from literature that can be applied locally.

Between October 2024 and April 2025, we interviewed various decision makers within unscheduled care to understand their experiences and views on decision-making within their contexts.

This report summarises these interview findings, including:

- Views on how decisions are currently made.
- What are decision makers looking for to inform their decisions?
- The gaps in existing insight that they feel would help inform future decision-making.

1. What did we do, and why?

When looking at ways to support decision makers, we often ask ‘what information do we have?’ and ‘how can we present this information for decision makers?’. What we have been hearing from decision makers within health and social care organisations across the seniority levels is that they need more than ‘more information’ and ‘more data’. They want ‘more insight’.

Starting with the questions ‘what information do we have’ and ‘how can we present this information better’ can lead to a focus on trying to fill monitoring data gaps and not necessarily lead to better ‘insight’. We want to try something different with this report and start with the questions ‘what types of decisions are decision makers trying to make’ and ‘what keeps decision makers up at night’. We want to see what happens when we flip the starting point. We hope the result is a more precise and focused understanding of what insight decision makers need to make decisions.

To inform this analysis, we conducted targeted qualitative desk and field research into the priorities, challenges, views and concerns of decision makers to be able to answer those questions of ‘what types of decisions are decision makers trying to make’ and ‘what keeps decision makers up at night’.

We conducted semi-structured interviews with 12 senior decision makers, or managers who inform senior decision makers, from NHS Boards and Health and Social Care Partnerships (HSCPs) between October 2024 and April 2025. These individuals had responsibility for making and/or informing decisions around unscheduled care, its provision, and changes that are made to it. These interviews explored:

- How decisions around unscheduled care are currently made?
- What are the priorities and concerns of decision makers in deciding what happens within unscheduled care?
- What connections to upstream drivers (see the services outwith the box in Figure 1) are decision makers grappling with and acting on?
- What information are decision makers currently using to inform their decisions?
- What are the gaps in information and insight that decision makers, if filled, would support improved decision making within unscheduled care and their ability to address upstream drivers of demand?

Interviewees included the following job roles: Deputy Chief Executive, NHS Board, Chief Officer, HSCP, Medical Director, Chief Nurse, Associate Nurse Director, Clinical Lead, Deputy Director and Public Health Consultant, Director of Planning, Transformation Lead, Head of Service, Change and Improvement Manager, Head of a delivery programme about preventative action for independent living, and Head of Health Intelligence.

This paper summarises the key findings from these interviews. It is designed to inform consideration within NHS Boards and HSCPs about what information and insight to explore as part of decision-making processes. We will also be using these findings to inform HIS’ development of the Scottish Approach to Change, with the hope that we can test these out within our Pathfinder sites.

2 Views on current decision making

The following are interviewees' insights into how national and local health and social care decision makers currently make decisions on unscheduled care. The findings are a thematic analysis of interview discussions, ensuring we are protecting the anonymity of participants.

1 Who is making decisions regarding unscheduled care is widening, but the right stakeholders aren't always in the room. There are decision-making or oversight groups for unscheduled care in each area in Scotland that bring together national and local health and social care decision makers to focus on the topic of unscheduled care. This contributes to a wider breadth of discussion, access to insight, and opportunities to address the drivers of unscheduled care demand further upstream. One example is data points from outside unscheduled care, which are now being discussed more often than previously.

2 Local decision-making is still primarily driven by reporting to the Scottish Government and the Key Performance Indicators (KPIs), like the four-hour Emergency Department (ED) wait time target, delayed discharge numbers, and interventions wait times. This limits the ability of decision makers to explore a more rounded understanding of the health of their systems and hinders attempts to address long-term systemic challenges in favour of short-term fixes.

"It focuses on a number and by its very nature, therefore, takes a reductionist approach to a complex issue. Changing anything in healthcare can be pretty complex, the unpredictability of whether a change will have the desired effect…but government communication is looking for certainty…so boards feel like they have to offer up certainty…by offering up certainty… they then have to justify what has happened or not happened."

3 Where decision makers are trying to do things differently, they are hindered by lack of opportunities to work across the system. Each organisation or part of the system is mainly trying to solve their challenges rather than working across the system to address the root causes of pressure points.

4 There is a general feeling amongst leaders across all levels that urgent operational tasks crowd out their ability to transform their services and systems strategically. They feel this results in large and important decisions being made in a hurry and not always optimal. They feel that there is:

- A lack of time to consider the evidence and options, and lining up the right stakeholders to participate before making decisions
- An emphasis that all changes need to be made immediately, despite staff generally feeling that rapid action on considerable/significant systemic challenges that we have been grappling with for years is unlikely to yield meaningful improvement.

"Sometimes we make the least worst decision rather than the best decision."

"Things can feel a bit like you can lack the time to make reasoned decisions, you are lurching from one crisis to the next."

"We have lots of ideas, but we need thinking space and time to make things happen."

5 There is a growing understanding amongst decision makers that 'just add water' solutions aren't effective when considering such a complex system. The more that decision makers are on the same page about the approach they want to take to making changes, the more effective their decision-making is.

6 There is an implicit hierarchy of priorities within decision-making in unscheduled care of the following three levels with most of the energy spent on one and two. Decision makers operating within unscheduled care often reported that they felt like they had little influence over level three:

1. How to route people to the right place at the start of their contact with unscheduled care (for example, NHS Scottish Ambulance Service, NHS24, emergency department)?
2. How to get people to go to the right 'entry point' when they reach out to unscheduled care?
3. How do we prevent people from approaching unscheduled care and address their needs further upstream?

Decision makers discussed that when funding is available for level three, it comes in small pots, of siloed and time-limited funding. This was felt to further engrain silos in the system but if used differently could be used to help take steps towards the overarching system wide objectives.

7 Decision makers reported wanting to form stronger relationships focused on addressing challenge together. Many reported that when pressure increases, decision makers across the system can turn inward and operate in silo. They also felt decision makers tended to articulate what others need to do to address a problem they are facing instead of exploring challenges and opportunities from a perspective of joint responsibility. Decision makers reported wanting to form relationships across the system that genuinely sought to figure out what could be done collectively.

8 Decision makers identified that we needed to build a culture of letting go of control and trusting each other to make the necessary changes to achieve a more sustainable system. They reported that assumptions about how delivery should be done, or who should play what role, can hinder the ability of decision makers to think differently about long-standing challenges.

9 Decision makers identified a high value placed on data, but a lower value placed on the relationships and culture required to implement decisions that are being made. It was noted that when developing strategies, we articulate what we want to achieve, but we struggle to engage in the realities of how it could be delivered with impact. That successful delivery requires the right relationships and culture, but that we have eroded the mechanisms and forums that support effective decision making – for example opportunities for staff to jointly explore issues, share learning and find solutions. Deprioritising relationships was felt to reduce the effectiveness of decision making.

3 What are decision makers looking for?

This section summarises our findings on what insights decision makers would find helpful in informing decisions.

Decision makers discussed the need to shift away from the reliance on output and throughput figures on the system. They want to see information (quantitative and qualitative) brought together to give decision makers a better sense of the health of their system. They felt that this would enable them to understand cause and effect across the system better.

They discussed that this is more than how we arrange the current quantitative data and more than how it is presented in dashboards. This is a shift to valuing information differently and having open discussions at a national and local level about the unintended impact on the quality of decision-making by the current focus on KPI and output/throughput data.

Decision makers felt that more quantitative data isn't always better. They reported feeling overwhelmed by the quantitative data available and not knowing what data they should look at. One interviewee felt this also reflected the multiple directions that decision makers were pulled in and the balance they had to make within their decision-making. Linking a shared strategy with the information that helps understand progress towards or away from that strategic direction was felt to help provide a more focused approach to data use.

Decision makers felt that insufficient insight, other than quantitative management data, was brought to the table during decision making. Sources like lived experience, literature, staff views, and expert opinion were often left out of large data packs that go to senior decision makers on unscheduled care. Decision makers discussed scenarios where they felt that information that wasn't easily measurable added to a list of 'exclusions' that never went anywhere, inhibiting decision making by presenting a partial and misleading picture. Effectively triangulating information from multiple sources in different forms enables more meaning to be drawn from what is given to decision makers. For example,

- Patient journeys can bring to life lived experience information.
- Evidence from literature on the effectiveness of changes or the causal links that drive need across the system can shortcut the need to prove that locally to inform decisions.
- Developing local insight by taking a sample of a population group and exploring their patterns of demand in more detail reduces the complications associated with linking this information to all the local or national population. This has been done within high-resource user studies. The concept has a broader application in understanding how people utilise services and support across traditional service boundaries for co-occurring needs.
- Investing in understanding of why people come to unscheduled care services may require a deeper dive into cases to understand the combination of drivers that goes beyond the quantitative data around things like "presenting reason".

The skill and confidence in analysing and interpreting qualitative findings was raised within interviews. To effectively utilise insight from qualitative sources, we need to be able to analyse and interpret analysis robustly and in a way that can be used by the system. There is willingness to engage in qualitative evidence, and there is evidence available from qualitative sources – for example the content within

complaints and feedback. But it was noted that various professions don't have qualitative analysis built into their education, and there are few specialists on this analysis within our organisations, with even fewer able to triangulate both qualitative and quantitative information together.

Decision makers felt that the story could be missing from the insights we looked at.

"We have lots of data bout bed occupancy. But what we don't have is the stories behind it and the detail that tells us what the data says. How do we understand it to know what the data means."

Several decision makers reported that the way we currently value information on activity and impact crowds out the services and organisations that are doing the work, and we need to see a transformation in our system.

"They want metric information in the way that we have always given this, the organisations doing [the work that reduces demand for unscheduled care] aren't geared up to administrate to produce that data in that way. We need to change the way we value evidence around impact"

"Sometimes the community work isn't good at telling their story. Which might increase their use and their investment."

"We miss out on them because we put hurdles in it".

4 What gaps in our insight would be valuable to evidence further

Through the interviews with decision makers and the findings in chapter 2 of this report and our other work in this area, the list below outlines opportunities to strengthen the evidence base on the link between the following areas and the demand for unscheduled care.

Evidence linking specific service areas and demand for unscheduled care:

1. The link between well-resourced **social care** and the demand for unscheduled care.
2. Better quantifying the link between **waitlists for planned care** on the demand for primary care, social care and unscheduled care.
3. Better insight into the **provision of primary care** within General Practices, specifically to:
    a. Help to plan what problems they are addressing that could be better addressed elsewhere – helps with planning by the HSCP/NHS Board to solve GP challenges
    b. Help with workforce planning to know what skills and competencies they should be supporting the development of
    c. Help to identify what impact GPs are feeling from changes in other parts of the system – what failure demand are GPs picking up helps tell us what the implications of the decisions we are making have on GPs
    d. Help to identify changing needs in terms of health needs, changing expectations in the population around their level of health and care they expect

e. Help plan infrastructure of primary care buildings, for example, location of community care centres and what to put in them. To inform their infrastructure planning, they want to triangulate where the poor premises are, what the GP demand is, what the health data of the changing population is.

4. The link between **admission rates and readmission rates** and **postcodes** to identify challenges within geography within local areas.
5. The impact of high quality **generalist care**, the ability to **personalise care** for groups facing multiple morbidities, multiple disadvantage, and the impact on **inequality**.
6. Better understanding of why people are **readmitted into mental health wards** and the other **support they utilised** before and after, and the other support needs they have.
7. The link between the changes to **social care criteria** and the **demand for unscheduled care** and other acute services.
8. Quantifying the evidence we have on the link between **hospital stays** and increased **social care demand** from deconditioning and hospital induced dependency.

General evidence:

1. The link between the **level of knowledge and trust in community-provided health and social care** and the level of **decision-making risk aversion** increasing things like rates of conveying, admission and duration of stay.
2. The link between **leadership and managerial skills** and the **quality of decision-making** and implementation of change.
3. The link between strong **learning cultures and infrastructure** and the **quality of decision making** and implementation of change.
4. The link between the extent to which **physical and digital infrastructure is fit for purpose** and the **productivity of services and staff**.
5. What **workforce and skills** are required to enable a **shift in the balance of care.**
6. Better understanding of the **impact of moving staff** around through our change programmes to identify where we have shifted staffing challenges around or worsened them elsewhere

5 What is next?

We are developing an alternative set of insights that can be given to unscheduled care decision makers that will enable them to make decisions across the services within and outwith the box in Figure 1. We will develop this through our local pathfinder work within the Scottish Approach to Change programme and plan to publish this in 2026.

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