Breaking the mould without breaking the system

new ideas and resources for clinical commissioners on the journey towards integrated 24/7 urgent care

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Foreword

The journey towards integrated 24/7 urgent care

In one of the case studies presented here, GP Donal Hynes gets right to the heart of the challenge for the new clinical commissioners when he says we need to 'break the mould without breaking the system'. The NHS Alliance, working in partnership with the National Association of Primary Care is committed to clinicians driving forward the changes we need, showing the bravery to think afresh and not accepting just because things have always been done this way, they always should. The aim is to be bold, but also to understand the complexity of the system, where actions can have unintended consequences; nowhere is this more the case than in commissioning urgent care.

Urgent or unplanned care – when any one of us feels the need to access care quickly – leads to at least 100 million NHS calls or visits a year. It represents about a third of the overall activity in the NHS and more than half the cost. Despite the scale of urgent healthcare, historically more attention has been paid to the way we manage planned activity, especially activity in hospitals (with the exception of the few previous national targets focussing on urgent and emergency care, in particular ambulance times and A&E waits).

The last few years have seen an increasing focus on urgent care. Too often, rather than working together, health services have tended to work against each other to redirect activity to another part of the system – not deliberately or with ill-will, but in response to the pressures and incentives in the system. At the same time, central government initiatives have encouraged primary care trusts (PCTs) to set up new centres broadening access, although these are not always justified in terms of their overall benefit to the wider healthcare system. So while the last ten years has seen real achievements – with more resources

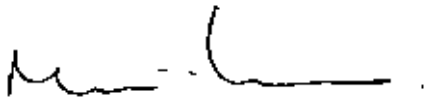
and new forms of access – it has sometimes resulted in a more fragmented system that is difficult for patients to understand or navigate.

Currently there is a real opportunity for the whole network to think afresh about how to get the best possible urgent care system across a local community. Some things are different and distinctive based on the needs of the local population or specific geography, but many other features are common across all.

This resource is not a blueprint for a commissioning strategy, nor do we believe any single blueprint would work in all localities, but it does make a series of suggestions about how urgent care of the future could be more joined up, provide better value for money and offer better patient care. Too often the incentives in the system encourage organisations to work against each other rather than as partners bound together to deliver the best possible care. The current pressure on budgets, combined with a fresh policy perspective from a new administration that is prioritising integrated 24/7 urgent care, makes it possible for commissioners to take a long, hard look at the current pattern of provision.

This is a practical guide for commissioners. It is the culmination of three years of reviews and innovation by the Primary Care Foundation for the Department of Health on different aspects of urgent care. This publication develops some of the ideas and thinking from this body of work, supported by the generous contributions of many people working in a range of services and has led to something we hope is more than the sum of the parts. It is intended to support your journey towards integrated 24/7 urgent care.

Currently there is a real opportunity for the whole network to think afresh about how to get the best possible urgent care system across a local community.



Mike Dixon: NHS Alliance Chairman

Chapter 1

How to use this resource

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This resource is designed to offer ideas and inspiration to everyone responsible for commissioning urgent and emergency care in the UK, in particular, the new clinical commissioning groups in England. Although the current changes offer opportunities for new people to bring a fresh perspective, it is a considerable challenge when there is also a loss of potential experience and expertise. This resource attempts to capture some of the insights gained over the last few years, with the aim of accelerating the learning process of those who are coming to this for the first time.

Experience

The Primary Care Foundation and the NHS Alliance have extensive experience in reviewing and shaping urgent care policy and practice. The Primary Care Foundation was commissioned by the Department of Health between 2007 and 2010 to review and develop services across the spectrum of urgent care: from urgent care in general practice, to establishing a national benchmark for out-of-hours services, plus a review of primary care in emergency departments and an, as yet unpublished, review of urgent care centres. The NHS Alliance represents the majority of out-of-hours providers in England and has an urgent primary care leadership group, with chief executives and medical directors elected by their peers.

Evidence

The aim here is to distil the evidence from our work, highlighting what has been shown to work, as well as debunking myths. In addition, we refer to the most recent evidence from others, such as the findings from the December 2010 King's Fund paper Avoiding hospital admissions: what does the research evidence say? If you are going to break the mould, you need to move forward based on evidence rather than assumptions or anecdote.

Case studies

These examples cover the work of urgent care commissioners over the last five years; they focus on specific aspects of commissioning, such as developing strong relationships between commissioners and provider, or addressing the needs of those in care homes. We do not present them as best practice – in fact, the attraction of some of these case studies is their honesty in addressing where they have gone wrong and how you might avoid some of their mistakes in the future.

Other reports

You may also want to follow links through to other studies. The Department of Health's Procurement guide for commissioners of NHS-funded services and Principles and rules for competition offer helpful guidance and cover ground that is not repeated here. The reports are available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218

Another publication is the recent report Guidance for commissioning integrated urgent and emergency care – a 'whole system' approach by the Royal College of General Practitioners (RCGP); this includes a comprehensive reference source highlighting work across the spectrum of urgent care http://commissioning.rcgp.org.uk/. Again, we have not covered all of the areas addressed in this guide.

We welcome your thoughts on any aspect of this report, in particular if you are making good progress in developing integrated 24/7 urgent care.

The aim here is to distil the evidence from our work, highlighting what has been shown to work, as well as debunking myths.

Chapter 2

Executive summary

Commissioners have six central themes to consider. They need to:

1. **Build care around the patient not the existing services**
2. **Simplify an often complicated and fragmented system**
3. **Ensure the urgent care system works together rather than pulling apart**
4. **Acknowledge prompt care is good care**
5. **Focus on all the stages for effective commissioning**
6. **Offer clear leadership across the system, while acknowledging its complexity**

1. Build care around the patient not the existing services

i) Attempts to define what is or isn't urgent tend to be unhelpful and confusing. Patients tend to make good judgements about how to access care and will make their own mind up about whether something is urgent based on their understanding of their own health and the local healthcare system.

ii) Patients need to be seen at whatever point they access the healthcare system; for those with urgent needs, this is especially important because of the likelihood their condition is more acute.

iii) The variation in demand for urgent care services is predictable. By carefully matching available resources, in particular, clinical staff to the demand for services from patients, it is possible to reduce waits, increase productivity and reduce risks to patient safety.

iv) All services need to ensure they develop systematic processes for seeking and acting upon patient feedback. This involves both patient satisfaction data that can be directly compared with other similar services as well as a detailed understanding of individual patient experience.

There is a need to simplify what is available between the GP surgery and the A&E department. Patients are confused about where to access care.

2. Simplify an often complicated and fragmented system

i) It is vital to make it easier for everyone to understand how to access urgent care. A national urgent care telephone number – 111 – is being tested and will soon be rolled out across the country. But, however, successful the use of a new, simple number to access services may be, it will only be as good as the network of local services underneath it.

ii) There is a need to simplify what is available between the GP surgery and the A&E department. Patients are confused about where to access care. In addition to NHS Direct, general practice, emergency departments and the ambulance service, a host of new facilities, including walk-in centres, urgent care centres, polyclinics, equitable access centres and GP-led health centres, all offer a slightly different range of services available at varying times.

iii) The evidence suggests opening new services is opening up new demand, only some of which is for urgent care. Careful examination of the case mix in many of these facilities indicates they are often delivering planned care with follow-up visits, such as changing dressings. Commissioners need to look at this objectively and consider if it is a service adding value to the local health economy.

iv) The fragmentation of services, with different organisations working alongside each other without any clear and shared agreement about governance, puts both staff and patients at risk. The governance regime and reporting must cover all patients and the whole of their episode of care. It is not acceptable if the information from different systems is not brought together to support the analysis required by proper governance.

v) It is critical to define who is responsible for care as patients move across organisational boundaries. Where two providers work together to deliver what is, for the patient, one service, commissioners should give prime contractual responsibility to one party, with the other acting as subcontractor; for example, if an out-of-hours provider is working with a walk-in centre to see some patients. Where a service works with many others, such as NHS Direct or 111, a mechanism needs to be put in place to promote direct feedback from the providers, so issues at the interface point are addressed.

vi) To support the delivery of integrated care commissioners might want to make clear that the service that refers a patient on to another provider is responsible for the hand-over. The lead clinician at the service where the patient first accesses the healthcare system needs to ensure that any referrals are appropriate and that the hand-over works as it should with the necessary information being made available in a timely fashion to the service taking on that patient.

3. Ensure the urgent care system works together rather than pulling apart

i) The ability of services to work together is one of the most important features of an effective healthcare system. When systems fail or patient safety is compromised, the inability of services to transfer patients or share important information is often a key factor.

ii) There is a need to develop system-wide metrics, but it's also essential to understand the performance of each part of the system. The quality of the overall urgent care system depends on the quality of each service, as well as how they join together to provide seamless care; it's not one or the other but both.

iii) It is vital to support clinicians to work together to ensure best care is delivered both within and across organisational boundaries. We have found repeatedly that services supporting clinicians to work well together and use their range of skills and expertise in an integrated team, provide a better quality of care. This also involves acknowledging and addressing difficult or dysfunctional relationships, either between individuals or across organisations.

4. Acknowledge prompt care is good care

i) There is clear evidence that patients with acute needs have better outcomes if treated rapidly, and that patients associate rapid care with good care. All services need to look carefully at how they can ensure patients are seen promptly; commissioning should focus on improved access to care across the whole urgent care system, rather than setting separate and differential standards across the urgent care pathway.

ii) Where patients are seen face to face It is much more effective for a service to be set up to see and treat patients straight away rather than relying heavily, as many do, on triage processes followed by a second 'full' consultation. All services need a contingency plan in case of a major emergency, but these are very rare events and not a good basis for the overall design of a service. Telephone assessment should also be carried out promptly but, where this meets the need of the patient for reassurance and advice, these may become consultations that are completed over the phone allowing the episode of care to be closed.

iii) A prompt response to potentially urgent requests for care is particularly important at the front end of the healthcare system. Many of the most urgent requests for care are received as calls for home visits in general practice. We urge clinical commissioners to ensure that all practices rapidly call back any request for a home visit so that those few cases requiring an immediate response are dealt with within a few minutes, allowing a community based response to be put in place as soon as possible or a rapid transfer to hospital for a specialist opinion, potentially avoiding a hospital admission.

5. Focus on all the stages for effective commissioning: the commissioning process can be thought of as a cycle, in which needs are assessed, plans are drawn up, contracts are let to deliver the plans, delivery is monitored and ideas are revised

i) Don't expect to get the specification right in every detail. Commissioning is a largely incremental process: changes should happen during the life of a contract and the commissioner and provider need to work together towards this. The ideal is that the re-tendering or re-letting of a contract will only require the commissioner to formally consolidate many of the changes agreed over the life of the contract into one document.

ii) Commissioners play a key role in monitoring arrangements. To do this, they must:

- have a good working relationship with providers and a sound understanding of each service and how it works
- observe the services themselves – including 'walking the floor' and talking to patients, staff and clinicians
- apply a consistent set of measures across all urgent care services in order to understand how the different services compare and to recognise any migration of patients to or from an area
- ensure systems can track patients so the pathway can be followed from beginning to end to support an integrated governance process across organisations and services

iii) An over-simplistic focus on reducing cost, such as by avoiding tariffs, is misguided – despite the increasing financial pressures on public services. Any new currency in the NHS, or the development of shared tariffs to incentivise new ways of working, demands a high level of cooperation both at a senior level between organisations and between frontline clinicians, and requires proper accounting to be sure any planned savings are both achievable and delivered. Too often, commissioners fail to look at the overall cost to the health economy or taxpayer and instead focus on reducing cost to one party, or in one part of the system.

iv) Financial incentives need to be aligned to ensure commissioners stop paying more than once for the same service provided at different points in the system. One opportunity to do this is by bringing all costs for urgent care back to the practice budget, or collectively through the budgets of clinical commissioning groups (this would include out-of-hours services, all 999 or 111 calls, all visits to urgent or primary care centres and A&E). Patients should be free to choose how to access urgent care, but if the cost tracks back to the practice budget there is an incentive for the practice to deal with as many requests for urgent care as rapidly as possible. Whether or not costs can be routed back to the practice, it is vital information is promptly fed back about the usage of urgent care services by practice patients (for example, through a dashboard as highlighted in case study four).

Case Study 1: Breaking the mould without breaking the system: managing emergency admissions in Somerset

Tackling emergency admissions in order to release resources was a high priority for GP commissioners in Somerset; led by GP Donal Hynes, over the last five years they focussed on a series of measures mainly deliverable in primary care. The successes were:

- **attaching a complex care GP to nursing homes with high levels of hospital admissions led to a dramatic drop in admissions for exacerbations or terminal events**
- **the local health system introducing a single point of access for all admissions. The clinically-staffed centre retains real-time information about available resources so clinicians are aware of options other than acute hospital admission for the onward management of patients**
- **introducing a chronic obstructive pulmonary disease rehabilitation team**

The initiatives having less of an impact were:

- **placing a GP into A&E**
- **setting up a nurse practitioner-led community assessment and treatment ward in community hospitals**
- **a rapid response community team**

Monitoring the impact of these changes revealed an initial drop in emergency admissions, but over time, these rose again. Further analysis revealed the increase was mainly in the zero-length-of-stay patient group and that, while GP admissions had gone down, A&E and ambulance admissions had increased. One suggestion is patients can't get to see their GPs, so are turning up at the hospital.

The commissioning group is now looking more closely at access to primary care. Another priority is building greater understanding and links between the ambulance practitioners and local general practices: the paramedic community would like access to urgent primary care support improved so patients can be stabilised in the community.

'It is important to challenge hospital trusts and the way they provide care,' says Donal Hynes, 'but it is equally important to challenge primary care, ambulance services and out-of-hours providers. The initiatives that didn't work well here have, in some cases, proved more successful elsewhere, so it is not just what you do, but how people work together. Commissioning is a long haul: things work for a while, then you have to look at them again and refine them. That's why it's so important to be clear how you are measuring success, to get regular information and act upon what you see.

There is a massive learning curve in coming new to commissioning care. We started with a clear view of how we wanted to change our local healthcare system in a way that was challenging for others and it took us a while to realise just how complex the system is. You need to have bold ideas, but you need to work out how you are going to see them through. To be suddenly given a great deal of power is also to be given a great deal of responsibility. The real challenge is to break the mould without breaking the system.'

For more information, contact Donal Hynes at Donal.Hynes@somerset.nhs.uk

v) There should be a greater emphasis on commissioning for quality, including making clear the 'quality cost'. This involves identifying the service costs directly relating to improving the quality of care, including the cost of recruitment and induction processes, staff training, support and development, benchmarking and audit processes. We recommend commissioners should require providers to explicitly identify the 'quality cost' within any tender they submit.

vi) Urgent care appears to have become the test bed for a market-based system in the NHS: urgent care centres, GP-led health centres and in particular, out-of-hours services, have increasingly been subject to tender processes. We do not have a problem with increasing contestability, or the idea services can be tested if all other routes for improving services fail, however, it is less clear why tendering has become the default position for commissioners in urgent care, while hospital contracts remain unchallenged.

The tendering process is costly: it's estimated the tender process costs in excess of £100,000 (plus the cost to the provider of bidding that has to be recovered). There is also a concern commissioners pay less attention to developing a clear commissioning strategy than to ensuring mistakes are not made in the procurement process. Better management of contracts by commissioners, armed with good information over a longer period than is typical, is the key to driving down costs and improving patient care.

6. Offer clear leadership across the system, while acknowledging its complexity

In the past, too many commissioners felt unable or unwilling to challenge existing arrangements and implement radical change: the challenge, as the title of this report says, is to break the mould without breaking the system

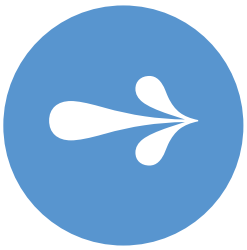
i) Given the current requirement for efficiency savings and greater value for money, all commissioners should take a fresh look at their urgent care strategy and the range of disparate services commissioned over the last ten years. Can all services really be justified? How do they add value to patient care? Are commissioners paying twice for the same service?

ii) General practice is the bedrock of any urgent healthcare system. There is a need for greater emphasis on ensuring individual practices respond rapidly and effectively to patients with an urgent need. If all practices improved the speed and effectiveness in responding to same day requests, there would be a substantial beneficial effect on the wider healthcare system; all commissioning strategies for urgent care should start by addressing the key role of general practice.

iii) Urgent and emergency care networks have an important role to play in leading local healthcare systems. Too often they have been seen as talking shops where no real decisions are taken, but if systems choose to give them real executive authority, for example in defining the clinical pathways and protocols for handover of care, then they can play a key role in improving care across organisational boundaries.

iv) Urgent care services need to develop a stronger culture of learning from mistakes. Commissioners should encourage providers to take part in wider initiatives that support rapid sharing and learning from incidents where patient safety was put at risk.

v) Commissioning is often seen as the passive partner within the urgent healthcare system, with staff perceived as too distant from the frontline services they commission. It is the responsibility of the new clinical commissioners to work with a poorly performing service and to insist on action being taken immediately. In every case of poor performance, there has been enough evidence to allow the commissioner to act and if necessary, terminate the contract early. We encourage all commissioners to manage their services closely enough to avoid terminations.



Defining urgent care: the key terms

How do we define urgent care?

The Department of Health's definition of urgent care is: 'Urgent care is the range of response that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using the services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need' (from Direction of travel for urgent care: a discussion document).

This covers a range of services including those provided by many specialist secondary care services, A&E departments, urgent care centres, walk-in centres and minor injury units, the ambulance service, GP practices and primary care services and other health and social services.

The RCGP says: 'The term urgent care should be used as the umbrella term to include unscheduled care, unplanned care and emergency care to ensure a single recognisable identity and to promote a more integrated approach to commissioning and service provision.'

For clarity, we use the term 'urgent care system' as this umbrella term covering unscheduled care, unplanned care and emergency care.

What is an urgent care centre?

A single, clear definition of an urgent care centre does not exist. The main types of services using this name are:

- urgent care centres located on a hospital site with an emergency department and with access to diagnostics and clinical staff in order to treat a large proportion of walk-in patients (and sometimes a proportion of those arriving by ambulance)
- urgent care centres not located with a hospital emergency department, but with a full range of diagnostics and clinical staff. These centres are able to treat patients with fractures and patients with complex illness and multiple conditions
- urgent care centres dealing with a narrower range of cases similar to those that might be provided in a walk-in centre, sometimes including minor injuries, though with limited, if any, ability to treat fractures

What does good urgent care look like?

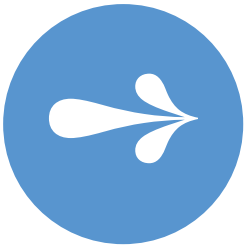
We suggest a high quality, effective and cost-effective urgent care service is one where:

- care is provided promptly
- patient's needs are met and patients are clear about the scope of the service
- the skills of the staff are such that a consistent high quality service is provided
- governance and management responsibility for improving quality and cost-effectiveness is clear and exercised
- the environment is conducive to the delivery of good quality care
- the process supports all these features

What is the difference between triage and see and treat?

These two terms are often confused. Our definition of them is as two opposed and mutually exclusive approaches: a patient cannot be seen by a clinician for triage and then progress to a see and treat consultation.

Triage is the immediate sorting of patients according to the seriousness of their condition. It is widely used in emergency departments and urgent care centres to assess how quickly a patient needs to be treated and to define the skill group most likely to meet the patient's needs. Any consultation resulting in completion of the episode of care has gone beyond triage.



See and treat involves seeing patients when they arrive without subdividing the assessment and consultation into separate processes. Many patients will conclude their episode at the first consultation and, in contrast to a triage process, this is the aim; some will require further investigations and a continuation of the consultation after results are available.

What are majors and minor'?

Minors is a term used in A&E departments for cases which are not life-threatening and are usually diagnosed, treated and discharged on the same day (albeit sometimes with follow-up). Historically, emergency departments have included primary care-type presentations in this definition. However, the term is misleading: many cases are significant injuries, which, unless treated and managed properly and expertly, will result in lifelong functional disability for the patient. In addition, minors are not synonymous with primary care cases because patients with many of the injuries in this category do not frequently present to general practice.

Majors are patients who tend to have more serious, potentially life-threatening conditions, or who will require more detailed clinical assessment and investigation by specialist staff. Many of this group are older patients with long-standing conditions that have deteriorated; it also includes patients who arrive after major trauma and require resuscitation. Although most PCTs and trusts exclude majors from any analysis of primary care cases, many of the patients in this category are the same patients who GPs treat in their homes. Often, it is only the marginal deterioration of one condition that leads to this group arriving at the emergency department.

Different streams in emergency departments

Some emergency departments are changing how patients are classified (this is as a result of the deeper integration of emergency medicine and primary care treatment). The new classification includes an ambulatory and non-ambulatory stream, as well as a separate injury stream and a system to ensure patients can move between streams when required.

This classification change has a number of advantages: both streams are expected to contain acute critical illness and hence there is the available expertise to respond effectively; the requirement to keep checking whether all ambulatory patients have only minor illnesses is removed, and there is a more effective deployment of a range of competencies and experience.

Chapter 4

Principles for commissioning urgent care

The following core principles apply across the urgent care system

Core principles for the urgent care system

- **patient safety is the priority**
- **capacity is closely matched to real demand**
- **clear objectives are set for all component services being commissioned**
- **clinical and operational governance must apply consistently to all patients and pathways**
- **changes to services should be evidence-based**
- **commissioning must be clinically-led and include the involvement of clinicians from the key component services**
- **quality must be measured and proven, not asserted – quality should be measured both within and across component services**
- **activity and outcome data should be produced in as close to real time as possible**

The 12 guiding principles for a healthcare system: building on the core principles, we have developed a set of 12 guiding principles designed to be a starting point for a healthcare system aiming to develop its urgent care strategy

1 Patients' needs will be at the heart of the strategy – in particular, the safety of the patient must come first in considering any changes to the urgent care system.

2 The urgent care system should be considered as a whole: each constituent service has to work well, but also has to work with others, if the whole is to function properly. Processes and services should be easy for patients and health professionals to use and should provide good quality care in an appropriate, safe environment. Attention should be paid to relationships between individuals and between sectors, so that mutual understanding and co-operation is actively nurtured.

3 Decisions about the location, remit, scope and need for specific services should take into account:

- the availability of, and impact on, other services across the local health community
- the actual or projected demand for the service
- accessibility, particularly for 'hard to reach' patient groups, and the need to provide an equitable service across the area, while recognising individual solutions may differ depending on the locality's needs
- the availability of back-up and support services, especially for patients whose condition is more acute
- the need for individual services to be of a sufficient size – this allows good governance, enables good use of services' skill mix and for staff to experience a sufficiently diverse range of cases to provide good quality care

4 Care should be prompt, minimising the risk of exacerbation and providing early relief to the patient so that, if the condition is found to be more severe than initially identified, appropriate action can be taken.

5 Design care pathways to minimise hand-offs – where responsibility for patients passes from one staff member or organisation to another – while ensuring the patient is seen by the right health professional with specialist skills to provide optimal care.

6 Where it is necessary for responsibility for a patient to be passed from one health professional to another, or from one provider organisation to another, the systems should support a seamless process so that, as far as possible, the patient does not see the join. The process should avoid the patient having to repeatedly provide their details.

7 Decisions about pathways and services should be based on evidence of good practice and proven beneficial outcomes.

8 The urgent care system includes different services; patients and health professionals should be clear what types of condition each service treats, with patients free to choose whatever service they believe will meet their need. The resources offered should be available throughout the services' opening times: a minor injury service should have suitably qualified staff and x-ray services available to deal with possible fractures throughout its opening hours, not just for part of the day.

9 Services that reduce demand on the urgent care system by minimising the acute exacerbation of a condition through supporting patients in the community are a valuable part of the strategic approach. Community services should be structured in such a way that they can work with the local GP practices to provide this type of preventative care and support patients after an urgent care episode.

10 Clinical staff will be involved in the development of the pathways and services. They have invaluable experience from their day-to-day observations of hundreds of patients; the views of patients are also valuable, but typically informed by less experience.

11 As part of collecting information on individual services, a number of common measures of quality, referrals, outcomes, timeliness, care and patient perception should be collected from all services to understand the operation of the urgent care system as a whole.

12 Providing a cost-effective urgent care service is critical. Urgent care systems providing prompt good quality care and aiming to provide support within the community if possible will be less costly and more cost-effective than those operating with delays, hand-offs and duplication.

Case Study 2: A clear commissioning focus: developing a local solution in Tower Hamlets

NHS commissioners in Tower Hamlets, a deprived and diverse community in London's east end, developed a comprehensive strategy aimed at improving access and care outside hospital. Despite considerable investment in primary care, a large number of patients are not registered with a GP practice, and there is high attendance at urgent care centres and the emergency department that could be addressed in primary care.

Recognising there was no simple way of changing patients' pattern of access, a range of measures were adopted. They included: addressing primary care through active performance management and development of general practices, introducing an urgent care dashboard, setting up practices in two locally-based networks, each linked to new GP-led walk-in services, commissioning an urgent care centre at the Royal London hospital (one of four major trauma centres in London) and developing a strong urgent care network, nurturing partnerships between commissioners and all urgent & emergency providers.

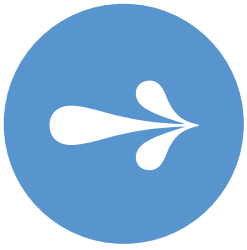
In addition, commissioners chose to invest in social marketing. A social marketing campaign began by looking at a breakdown of emergency department and GP practice attendances – not by demographic, but by the reasons why patients attended. The campaign was then designed around patient behaviours. Working with local community groups, such as the Faith in Health programme, to ensure community leaders understood the social marketing messages, was also a vital part of the programme. The long-term effects of this work are not yet clear, however, an initial evaluation was positive.

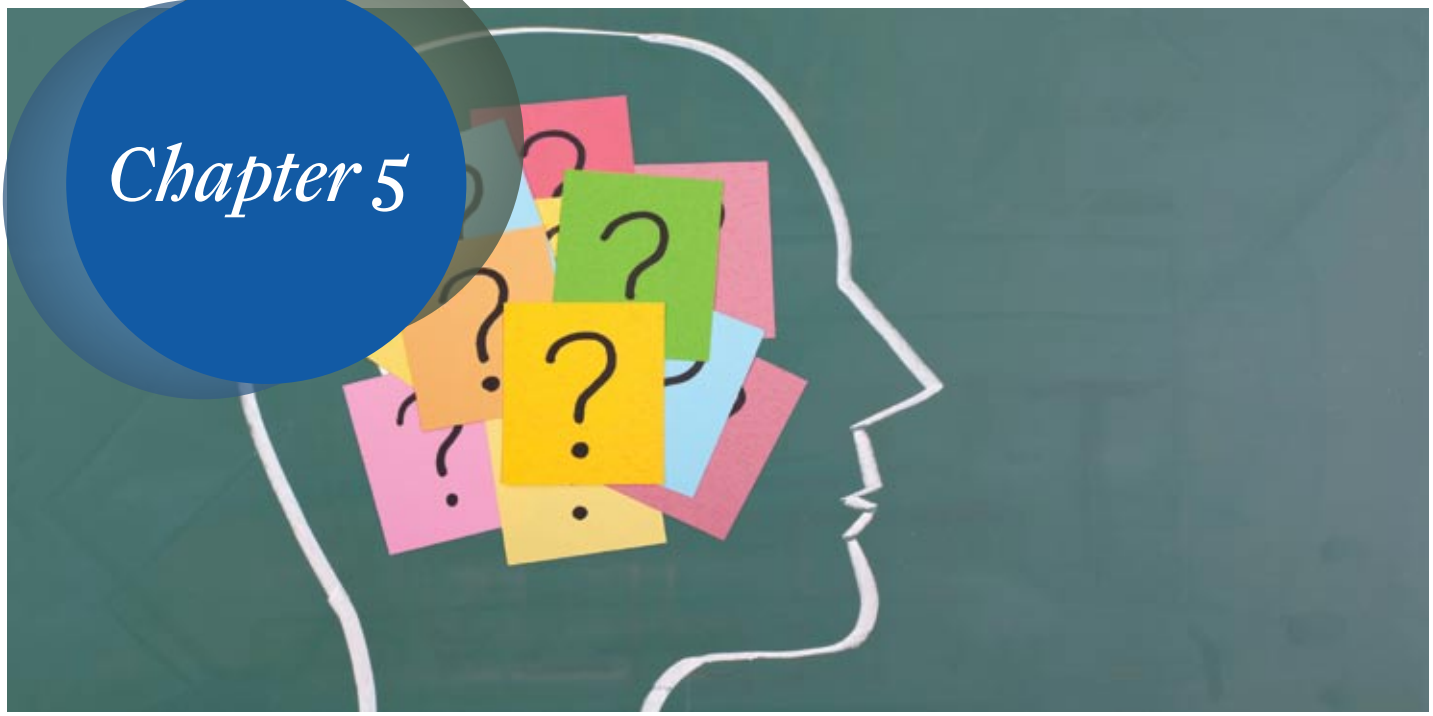
Tower Hamlet's urgent care centre/emergency department operates a GP-streaming system to direct non-urgent cases to primary care. Great care is taken to ensure that no potentially urgent cases might be missed and that immediate clinical needs are met. Patients are also actively supported by non-clinical navigators to register with a GP practice, make a rapid appointment with a practice, or are directed to other services in the area.

In 2010, a clinical audit of GP-streaming showed 87 per cent of patients contacted were satisfied with the streaming process. Many of the patients streamed were young people (aged 18–34), especially young men; there were a high proportion of minor injuries, including soft tissue injuries, such as sprains, which were referred to others in the urgent care centre. Streaming was found to be effective, but clinician-dependent.

So what can others learn from the Tower Hamlets experience? Liz Price, urgent care commissioner in Tower Hamlets from 2008–11, has played a central part in this programme, she says: 'Clarity about the issues, understanding patient behaviour and the reasons why different groups of patients attend the emergency department, instead of their GP, was crucial to making a difference. The challenges in our area meant we needed a clear vision for how we wanted to improve things across GP access and urgent care, with a joint strategy, strong executive leadership and a commitment to see it through over a number of years.

We focused on making care accessible at all levels, as well as actively supporting patients to access care closer to home – at their local GP practice. I would start with improving access and care across all practices – using the tools that are available – as well as ensuring good information is used well to drive improvements.'





Chapter 5

The seven myths of urgent care

We have identified seven urgent care myths; it's time to challenge them and do some myth-busting.

Myth 1. Much of the care being delivered in A&E is primary care

The reality: when we used a consistent definition of primary care (cases regularly seen by GPs in general practice) and a consistent denominator of all emergency department cases, we found the proportion of A&E cases that could be classified as primary care was between 10 and 30 per cent. Whilst it is undoubtedly true that primary care clinicians can relearn the skills needed to deal with the minor injuries that were excluded from the definition of primary care cases, there seems little value in this when A&E nurses already do this work well.

Myth 2. There is always too much demand for services to cope with

The reality: Our analysis reveals it is rare for the footfall per hour to vary more than 50 per cent from the average per hour on any given day. This means it should be possible to staff for, and consistently deliver, a timely one-stage response; we are familiar with services which deliver this model consistently and reliably both in urgent care centres and emergency departments.

Inserting a triage or assessment stage in a bid to dispel queues and delays is wasteful of resources (see Myth 5); the aim must

be to match capacity to demand. The reasons for queues developing can often be traced back to an under-staffed unit due to absence, or clinicians working at different rates.

Myth 3. Patients misuse urgent care services – the myth of inappropriate attenders

The reality: There is a small group of users who will consistently use the system in a different way from most and many service plans are built around this minority group. However, the operational and academic evidence shows the majority of patients use the services appropriately, given the patients' perceived urgency at the time of use. We feel there is a tendency for services that do not have an effective operating model to blame the users, rather than looking at their performance.

Myth 4. It is important for commissioners to educate the public about services

The reality: There is good evidence that initiatives, such as the expert patient programme, and providing condition-specific information for patients is beneficial. In contrast, there is no evidence that general education about how to use a system has any impact.

For most people, using the urgent care system is a rare occurrence: once every six years for out-of-hours, on average every three years for A&E. Giving information at the time of use, will have an impact over time, and we recommend this approach be adopted. For the message about how to use health services to get across, it needs reiterating consistently as a routine part of the consultation in all urgent care services over many years.

Myth 5. It is safer for patients and better for services to assess and triage everyone

The reality: There is good evidence that a rapid see and treat process is safer than a system involving multiple assessments and delays. Triage is most often used to compensate for delays caused by poor capacity planning; there is no evidence that an assessment and triage service can improve utilisation and outcomes.

There is a real danger that an assumption is made that the assessed patient is safe to wait when, in reality the condition of some patients can change rapidly.

There is also a view that if everyone is assessed, patients can be directed to the most appropriate endpoint. However, the evidence suggests most patients will make the right choice themselves and if the service is available they will use it.

We have identified seven urgent care myths; it's time to challenge them and do some myth-busting.

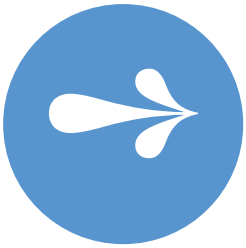
In addition, evidence shows the feature patients value most is rapid access with minimal steps: they do not want multiple phone calls, ring back and delays, nor do they like to be assessed and then put to the back of a long queue in the waiting room.

Myth 6. There is a direct link between A&E attendance and hospital admissions

The reality: There is some evidence that when A&E departments become overwhelmed junior staff will admit more people – the primary failure is in the A&E system not the volume presenting.

There are a number of key factors driving hospital admission numbers. These are: the number of individuals referred by GPs, 999, 111 and NHS Direct staff and out-of-hours services (which are all influenced by access to GP urgent care), and the efficiency of the process in A&E and acute medicine, including the availability of senior staff. There is little or no evidence for the effectiveness of diversion schemes on admissions; some have had serious safety questions raised; while diversion schemes tend to focus on people who were never likely to be admitted because all they needed was advice or more basic care.

Good acute care by GPs in the community, combined with early assessment of the severity of an episode by the GP, has been shown to reduce admissions; this is because there is time to arrange alternatives keeping the patient away from hospital. Out-of-hours providers should also focus on the clinical activity of their staff to ensure unnecessary referrals to hospital are avoided. Targeted approaches, looking at each area where the decision to admit is made such as improvements in ambulatory emergency care, are likely to be much more effective at reducing admissions.



Myth 7. Commissioners should tender out-of-hours services frequently

The reality: there are the same expectations about out-of-hours services as every other commissioned NHS service, yet for some reason, out-of-hours services are put out to tender frequently, apparently with the view that this guarantees value for money.

Commissioners are required to procure services in a way that is transparent and non-discriminatory. Contestability, or the knowledge that if all else fails, services can be market tested, is important, but it is far from clear that the full range of traditional performance management processes have been deployed to raise the performance of the service during the contract. If a provider is to invest in a service their time horizon needs to be long enough to make it worthwhile – or at least five years – short contracts and short-term extensions will discourage investment in training, equipment, staff and systems.

Tendering is expensive (estimated as at least £100,000 for the commissioner and for each provider involved) and disruptive and in some cases may lead to too much focus on the tender price rather than quality, patient safety and the overall cost to the wider healthcare system.

There are times when commissioners will want to tender services, but this should happen far less frequently. A much more effective way of improving care for patients and driving cost-effectiveness is to work consistently with providers looking for one incremental improvement after another.

Chapter 6

The evidence: what we know

The first part of this information is drawn from the Primary Care Foundation's four reports covering the spectrum of urgent care (detailed in Appendix B). In the subsequent section, we summarise three broader reviews of the literature: two from Warwick Medical School, which were commissioned as part of our studies, and a recent review by the King's Fund Avoiding hospital admissions – what does the research evidence say?

Research shows:

Most service users are accessing care in the right place. While a small number of patients will make inappropriate use of the system, processes should be designed on the assumption that the vast majority make sensible decisions in attending urgent care services and, particularly at emergency departments, are likely to have a relatively high proportion of more acute cases.

Prompt care is good care and it is cost-effective. There is plenty of evidence that addressing the needs of patients with more acute conditions quickly means they are likely to enjoy better clinical outcomes. Meeting the immediate needs of a patient having carried out an assessment is far cheaper for the NHS and tax-payer than sending them elsewhere for the whole process to be repeated.

Patient satisfaction and speed of response are connected. In out-of-hours care, there is a very strong link between patient satisfaction and how quickly patients think they are seen; we are sure this commonsense relationship applies elsewhere in urgent care.

Successful providers:

- match capacity to predictable demand, giving clinicians time to do their work well
- meet performance standards
- introduce governance processes to ensure a consistent and safe response to patients
- engage clinicians and patients in the design and delivery of the service

Demand is predictable. There is considerable consistency in the pattern of demand by day of the week in the numbers of A&E attendances across England: Monday has the highest number of attendances and all days experience a predictable rise to a mid-morning peak. The pattern for individual urgent care centres is essentially similar; demand also follows a predictable pattern in general practice.

In addition, the random variation of demand by hour around the norm is predictable. Even in modest-sized urgent care services demand only exceeds 150 per cent of the average level of demand rarely.

Matching supply to demand works. Urgent care services that manage clinicians and capacity to match the predictable demand from patients, and to ensure all patients are seen promptly, avoid the build-up of significant queues. Other advantages of this approach include:

- minimising the need for triage with the 'double-working' of each case
- reducing the peak load on individual clinicians
- improving patient satisfaction by reducing delays
- improving safety and outcomes through an early consultation

Queues are usually caused by management and governance decisions. The main reasons long queues build up seem to be poor scheduling of staff, staff absence or inadequate premises that make it difficult to deploy staff effectively; these are management issues.

Preliminary assessment involves some risk. Any preliminary assessment, such as triage, to stream or prioritise patients carries a higher risk that an urgent case might be missed, than when a full assessment is carried out. This initial streaming is appropriate and safe if the patient moves quickly to the full clinical consultation, but tying a clinician up in triage does adversely impact productivity.

Telephone assessment can involve risk too because of the difficulties of assessing a patient over the phone, especially if the caller is not comfortable with using the phone, is poor at describing their history or if there are language difficulties. This risk can be managed and assessed by auditing individual cases and measuring individual clinicians or call-handlers, but it is still there.

Measure individual clinical productivity. It is important to recognise how much individual clinical productivity can vary – because of differences in training, experience, judgement style or the patient's clinical presentation – and that, beyond a certain level, this can impact negatively on a service. Taking steps to reduce variation by making information available that highlights differences and then exploring performance with clinicians can have a substantial impact on improving overall care and organisational performance.

Urgent care centres do not provide an A&E 'quick fix'. There is a lack of published evidence to support the hypothesis that urgent care centres and walk-in centres will reduce attendances at emergency departments; in contrast, indications suggest they increase total burden on the NHS. Where the vision of the urgent care centre is that it is fully integrated part of the A&E service as described below it will take time to establish and much longer for the relationships and mutual trust to grow so that the centre functions with full effectiveness.

Primary care skills can be helpfully integrated into a multidisciplinary team. Primary care practitioners can enhance emergency departments by bringing vital skills and expertise to a multidisciplinary team. To achieve this, managers and clinicians need to develop strong working relationships; building mutual respect takes time, but it is vital if initiatives of this kind are to lead to a more integrated service.

Savings have to be real if they are to be realised. The idea that putting primary care practitioners into A&E or establishing a new service at below tariff cost per case will result in savings is flawed: without commensurate savings being made or other benefits realised, this does not result in savings for the NHS or taxpayer – in fact, costs rise.

Services developing local tariffs that incentivise all partners to work in the patients' best interests and allow resources to be saved elsewhere appear to be heading in a more promising direction. In time, this approach may achieve an overall cost reduction.

Missing thresholds and monitoring performance matters a lot. Many out-of-hours providers are falling short on the standard for definitive clinical assessment of urgent cases – which we see as an important issue of patient safety. The out-of-hours benchmark also highlights the variability across services in the proportion of cases identified as urgent.

In emergency departments, differences in the time to discharge clearly demonstrate how some hospitals stay on top of demand, while others are running to catch up. Commissioners should look particularly carefully at these types of measures and identify those well below the norm, or slow in providing care.

Use other data as well. We recommend commissioners use poll data from research company, Ipsos MORI, about how patients see their out-of-hours service. In the hospital setting, use national comparisons of patient experience and consider designing local surveys based on the national comparison questions and the scoring framework.

Systematic reviews of the literature: the key points

1 The King's Fund report *Avoiding hospital admissions – what does the research evidence say?* found the following:

The interventions where there is evidence of a positive effect on avoiding hospital admissions include:

- continuity of care with a GP
- hospital at home as an alternative to admission
- assertive case management in mental health
- self-management
- early senior review in A&E
- multidisciplinary interventions and telemonitoring in heart failure
- integration of primary and secondary care

The interventions where there is evidence of a positive effect on reducing readmissions include:

- structured discharge planning
- personalised healthcare programmes

The interventions with little or no evidence of beneficial effect include:

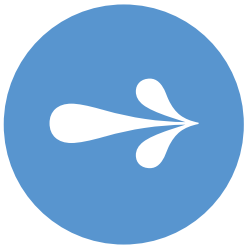
- pharmacist home-based medication review
- intermediate care
- community-based case management (generic conditions)
- early discharge to hospital at home on readmissions
- nurse-led interventions pre- and post-discharge for patients with chronic obstructive pulmonary disease

2 A literature review on primary care in A&E by Warwick Medical School found:

- a GP working in A&E may result in fewer referrals for admission and less tests being undertaken. Cost benefits may exist, but the evidence is weak
- redirection away from A&E has variable results regarding future attendances, and assessments of the safety of this type of intervention are also variable; patients redirected from A&E to primary care do not always attend these appointments
- educational interventions do not change attendance patterns
- there is a paucity of evidence available to support the current system

3 A rapid literature review of urgent care centres by Warwick Medical School concluded:

- there is a lack of published evidence supporting the hypothesis that urgent care centres and walk-in centres reduce attendances at emergency departments, and some suggestion they may increase total burden on the NHS
- the NHS should be careful with expectations of new services. Any new service should be carefully analysed measuring the impact across the whole health economy and should be encouraged to publish and share results



Chapter 7

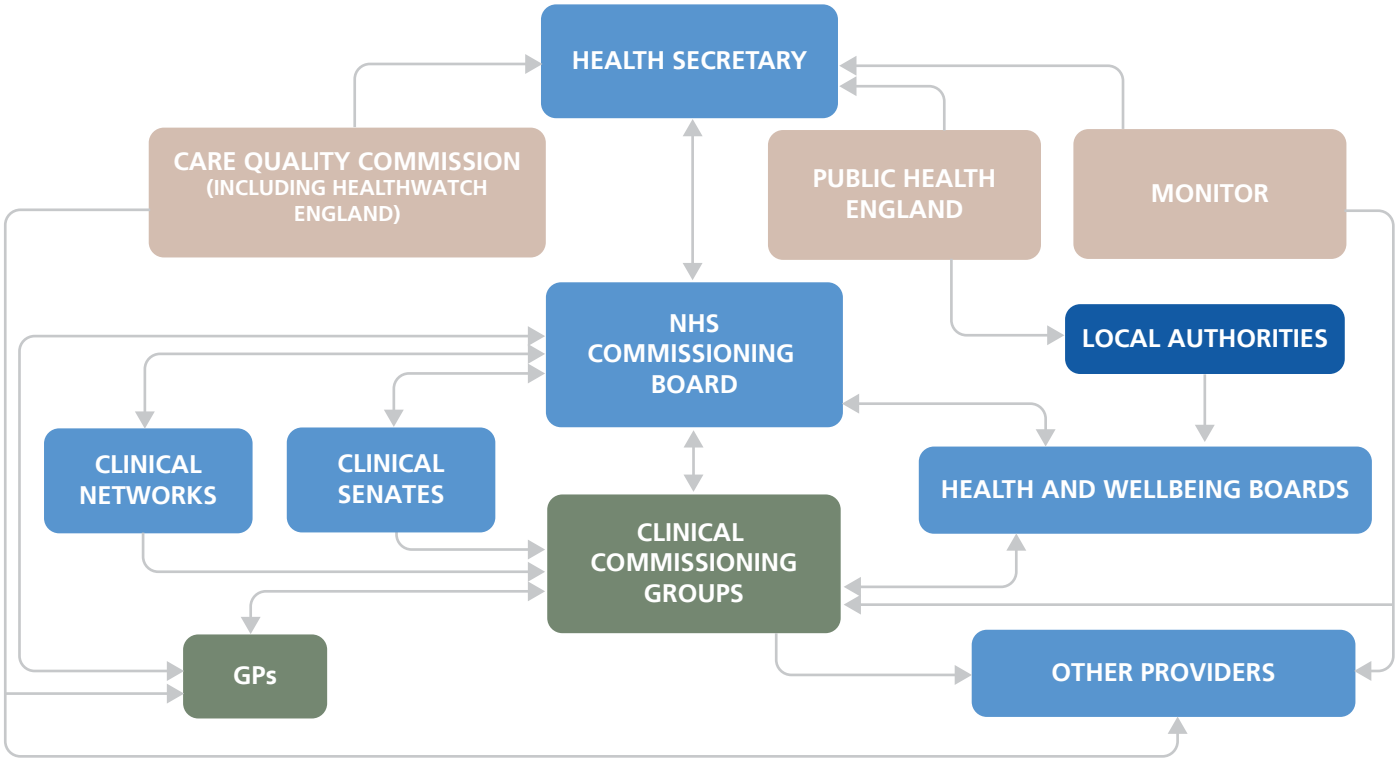
Commissioning the whole system: why the big picture matters

Clinical commissioning groups are taking centre stage in deciding how to make best use of NHS resources. They are not alone in making these decisions, but one part of a complex web of organisations and regulatory bodies with an interest in shaping commissioning (see diagram overleaf).

The urgent care system is made up of a number of components which need to function effectively for the system to work well. However, there is a constant tension between understanding the detail of how services operate and maintaining a clear vision for the service as a whole; this tension can be creative or destructive.

Where the individual parts connect is the most challenging aspect of developing effective services. These handover points are highly important: when things go seriously wrong in healthcare, investigation often finds significant gaps not just within, but between services.

Currently, services tend to be commissioned separately. The advantage of this approach is it makes it easier to look at the individual performance of organisations and it is simpler to measure one part of the system. The difficulty is that patients don't see things in this way. They do not distinguish between individual providers – but think of the overall quality of care. Even if each part of the care was good, if the links between



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them were poor, and information was not passed on and they were repeatedly assessed rather than given care, then the overall impression is likely to be the system has failed.

There are two major ways in which the commissioning of urgent care could be improved and joined up: by improving the commissioning of existing services and by moving towards the commissioning of an integrated 24/7 urgent care system.

A. Improving the commissioning of individual services: the role of different stakeholders in urgent care

1. General practice

General practice is the primary contact point for most patients seeking help with an urgent healthcare problem and is where most consultations take place. As a result, a small change in general practice will have a significant impact on flows to other parts of the urgent care system. This gearing impact means effective and timely responses in general practice benefit patients and reduce acute referrals to hospital.

Ensuring general practice develops a rapid and effective response in every practice should be a fundamental part of every urgent care strategy. In order to achieve this each practice must have:

- adequate telephone capacity
- the ability to respond quickly (ideally within ten minutes) with telephone assessments of patients who may have an urgent problem at risk of admission
- the ability, alone or in cooperation with other practices or services, to be with the patient within an hour or so of the initial call
- adequate capacity, matching expected demand for all patients seeking same-day care

The Primary Care Foundation's 2009 report Urgent care in general practice, supported by the British Medical Association and RCGP, suggests simple ways of improving access and the management of urgent care in general practice; its web-based tool designed to enable practices to operate more effectively has been used by over 200 practices across the UK. More information on all aspects of managing access and urgent care in general practice is available at: http://www.primarycarefoundation.co.uk/what-we-do/urgent-care-in-general-practice.html

Continuity of care in general practice is important in reducing acute referrals. There is good evidence patients value continuity, not only in routine care, but when their condition requires a more urgent response.

Practice systems should not only deliver a rapid and effective response but, particularly for those with long-term conditions, seek to provide access to the GP of choice who is familiar with the patient's condition. We have found improved continuity results in overall reductions in the number of appointments practices need to deliver (see also King's Fund paper Avoiding hospital admissions: what does the research evidence say?).

Case Study 3: Improving access and urgent care in general practice: clinical commissioning in Gateshead

As part of its urgent care strategy, Gateshead network commissioning consortium in Gateshead, Tyne & Wear, identified GP practice activity, access and response to urgent care as an important area to look at. Between the end of 2010 and spring 2011, 31 of the consortia's 33 practices utilised the Primary Care Foundation's web-based tool to enable practices to operate more effectively.

Practices submitted data online and then each received a report from the Primary Care Foundation analysing their practice – how easily or not patients can access care, the relationship between demand and availability of appointments, and how staff recognise and respond to requests for urgent care. Reports also highlighted how practices compared to others in the locality, as well as nationally.

Sheinaz Stansfield is practice manager at Gateshead's Oxford terrace medical group. The practice has a lower doctor to patient ratio than the national average but, before working with the Primary Care Foundation, staff still struggled to meet patient demand. 'By 8.30am all our appointments were gone,' explains Ms Stansfield. They were also concerned that in a list showing which of Gateshead PCT's practices had the highest number of patients attending A&E they were in the top ten.

After completing the web tool and receiving the Primary Care Foundation's report which highlighted the practice's complex system for accessing appointments, the practice is making a number of changes. These include reducing triage appointments and being able to convert any appointment into a phone appointment; initial feedback from patients suggests the latter is very valuable. 'We've managed to strip some of the waste out of the system. It's the tiny little changes we're making in general practice that are making a real difference,' says Ms Stansfield.

Since the majority of practices completed the work with the Primary Care Foundation, there has been a reduction of up to 20 per cent in the number of people attending one of Gateshead's two urgent care centres. The hope is that this fall is at least in part due to the work with the Primary Care Foundation, however, there are other factors to consider: the introduction of another urgent care centre 18 months ago will be having an effect, as will neighbouring Newcastle recently relocating an A&E department to one more accessible to Gateshead residents.

The overall approach in involving all practices enables the clinical commissioning group to emphasise urgent care is the business of all GPs and practices. Sam Hood from the commissioning consortium says: 'We believe it is really important not only to involve GPs in the commissioning of the wider urgent care system, but to also engage them in the development of their own systems and response to patients' urgent care needs. The universal nature of the project has helped significantly in this aspect.'

For more information, contact Sam Hood at sam.hood@sotw.nhs.uk

As general practice is a key component of the system, each practice should receive information on a regular basis regarding their referrals to the urgent care system (adjusted for prevalence and demography of the practice list). This allows practices to compare their organisation with others and be a component of the whole system metrics; GPs should see how the rest of the system is performing against key metrics.

2. GP out-of-hours services

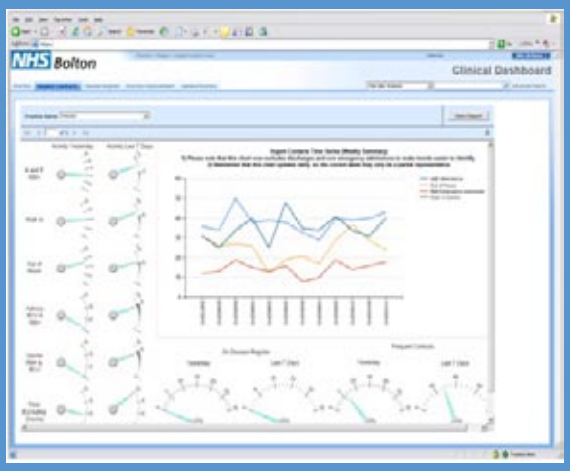
A series of steps to improve the commissioning of out-of-hours services was highlighted in the Department of Health's report General practice out-of-hours services: project to consider and assess current arrangements and the Care Quality Commission's Report on an enquiry into out-of-hours care at Take Care Now. Priorities include assuring the quality of clinicians through good recruitment, training and development of staff, effective use of the Performers List and addressing clinical variation across services.

Most out-of-hours services now benefit from consistent measurement and comparison with others through the national out-of-hours benchmark. This enables commissioners and providers to highlight the areas of comparative weakness needing improvement.

The Department of Health report specifically recommended that 'PCTs and out-of-hours providers should benchmark their services in ensuring the validity of their performance data. For instance, this could include participation in the Primary Care Foundation Benchmarking exercise. Benchmarking will enable PCTs to consider whether the resources allocated to the service are sufficient to ensure delivery of productive and high quality services.' More information is available at: http://www.primarycarefoundation.co.uk/what-we-do/gp-out-of-hours

Case Study 4: The urgent care clinical dashboard: proactively managing care in general practice

The urgent care clinical dashboard is a web-delivered application that can be accessed by GP practice staff from any desktop. It collates all the previous day's activity data from A&E, hospital admissions, discharges, out-of-hours and walk-in centres bringing it together to be viewed via the dashboard. Clinicians can click on any dial and drill down to a more detailed picture showing individual patients.



At NHS Bolton, where the system was piloted in 2008, the dashboard has enabled clinicians to see which of their patients are seeking urgent care, and to make better-informed decisions on managing their care, especially for the more vulnerable patients and those with long-term conditions. It enables them to find patients who are just below the clinical radar and to intervene more quickly, leading to improved clinical outcomes.

The information provided by the dashboard can be used at different levels: to identify and manage the care of individual patients; to identify any issues of access to primary care at practice level; and, at primary care trust/clinical commissioning group level, it can be used operationally to recognise poor patient pathways and training needs.

Dr Anne Talbot is national clinical lead, urgent care clinical dashboard. She says: 'When I first used the dashboard, it was like suddenly having the blinkers taken off: it was a real eye opener. I was actually quite shocked by the fragmentation and duplication in the system. As a clinician, the dashboard is invaluable: it allows me to bring together a wealth of data relating to my patients, on my desktop, so I can make more informed decisions.'

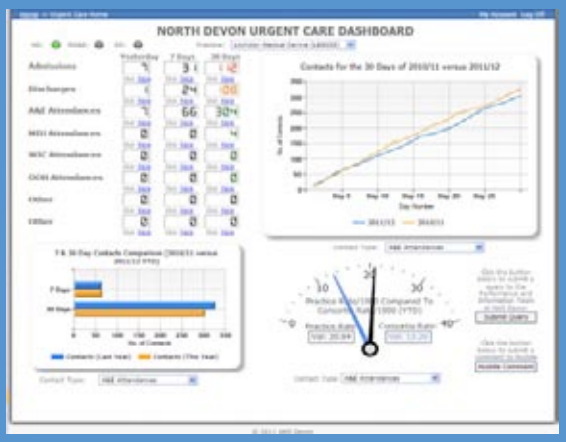
Using the dashboard alongside other service improvement initiatives, A&E attendance at NHS Bolton has reduced year on year: activity per 1,000 patients in April to September 2008/9 was 145; in 2010/11 it had dropped to 140.

The dashboard is being implemented across England as part of the national Quality, Innovation, Productivity and Prevention (QIPP) agenda. Nine sites now have dashboards; a further seventeen sites are developing their own local urgent care clinical dashboards.

One of the strengths of the dashboard concept is its flexibility: there is no pre-developed dashboard software solution and so sites with an existing data warehouse and/or secure web portal can use these to build their dashboard; all dashboards look different as they are locally developed.

Many of the dashboards incorporate additional functionality: several have included risk stratification scoring to identify patients who are at the greatest risk of urgent care attendance and admission. Other innovations include: alert systems informing clinicians if a patient they have flagged has attended an urgent care setting, urgent care attendances displayed by time band, showing when patients attend within practice opening hours, yearly activity comparisons, and monitoring unregistered patients via a virtual practice.

Some sites are also beginning to use their dashboards to address variance in primary care, for instance, by comparing urgent care attendance rates in practices to the consortia average. In addition, the central dashboard team are exploring the possibility of linking the dashboard and NHS 111, which will provide further information flows and also a feedback loop on whether patients follow the advice they receive from the 111 service.



For more information contact Dr Anne Talbot, National Clinical Lead, Urgent Care Clinical Dashboard at Anne.Talbot@bolton.nhs.uk

Case Study 5: Using benchmarking to drive improvements in care: commissioning out-of-hours services in Bedfordshire

NHS Bedfordshire joined the out-of-hours benchmark in November 2008. The head of acute and urgent commissioning, Lynda Lambourne, who manages out-of-hours services, wanted to make direct comparisons across four different providers each with a different service model. Although all were monitored within the national quality requirements (NQRs), they all did this in slightly different ways, with the result that it was confusing and difficult to make meaningful comparisons across different services.

The benchmark acts as a focal point for identifying what is being done well, in addition to identifying areas of comparative weakness, says Ms Lambourne. 'We now all understand what is happening in out-of-hours … now that everyone is compared in the same way with everyone else – we can work together to sort out any issues. The benchmark is driving greater consistency across the different services across the patch.'

She adds: 'This is not a stick to beat people with, but a positive tool for service development. It is easier to see where we need to take action and easier to identify those areas where we can be confidently assured of performance and governance processes.'

Information from the benchmark is driving improvements, including the key NQR measuring time to clinical assessment for urgent cases. Last year, performance was variable and mixed, ranging from 64 to 91 per cent. After focused effort in this area, all providers are now fully compliant with the national target of 95 per cent. There were also concerns about the high percentage of calls identified as urgent by call handlers. There is now a better understanding of the significance, how it is likely to put a strain on the service and that addressing it can reduce clinical risk.

In addition, information from the benchmark, coupled with feedback from patients and visits to all services provided evidence revealing performance was good and patients satisfied, suggesting the PCT is getting value for money in line with the QIPP agenda.

For more information, contact Lynda Lambourne at Lynda.Lambourne@bedfordshire.nhs.uk

3. Community and social services

Aligning community care with general practice lists is key if they are to be most effective in providing care. The structure of the teams should ensure adequate capacity and enable regular operational contact between the nursing and therapy teams, social services and the clinical teams in general practice. The aim should be to ensure community and social services can support the practice's urgent care response.

There is an increasing realisation that many community and social services need to operate around the clock, or at least well into the evening and over weekends; there is also a requirement for greater standardisation of services, skills and expertise to avoid a varying response dependent on the abilities of the individual available at a particular time.

There is little evidence stand alone intermediate care schemes have a positive impact on the overall numbers of patients admitted to acute care. Some have improved care to certain groups of patients, but this has been at the expense of developing links with GP teams and a reduction in the baseline service to GP lists (for further information see King's Fund paper Avoiding hospital admission – what does the research evidence say?).

Good quality information prepared in a consistent way across all services: recording outputs and outcomes and not just inputs and process, would substantially improve the ability of community services to identify areas of comparative strength and weakness. The range and limitations of most information systems supporting community services remains a substantial barrier to driving forward service improvement and inhibits the process of working with others.

Now many of the organisational issues around the initiative Transforming community services have been addressed, there is an opportunity to use it as a lever for developing greater integration with general practice; this would create fully integrated community and primary care teams, closely aligned with social care.

A good list of indicators is provided in the 2011 Department of Health report Transforming community services – demonstrating and measuring achievement: community indicators for quality improvement. However, if services are to be cost-effective and targeted, activity data understood by local practices needs to be collected and related to patient needs. We suggest, given the slow development of systems across community services in England, that monitoring these services through general practice or out of hours systems (which tend to be more advanced) may be a better way of collecting community data and sharing it with other professionals.

4. Urgent care centres

There is a range of centres offering different services at varying times. They include: walk-in centres, minor injury units and other urgent care centres where the spectrum of cases covered is often dependent on which specific staff are on duty. This variation is confusing both for patients and for others in the NHS. It is so confusing that the information service NHS choices does not recognise urgent care centres in its listings of 'health centres near you'; it suggests patients ring ahead to the service, NHS Direct or 111 to check if the care they require is available from the urgent care centre.

There is clearly a need for integrated commissioning of urgent care rather than the piecemeal developments of urgent care centres. We would encourages local commissioners to take a clear strategic view of all their urgent care services, of which urgent care centres, in all their forms, are just one small part. In some cases, the key purpose may be to extend access to primary care rather than offer separate urgent care services and local clinical commissioners need to justify the continuing contribution of all services to the wider healthcare system.

The Primary Care Foundation conducted a review of urgent care centres, commissioned by the Department of Health, visiting 15 Centres early in 2010. It currently remains unpublished, but will offer further evidence and recommendations on developing urgent care centres within an integrated urgent health care system.

5. NHS Direct and 111

NHS Direct has been an integral part of all urgent care systems operating to national standards and quality metrics (except in Northern Ireland) although by 2013 this will have been merged with the new NHS 111 service across England.

The 111 service is being trialled in four parts of the country, with calls from patients assessed by non-clinicians using NHS Pathways decision support software. The idea is 111 will be easy for patients to remember and will ensure patients get the right help, potentially directing significant numbers of patients to a different part of the system than they might otherwise have chosen. For some of the successes from the pilot in County Durham and Darlington, see case study six.

The NHS Alliance supports the simplicity of a new national number but has some concerns about how it will be implemented nationally by April 2013. It is less about the technological challenge and more about how much work there is to connect local urgent care services on the ground; while pilot sites have been operating for some time, others have just started developing plans and have a lot to do in a short period of time.

There are also concerns 111 could, potentially, undermine the key role of general practice in managing urgent care. In most cases, during the day, patients will still need to call their GP practice, although it does offer a different option if patients are unable to get the rapid response they feel they need. Supporting practices to improve access and their ability to respond rapidly will be vital if the 111 service is not to be overwhelmed with calls that are redirected back to GPs. For these reasons it will be vital for clinical commissioning groups to engage with those responsible for commissioning the 111 service as well as with the chosen provider and the range of services that will need to support the service locally.

The NHS Alliance report A new approach to 111: re-establishing general practice as the main route in to urgent care explores some of the concerns with the current model and encourages local systems to think in new ways about how the 111 service can support local services. More information is available at: http://www.nhsalliance.org/member-networks/urgent-primary-care/

6. Ambulance service

The Department of Health introduced revised ambulance quality indicators in September 2011; these cover a number of measures regarding the quality of ambulance services in England. The ambulance service primarily has two roles in urgent care: responding to 999 calls and transport of acute, mainly older, patients to hospital; both are important.

The strategy implementation should include work to ensure both responses are appropriate and supportive of the rest of the system. The current two-hour transport time for acutely ill, but non-999 cases, should be cut to one hour to guarantee patients reach acute assessment units early in the day, avoiding harmful and unnecessary delays. The changes proposed elsewhere regarding improving general practice access and minor injury unit services should reduce the 999 rate at the times of day urgent transport is required.

The ambulance service has a key role in delivery of the pathway for many patients. There have been a number of initiatives, such as the use of emergency care practitioners, introduced in many services. In some places, their availability has been patchy, while in others they have added to the available options for treating acutely ill patients. While it is worth continuing with reliable community options, these must be sustainable and continuously available and not robbed of expert staff when the service becomes under pressure meeting its basic response.

Commissioners should engage the ambulance service at all times and ensure they are aware of their role and the importance not only of 999 work, but also the urgent transports; not enough attention has been paid to this aspect of care in most systems. There is wide variation in the rates of ambulance transport to local A&Es, as demonstrated in the experimental A&E statistics. Commissioners should examine the rates and engage with the ambulance service to ensure

Case Study 6: Taking the long view: implementing a strategy and piloting NHS 111 in County Durham & Darlington

County Durham and Darlington was faced a few years ago with a steep rise in A&E activity, inappropriate use of the 999 service, increasing patient complaints, professional confusion around the services offered and unclear pathways relating to patient access. In response, commissioners produced an urgent care strategy, reviewing all aspects of the system and establishing a baseline for measuring the performance of local services.

Berenice Groves, lead commissioner for County Durham & Darlington, says: 'All stakeholders were confused about what was meant by urgent care and what, where and when services were available. The strategy was developed around a number of key principles, and as commissioners we put together a process encouraging existing providers to form partnerships and develop additional services where there were clear gaps.' The new service specifications focussed on a new single point of access, urgent care transport and clinical services.

The single point of access was initially run as a pilot by the local ambulance service and sought to test out NHS Pathways and integration with the 999 system. It was then reviewed to meet the new NHS 111 specification and developed to become one of the four national pilot sites.

One year into the delivery of the NHS 111 service, the pilot is complete and the plan is to introduce 111 across the North East through a further tender. Other developments include clinical dashboards to support the service and provide GPs with real-time information, as well as improving the directory of services to ensure access to urgent care is as simple as possible for patients. Whilst the service is still awaiting formal evaluation, the indications are that a range of improvements have been made:

- reducing self-referrals to A&E and achieving an overall net fall of 9 per cent in A&E attendances compared to control site
- a 4 per cent increase in the use of community-based services
- a drop in 999 calls and transports
- a range of case studies showing improved patient experience
- a 44 per cent decrease in calls to NHS Direct, compared to the same period last year
- during the extreme winter conditions of 2010/11, the resilience of the new 24/7 access model for the urgent care service reduced pressure on GPs

So what have we learned from implementing a complex programme for changing urgent care? If you are planning to make changes on this scale we recommend you:

- be prepared to carry out a whole systems review. The reconfiguration and change of name of the urgent care services was required so it does what it says on the tin, simplifying things in the minds of the public and professionals. There is no quick fix
- define clear objectives and outcomes and a robust process for tracking improvements
- approach this project as a commissioner, but ensure all providers are part of the team. A strong partnership increases your chances of success especially at those problematic areas where care transfers across organisational boundaries
- ensure you develop a GP-led service by involving GPs as early as possible in service design and implementation. GPs are crucial advocates of urgent care and 111 and have an essential role to play in influencing and changing patient behaviour
- appoint enough clinical champions as critical friends, early adopters and key advocates of a single point of access; we didn't appoint enough in the early stages of our programme roll-out, which delayed progress
- design the service from a patient perspective, remembering patients want to access care when and where they feel they need it

- **don't talk money during the service re-design phase as it will constrain service improvement, but remember to then define the costs prior to developing the service specification**
- **build a capacity management system directory of services as early as possible so you have a clear understanding of your current services – where there may be duplication and what this means for future levels of activity**
- **set ambitious targets and ensure you meet them by establishing strong programme management processes and regular progress reviews**
- **stakeholder communication and engagement is at the heart of our success – raising awareness is not enough on its own to change the public's behaviour**

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the transports are effective. Some areas have utilised new developments, such as NHS Pathways, to impact successfully on this aspect of care.

7. Emergency departments

A&E services are well recognised and understood by the public and are always likely to be used as a key access point for care, especially in urban and inner city areas where large populations will be within easy reach of the department.

The Primary Care Foundation's 2010 report Primary care and emergency departments recommends an integrated team, incorporating primary care clinicians, is a more effective way of dealing with the range of urgent and primary care presentations at A&E than diverting patients back to other services, such as general practice. We also suggest triage processes are an ineffective use of resources and tend to slow down access to consultation and treatment.

Commissioners should use all the available information, such as the experimental A&E statistics. We find when commissioners are presented with a fuller picture of local activity, benchmarked regionally and nationally, they alter their commissioning priorities.

8. Other acute hospital trust services

Ensuring a robust hand-over of patients that are (or are likely) to be admitted is clearly important. The receiving and assessment function for acute medicine, surgery and orthopaedics departments should be seamlessly integrated with the A&E majors or non-ambulatory process. In addition to referrals of these types urgent care services outside the hospital should look at the process for patients being referred to obstetrics and gynaecology departments and how patients suffering from a mental health crisis are referred as these patients will not usually be referred through A&E.

Trusts and local commissioners should agree a set of process and quality metrics to ensure patients are assessed rapidly by senior staff after arrival and then have prompt access to appropriate diagnostics, followed by a senior decision within a two to three hour window for the whole episode. The outcomes after this process will be a range of local options. What is not in doubt is that rapid senior assessment and treatment results in improved outcomes; the range of quality metrics should focus on clinical processes and outcomes.

In addition, the acute trust should ensure there is a positive and clinical dialogue between the referring doctor and the senior receiving doctor within the specialist area. In too many cases, the process of admission is reduced to an administrative process involving little or no clinical handover from the admitting clinician to those taking on responsibility for the patient. The improved process will allow a more sensitive and appropriate plan to be developed for the patient in advance of arrival at the hospital; it may also allow alternatives to be used, such as rapid outpatients, or community and ambulatory-based alternatives to admission.

Acute trusts will also want to look at implementing the improvements outlined in the NHS Institute's Directory of Ambulatory Emergency Care for Adults published in 2007. It offers an evidence-based guide to 50 emergency conditions and clinical scenarios (e.g. cellulitis) that have the potential to be managed on an ambulatory basis or, in other words, without admission to an acute hospital bed. It describes how this involves looking at new ways of working across health and social care, focusing on the patient's safety, outcomes and satisfaction.

The relationship between the emergency department and the rest of the hospital is a crucial interface in the urgent and emergency care pathway. It tends to be put under particular strain when the emergency department is under pressure or failing to treat patients within four hours. The recent Royal

Case Study 7: Preventing hospital admissions in Gateshead: better support for care home residents

In August 2009, Gateshead's GP commissioning consortia GATNET commissioned a 12-month pilot project to support care homes; the aim was to provide proactive rather than reactive care, in an attempt to reduce emergency admissions.

During 2009 to 2010, the cost of admissions from care homes in Gateshead was £3 million; a significant proportion of this was for inappropriate zero to one-day length-of-stays for falls and for end-of-life care, where the patient would have been better supported in their residential setting. Despite the range of services involved in providing care for this population, the only specialist provision for over 40,000 people aged 65 and above was one community geriatrician.

A nurse specialist led the changes in the five care homes with the highest rates of emergency admissions. Each implemented:

- **weekly ward rounds attended by the multidisciplinary team, care home staff and family members; other practitioners were involved, as and when necessary**
- **comprehensive geriatric assessments and personalised care/end of life plans for each patient in the care home**
- **regular education, training and updates for care home staff to increase their skills and competencies, further improving patient care and raising standards**
- **promotion and enablement of other established community teams, such as the urgent care or intermediate care teams, as an alternative to a hospital admission**

A clinical audit demonstrated a reduction in hospital admissions of 45 per cent when comparing admission data in the 12-month period prior for the 98 patients in the pilot; this resulted in a saving of 440 bed-days or a cost of £243,146.

Mark Dornan, GATNET chair, says: 'The project improved healthcare for this population, improved collaborative working, coordinated care and improved communication between practitioners. It also received overwhelming support and very positive feedback from care home staff, patients and families.

There is no doubt this enriched understanding of local needs, underpinned by a wealth of clinical evidence, provides the impetus for adopting a different approach with the aim of ensuring proactive care planning and long-term condition management with training and education at its core.'

Using the learning from this pilot, new commissions are planned, including:

- **the provision of a specialist team of nurses to support the care of residents in care homes**
- **a review of current service delivery models of existing community nursing teams to link up professionals to residential homes to mirror some of this work**
- **the development of a 'one GP practice: one care home' approach locally through the implementation of a service level agreement with local practices**
- **improved access to learning and development opportunities for care home staff regarding the assessment and management of older people with complex needs**
- **reviewing the care records in care homes to move towards a single electronic record**

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College of Surgeons publications The higher risk general surgical patient: towards improved care for a forgotten group and Emergency surgery: standards for unscheduled surgical care emphasised the importance of a rapid response to surgical emergencies: a slow response increases mortality, length of stay and downstream morbidity. In addition to the already published evidence on the effectiveness of rapid care for acutely ill patients, it has been shown moving patients who are awaiting a bed assignment out from medical assessment or high dependency units into other wards increases mortality, length of stay and readmission rates.

B. Towards an integrated urgent care system

1. Involving networks in commissioning

All of the services identified above are likely to be part of your urgent and emergency care network. These networks have an important role to play in leading local healthcare systems: if they are given real executive authority to shape pathways and processes they can play a key role in driving changes across the urgent care system and improving care across organisational boundaries.

2. Commissioning patient pathways

One way of potentially overcoming the organisational complexity is to commission patient pathways rather than individual services. Although there is a widespread acknowledgement of the importance of focusing on pathways, few commissioners are doing this in practice.

In general, four or five conditions make up the majority of urgent care consultations: concentrating on these groups of conditions (likely to include cardiovascular, respiratory, and older people with a range of complex needs) means most urgent care will be covered. The recent NHS Alliance report *Making it Better* contains examples of how clinical commissioning groups are implementing these ideas http://www.nhsalliance.org/documents/view-all/?no_cache=1&tx_damfrontend_pi1%5Bpointer%5D=1

This approach requires a lot of people to work together to place the patient at the centre of the process. Working across organisational boundaries also has the potential benefit of minimising the number of times a patient is handed off between staff and organisations: ensuring the patient is seen by the right health professional to provide optimal care.

3. Commission for quality – including making clear the 'quality cost'

Cost and quality are related in healthcare, although the relation is not necessarily one whereby an increase in the former raises the latter; frequently improved quality will result in a lower overall cost, as well as providing better care for the patient. While it would be naïve to think cost will not be an issue when commissioners assess provider bids, one option is to require bidders to describe and cost the processes they will use to raise the quality of the service, introducing an explicit 'quality cost' element within bids.

Such a 'quality cost' approach would require bidders to separately identify the costs of the service related to:

- recruitment and induction processes
- staff training, support and development
- clinical audit
- measurement and reporting of performance and outcomes
- quality accounts
- responding to, and learning from, patient feedback (including questionnaires, complaints and incidents)
- benchmarking
- clinical leadership to ensure that all this activity to support quality is implemented – investment in high quality clinical leadership will be repaid not just in better care for patients but also in more cost-effective use of clinical staff

This 'quality cost' could be included as part of a total cost for the service. This would let commissioners compare not just the overall cost of bids, but the specific resources bidders plan to dedicate for driving quality improvement.

Clearly, such an innovation would have challenges and potential risks. It is possible to argue that everything contributes to overall quality of care, and that it is artificial to separate out specific activities as in the list above. It could also lead providers to start trying to load much or all activity into the 'quality cost'.

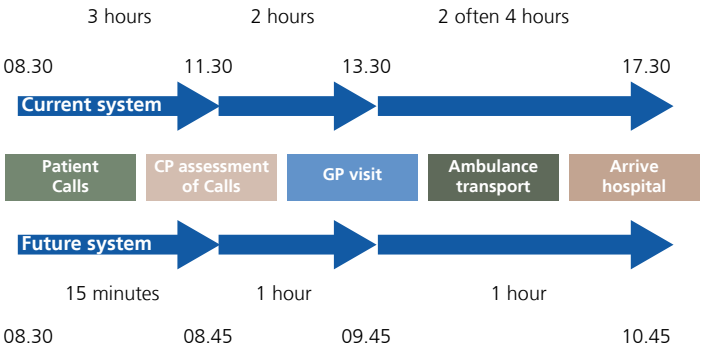
The major benefit of including this 'quality cost' is that it will require providers to explicitly commit to a series of quality initiatives and to working with the commissioner and other services to drive improvement through them.

4. Commissioning improved access to care across the whole urgent care system

We know being seen rapidly is closely linked to overall patient satisfaction; one way of improving the focus on the patient's experience is to set standards for access across the whole system, rather than having differential standards for each service.

The example below shows in the top line the time it takes for a typical healthcare system to see, assess and admit patients requesting a home visit: the result is patients arrive at hospital at the end of the working day when most of the alternatives to hospital admission are closing (and when there is a risk that decisions about treatment may be delayed until the following day). By implementing a different and faster process – calling back patients who request a home visit within 15 minutes and seeing them within an hour – there is a greater chance of avoiding hospital admission; this is illustrated in the improved lower timeline. Importantly, if admission is required the patient will arrive at the hospital earlier, with less chance that their condition has deteriorated and with the full expertise and staff

Acute admission timeline



capacity to provide the care that the patient needs.

5. Using whole system metrics

We need to develop system-wide metrics and ensure we fully understand the performance of each part of the system: the quality of the overall urgent care system depends on the quality of each service, as well as how they join together to provide seamless care.

The Department of Health is developing system-wide metrics for urgent and emergency care, starting with the publication of a set of clinical quality indicators for A&E and ambulance services, implemented during 2011 and 2012. This approach acknowledges when a patient needs care it is often from more than one NHS organisation and it is important for them to work together to provide seamless care from the patient's perspective. So for A&E, the focus on a four-hour standard has been replaced with a range of measures looking at the quality of care in terms of outcomes, clinical effectiveness, safety, experience and timeliness (more information is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

6. Integrated audit across urgent care services

The RCGP has focussed on developing detailed audit tools, initially for out-of-hours providers and in April 2011 across the whole of urgent care. The urgent and emergency care clinical audit toolkit is aimed at all providers of urgent and emergency care and seeks to promote the delivery of high quality care across a range of NHS services that is delivered consistently by all of the individual clinicians involved. More information is available at: http://www.hqip.org.uk/new-audit-tool-available-from-rcgp/

The complex nature of the urgent care patient pathway and the variety of care workers with direct patient contact means such services face particular challenges in ensuring continued monitoring of clinical standards for consistency and quality improvement. The new toolkit provides practical guidance to providers on checking the quality and care given and continually learning from experience to improve care, regardless of setting.

7. Single point of access and the new 111 service for urgent care

Many services across the country have introduced a single point of access to make it simpler to access the right service at the right time. These services are generally aimed at clinical staff working within health or social care, seeking to reduce the time and complexity for accessing appropriate care for patients who need more support and may need a hospital admission. Where they have worked well they have been carefully planned and promoted in advance with the active engagement and support of local GPs.

The new number for urgent care – 111 – has been introduced in four areas across the country and will be rolled out across the country by 2013; it gives free access to a rapid and effective signposting system based on NHS Pathways and local service directories, with local systems working out the best approach for introducing this new system.

The benefits of 111 are that it should make it easier for patients to access urgent care, but, there are complex issues local commissioners will need to coordinate about the practicalities of introducing this new national number.

8. Clarifying who is responsible for hand-over

There will always be occasions when the responsibility for providing care is passed on to others (within the same organisation or in another organisation). If joined up care is to be provided the referral should be appropriate and the right information must be passed across in a timely fashion. We recommend that the lead clinician in the organisation that is handing over the patient be given clear responsibility for ensuring that this process works reliably.

Two examples perhaps illustrate this. The clinical lead at an out-of-hours service will want to make sure that in the case of patients sent by the call handlers to 999 or to A&E that the referral was appropriate whilst the lead in a walk-in centre would want to hold the ambulance service to account if there was a delay in transporting an acutely ill patient because the ambulance service had wrongly assumed the patient was in a 'safe place' when in reality the care that was required could not be provided. Should the lead clinician have concerns about aspects of the service within the recipient provider they will want to raise these both with the provider and through the commissioners.

9. Aligning financial incentives

One way to do this is to bring all costs back to the practice budget – which will also overcome the current problem of commissioners paying more than once for the same service provided at different points in the system.

Rather than separate budgets and contracts for different urgent care services, the practice is apportioned the budget for services currently used and pays for all future use. Services suitable for including in the practice budget include: out-of-hours services, all calls to 999 or 111, GP access centres/walk-in centres/urgent care centres and A&E.

This approach relies on access to good quality information, but increasingly it should be possible to identify how patients are using services and track this back to practice budgets. It also requires areas with high number of unregistered patients, such as vulnerable groups or those on holiday, to ensure other forms of access, as part of the wider PCT strategy. Whatever the practical issues of bringing such costs back to the practice budget, GPs within a practice should receive current information about the usage of urgent care systems to support improved care management.

Case Study 8: Developing effective relationships in out of hours services: support and challenge in Liverpool & Knowsley

Urgent Care 24 (UC24) is an NHS out-of-hours primary care service jointly-commissioned to cover the registered populations of NHS Knowsley (140,614) and Liverpool PCT (490,371). The current contract, set up in 2008, has a value of around £4.5 million, with a call volume of 100,000 a year.

Commissioner for Liverpool, Beth Collins says: 'The contract works well because we were clear and specific about what we expected in our initial procurement documentation – so, for example, we specified we not only expected the provider to undertake clinical audit, but also required them to use the RCGP toolkit.'

The contract management process involving monthly contract board meetings between the executive team at UC24 and the commissioners is an essential part of the relationship. Ian Davies from NHS Knowsley says: 'It is the continuity and seniority of staff that has helped build understanding and trust on all sides. There is a clear structure for addressing any concerns, so we can work together to find remedies and potential solutions.'

In order to understand how the data flows for the NQRs, data analysts from Liverpool PCT spent time shadowing UC24 colleagues. Commissioners have also taken the time to understand the out-of-hours environment and this has enabled sensible, meaningful discussions to take place. Collectively, they have worked at understanding the data available to ensure it is timely and relevant and that any potential data quality issues are investigated and quickly put right. This has made it possible for the systems used by UC24 to sit on the NHS IT platform so they can benefit from NHS net connections and the added resilience of being part of the wider NHS infrastructure.

An agreed suite of information around the NQRs was developed and produced on a spreadsheet developed and locked by the PCTs; considerable time was spent understanding what is monitored and why. Commissioners also use the UC24 data to help performance manage other parts of the system: they look at trends and reflect these across activity levels in the ambulance service, accident and emergency departments and general practice.

Nigel Wylie, chief executive of UC24, says: 'We feel part of the NHS family… We participate in all aspects of the heath economy, whether it is capacity planning, preparing for a bank holiday or looking at how we might generate quality, innovation, productivity and prevention savings by redesigning the urgent care pathway. The support works both ways at times of particular pressure – not only in the usual flu and winter pressures, but also in exceptional circumstances such as the swine flu pandemic.'

An example of how this integrated system works successfully is the way PCTs facilitated additional support for UC24 at times of extraordinary demand through innovative use of the GP-led health centre access services, allowing the best possible use of primary care capacity across the health economy.

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10. Commissioning based on patient experience

There is the potential for commissioners to build in, not only the requirement to design and improve services around patient experience, but to reward or penalise services based on the quality of patient experience.

Some of the more successful approaches used by commissioners to understanding and measuring patient experience, include:

- discovery interviews offering a more detailed understanding of how an individual patient has experienced their contact with services
- local surveys, including a core set of standardised questions about patient experience, so that results can be directly compared across services nationally; for example, the Picker Institute survey of emergency departments
- using standardised surveys for urgent care centres and out-of-hours services, such as those developed by the organisation CFEP UK Surveys
- Exploring the merit of getting immediate feedback; Dr Foster have trialled the use of a computer pad with five questions for patients immediately after they have used the service

11. Effective performance management of urgent care systems

All commissioners need to ensure the basic elements of effective performance management are in place, including regular review meetings, involving senior managerial and clinical leaders, supported by a supportive and challenging culture and by good information enabling clear judgements about how to improve care. The 2010 Department of Health review of out-of-hours services suggests that in many areas this is not the case. Similarly, the Primary Care Foundation's review

Primary care & emergency departments found the performance management of services crossing organisational boundaries is often problematic.

12. Learning from mistakes

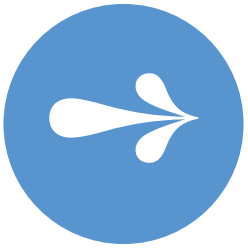
Recent reviews into major service failures, such as the death of David Gray in 2008, have highlighted the failure to learn from mistakes or share lessons more widely. A recent pilot by the NHS Alliance urgent care network, involving 10 out of hours providers, has developed a new anonymised system for rapid sharing and learning. It aims to address the prevailing culture in primary care where few incidents that put patients at risk are reported nationally. Currently, providers are reporting any incident where something has gone wrong and others could learn from what has happened to improve patient safety and care.

During the pilot stage 60 reports were logged on to a specially designed website, highlighting a wide range of incidents, all offering learning to other organisations. Leaders from across the providers meet regularly to review progress and test out and improve this approach for sharing reports on 'avoidable serious events'. It is already proving to be a powerful tool for individual and organisation learning. A paper reviewing this initiative will be available from December 2011 and explores what one clinical leader described as 'the new culture of sharing and acknowledgement of error that is crucial … if sustained and developed it will evolve into something deeper and more important than we ever envisaged at the outset'.

13. Tendering – the final option

Tendering services should be the final option for commissioners when a service has failed or where no appropriate long-term partner exists to develop a new service. We recommend before any existing service is tendered out, commissioners should ensure:

- there is clear evidence about the performance of the service (with national benchmark comparisons) and how it needs to be improved
- all possible steps have been taken within regular review meetings to address any concerns or shortcomings in the service
- a clear and comprehensive urgent care strategy is in place
- it is clear how this service fits within the overall urgent care service and how any changes will impact on the service as a whole
- the tender requires providers to explicitly identify the 'quality cost'
- cost is seen not just as the headline cost of the contract, but the cost to the healthcare system as a whole (for example, a low cost tender may lead to a high level of cases being passed on to A&E and becoming hospital admissions)
- care should be taken in developing a specification to ensure it is specific enough to deliver the service being procured, but open enough to allow providers to innovate and develop the service
- the procurement process should reward innovation and genuine cross-organisational working to improve the integration of the urgent care system
- conflicts may arise when local members of clinical commissioning groups are also involved in local provision, which is potentially being procured. The simple solution is to involve clinical commissioning groups in development of the specification, but ensure conflicts do not arise during procurement



Chapter 8

What do providers think makes a good commissioner of urgent care?

What makes a good commissioner? This was the topic discussed by urgent care providers within the NHS Alliance's urgent primary care leadership group. The key points are:

1 Continuity matters – having the same contacts within a commissioning organisation over an extended period of time, developing good, long-term relationships. Most providers have experienced constant change making it impossible to develop consistent, informed relationships.

2 Working together – effective commissioners see themselves as working in partnership with their providers to improve care. Providers welcome commissioners who want to understand the service in detail.

3 Understanding local needs – commissioners need to have a good understanding of local demography and how current services meet, or fail to meet, these needs.

4 Walking the floor – very few commissioners regularly visit services, even when they are seeking a new provider; as one provider said, 'It's a bit like buying a car unseen.' The insight gained by spending time in the service, talking to frontline staff, is essential if you are to understand the service, offer ideas for improvement and hold the provider to account.

5 Evidence not anecdote – too often assertions are made and services are even changed on the basis of an individual anecdote, which may not match the wider evidence. Effective commissioners will do detailed work to understand patient experience, such as carrying out discovery interviews looking in-depth at an individual's experience of their journey through local services; in contrast, a series of anecdotes is not a good basis for redesigning a service. Commissioners should use information and analysis, as well as benchmarked information to make decisions and inform strategy development; ensuring best practice is always commissioned should be the norm. Quick fixes promising huge changes rarely deliver improvement.

6 Constructive challenge – there is a balance to be maintained between challenge and support, but the best relationships are perceived to be consistently challenging, based on a detailed understanding and good evidence, leading to constant improvement.

7 Clear distinction of roles – while commissioners and providers need to work well together, if boundaries become too blurred relationships can quickly become collusive, avoiding addressing difficult issues.

8 Clear and concise specification – a service specification should offer clarity about the future direction and provide specific and measurable performance targets based, as far as possible, on outcomes rather than measures of process. There is often a link between over-specifying and under-performing: commissioners should seek to set the direction then trust the provider to deliver, while monitoring progress.

There needs to be clarity about what resources are available before developing an unachievable specification. The specification should also allow for innovation and development by providers; over-specification is often the enemy of innovation.

9 Avoid endless informal favours – all agreements on providing additional services should be explicit and recorded. In some places, providers have tried to help out when there are gaps in services and have taken on extra work on the understanding funding will be received at some point in the future. Changes in personnel or the rapid tendering out of a service can leave providers exposed and with a significant financial gap, embarrassing all involved.

10 Whole system rather than a silo mentality – too many commissioners break down urgent care into its separate components when so much of what makes a service successful is how the parts join together. Good commissioners will be able to take a longer-term strategic view and commission services across the healthcare system.

11 An accountable provider model – commissioners should consider delegating some of what is traditionally seen as performance management of provider services. Instead of letting a number of separate contracts, commissioners could look to prepare an integrated specification for urgent care, where the successful bidder is held to account for the whole service but subcontracts parts of the service to others.

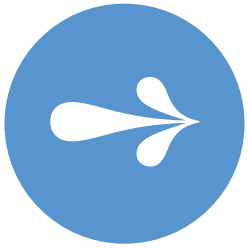
In effect, care is commissioned from a network of providers, and the responsibility for working together is delegated to one lead provider with a financial interest in making the separate elements work well together.

12 Implementation is crucial – there are too many examples of how commissioners have spent years discussing and planning only to expect providers to implement the new service in weeks. Recruiting staff, identifying and equipping premise and developing IT systems all takes time.

13 Being bold – there are times when commissioners have to take difficult decisions, which may involve challenging the status quo and existing power bases. Many commissioners have developed plans for freeing up resources; very few have identified how these resources will be released from hospital services. It is easier to make bold, brave decisions if clinicians are leading and making the case.

14 Tendering as a last resort – effective performance management should ensure shortcomings are addressed within a contractual framework and that if a provider falls consistently short of agreed standards, contracts can be terminated.

15 Clear tendering process – when a commissioner does decide to test the market, they need to be absolutely clear what they want and how this fits into the wider healthcare system. Tenders should avoid endless detail about how services are delivered now and focus on clear and measurable outcomes for the future.



Chapter 9

A specification checklist for an urgent care service

This section provides a brief outline of what you might want to cover in a specification for urgent care. Currently, most specifications tend to be very long, with a lot of detail about how the service should be delivered and policies required. In the future, commissioners will be looking to identify the outputs and outcomes they want for the system and how this might be measured, rather than the detail of how this might be done.

To achieve this, you will need to:

1. be absolutely clear what you are trying to achieve from the urgent care system as a whole and how you are seeking to measure this. The development of a set of metrics for the whole of urgent and emergency care – currently being explored by the Department of Health – may help with this. The specification for any part of the urgent care system should be developed within the context of your overall plan and certainly not work against or destabilise other providers in the network

2. ensure there is genuine consistency in the way metrics are being measured

3. understand the individual parts of the system making up the whole, with clear performance measures for each service

4 ensure you pay careful attention to how the different parts in the whole system join up – it is the way they link up, or the failure to do this, that is crucial for delivering consistent, high quality patient care

5 consider the potential for commissioning services as a system with one joined-up specification, with clear service outcomes and success criteria, and led by one agency, who in turn, may subcontract various elements of the service

A specification for individual parts of the service should be specific enough to ensure the service is delivered, but not in so much detail as to destroy innovation or indeed prevent providers implementing efficiencies. So, for example, specifying detailed staffing levels and skill mix carries the risk of locking a provider into a model that is less efficient and may be difficult to staff if the specified skill mix cannot be recruited locally.

A specification should broadly have the following sections

The service requirement: a description of what the service is, to whom it is delivered, and to what standard with some reliable indicators of volume, case mix and outcomes

Integration with local services: clarify your expectation of how the service will work with other providers of urgent care in the local area and the level of referrals expected to and from other services

A specification for individual parts of the service should be specific enough to ensure the service is delivered, but not in so much detail as to destroy innovation or indeed prevent providers implementing efficiencies.

Clinical quality and assurance: what is your expectation in respect of governance and the clinical quality, outcomes, compliance with best practice and statutory requirements? You should require bidders to not just describe the process, but to identify what resource (the 'quality cost') will be allocated to, to drive the quality processes and improvements

Patient and user involvement: your expectation of the extent and influence of service user on the development and delivery of the service

Resources and staff to be inherited: the bidders will need information not just about staff and the transfer of undertakings (protection of employment) regulations, but also about the buildings, facilities, contracts and relationships they will inherit from predecessor services

Mobilisation: how the provider will develop the service infrastructure including buildings, IT, transport, recruitment and delivery to specification and on time

Workforce: your expectations of the workforce requirements to satisfy yourself that the provider can deliver the service without overspecifying this area

Relationships: how the provider will recognise the critical importance of supportive and co-operative relationships and will invest resources into making this happen

Service cost and financial arrangements: your expectation of the costs of the service and the mechanism of managing risk of over or under performance

The metrics for successful integrated 24/7 urgent care in your community might include:

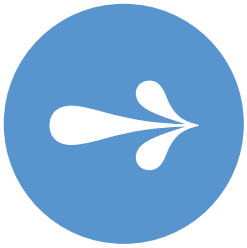
Please note that indicators of this kind work best as a group of measures taken together rather than individually

✓ the median and 90th centile time from the patient arriving to the first full consultation (not triage), and the percentage of cases where the episode of care is completed in this consultation

✓ the median and 90th centile time from the initial contact with the NHS to discharge/completion of the episode of care or admission to hospital. To be meaningful across the mix of services in the urgent care system, these will need to be broken down to identify those received by phone, those requiring a home visit and those requiring diagnosis and tests. In addition, it may be useful to separately monitor those cases identified as urgent

- ✓ the percentage of cases where the episode of care is completed by the service and there is no requirement or recommendation for follow-up, and the percentage where follow-up is needed, identifying which service is responsible for the follow-up and the proportion of cases admitted
- ✓ the percentage of cases where the patient leaves the unit before being treated, fails to turn up when advised over the phone to attend a centre or where the clinical assessment of the patient is not completed (for example, because the patient rang off or could not be re-contacted by phone)
- ✓ the percentage of vulnerable and palliative care patient cases seen by the urgent care service where suitable special notes and a current care plan (if appropriate) has been made available by the GPs practice
- ✓ the percentage of patients that re-attend the service within seven days for the same or a related condition, where this was not planned. If the Connecting for Health Spine (part of the NHS care records service) allows, this might be expanded to include attendance at other service providers in the NHS
- ✓ the percentage of cases where full information (history, examination, results, diagnosis, treatment, follow-up action) is made available to the GP (and, when the service is available to local GPs, to the Connecting for Health Spine) before the start of the next working day
- ✓ some specific measures associated with sentinel conditions, such as, time to pain relief and follow-up after falls
- ✓ specific measures for high volume presentations and high-impact, resource-intensive, presentations
- ✓ the above measures should be set against the overall mortality and morbidity measurements that are already measured by the organisation
- ✓ rapid care is often good care; acutely ill patients all benefit from a rapid response. Systems should ensure each organisation has a clear view of the executed time it has to deliver its portion of the pathway

Rapid care is often good care; acutely ill patients all benefit from a rapid response. Systems should ensure each organisation has a clear view of the executed time it has to deliver its portion of the pathway.



Appendix A: Acknowledgements

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Appendix B: Key publications referred to in this document

Primary Care Foundation

- PCF (still awaiting publication) *A review of urgent care centres* David Carson, Henry Clay & Rick Stern
- PCF (March 2010) *Primary care & emergency departments* David Carson, Henry Clay & Rick Stern
- PCF (January 2010) *Improving out-of-hours care: what lessons can be learned from a national benchmark of services?* Report for the Department of Health, Henry Clay
- PCF (May 2009) *Urgent care: a practical guide to transforming same-day care in general practice* David Carson, Henry Clay & Rick Stern

Further information is available at: http://www.primarycarefoundation.co.uk/downloads/reports-and-articles.html

NHS Alliance

- NHS Alliance (June 2011) *A new approach to 111: re-establishing general practice as the main route in to urgent care*, Ray Montague
- NHS Alliance (June 2011) *Making it better: how GP-led consortia can unlock the full potential of the NHS*

Care Quality Commission (and predecessor bodies)

- Care Quality Commission (July 2010) *Report on an enquiry into out-of-hours care at Take Care Now*
- Health Care Commission (September 2008) *Not just a matter of time: a review of urgent and emergency care services in England*

Department of Health

- Department of Health (September 2011) *Ambulance quality indicators*
- Department of Health (December 2010) *A&E clinical quality indicators: implementation guidance and data definitions* Professor Matthew Cooke
- Department of Health (July 2010) *Procurement guide for commissioners of NHS-funded services*
- Department of Health (February 2010) *General practice out-of-hours services: project to consider and assess current arrangements* David Colin-Thomé & Steve Field
- Department of Health (Carson Review, 2000) *Raising standards for patients: new partnerships in out-of-hours care*

Royal College of General Practitioners

- RCGP (August 2011) *Guidance for commissioning integrated urgent and emergency care – a 'whole system' approach*, Agnelo Fernandes. This is a good source of references to the wider literature.
- RCGP (April 2011) *Urgent and emergency care clinical audit toolkit*, Agnelo Fernandes

Other reports

- King's Fund (December 2010) *Avoiding hospital admissions – what does the research evidence say?* Sarah Purdy
- NHS Institute (2007) *Directory of Ambulatory Emergency Care for Adults*
- Four inner London PCTs (May 2007) *Report into the death of Penny Campbell*
- National Audit Office (May 2006) *The provision of out-of-hours care in England*

NHS Alliance

The NHS Alliance brings together GP consortia, PCTs, clinicians and managers as the leading organisation in primary care. We are an independent non-political membership organisation proud to be at the forefront of clinically-led commissioning. Its leaders are all dedicated professionals, who represent the Alliance's diverse membership, working ceaselessly to meet the challenges facing the NHS today. Find out more at www.nhsalliance.org

The Primary Care Foundation

The Primary Care Foundation was set up to promote best practice in urgent and primary care. It was commissioned by the Department of Health between 2007 and 2010 to review and develop services across the spectrum of urgent care: from urgent care in general practice to establishing a national benchmark for out-of-hours services, plus a review of primary care in emergency departments and an, as yet unpublished, review of urgent care centres. Find out more at www.primarycarefoundation.co.uk

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