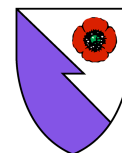# RCGP
Royal College of General Practitioners

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Paediatrics and Child Health
Leading the way in Children's Health

The College of
Emergency Medicine

Urgent and Emergency Care Clinical Audit Toolkit

With Forewords from:
Royal College of General Practitioners
The College of Emergency Medicine
London Ambulance Service
Department of Health
Royal College of Paediatrics and Child Health

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Contents

Forewords

Out of hours care is usually accessed at a time when patients can be at their most frightened and vulnerable. There are of course many excellent examples of services but patients can find it difficult and complicated to navigate the system.

Therefore the Royal College of General Practitioners (RCGP), in partnership with The College of Emergency Medicine (CEM), has developed this Urgent and Emergency Care Clinical Audit Toolkit, which we hope will be of use to all commissioners and providers.

This toolkit has also been extensively piloted by the RCGP and CEM and is also endorsed by the Ambulance Service and the Royal College of Paediatrics and Child Health.

Our patients have a basic right to a high quality of urgent care at whatever time they use the health service and we have the knowledge and ability to provide robust system checks to help deliver and ensure good, safe practice is learnt from and maintained.

This toolkit has been produced and piloted with funding from the Department of Health. I would like to acknowledge the excellent work of Dr Agnelo Fernandes, RCGP Clinical Champion for Urgent Care, and Professor Steve Field, immediate past chair of the RCGP, for all their hard work and sterling efforts in driving this project forward. We would like to see it adopted by all urgent care providers to ensure a seamless, safe and effective journey for all patients wherever urgent care is provided.

Dr Clare Gerada, RCGP Chair of Council

The College of Emergency Medicine welcomes this important initiative. The recognition that urgent and emergency care comprises a continuum of practice will drive better, more consistent models of care. The current fragmented system inevitably leads to confusion and uncertainty amongst the public. There are important inefficiencies in both clinical and cost arenas. The risk and safety agenda are inadequately addressed.

Quality assurance and continuous improvement are fundamental requirements of any healthcare system. This robust and tested toolkit will provide those involved in commissioning and providing urgent and emergency care 24/7 with an invaluable addition to evaluate current practice and deliver better care for our patients.

Mr John Heyworth, President College of Emergency Medicine

The ambulance service welcomes the development of this urgent and emergency care clinical audit toolkit. It recognises that ambulance services are a key part of urgent and emergency care provision and helps to not only compare the standard of care provided across providers but also gives us an opportunity to begin to audit face to face care as well as telephone assessments. The toolkit really does help us focus on the quality of care we provide.

Peter Bradley, National Ambulance Director DH & LAS Chief Executive

As an emergency medicine consultant my job is to provide the best care for my patients, so that they recover quickly. To help me achieve this I need some evidence of the quality of the care I deliver and of that given in my department.

Clinical audit, with timely feedback to all staff, is one of the most powerful tools available to assess, and therefore to drive improvements in, the quality, safety, consistency and value for money of urgent and emergency care. It can also be of enormous benefit to individual clinicians and, carried out correctly, can provide real motivation to all of us to improve the quality of the care we deliver. Undertaken routinely, clinical audit can contribute to the culture of continuous improvement we need to adopt in the NHS.

The NHS is undertaking various initiatives to improve clinical outcomes and service experience. Nationally new indicators have been announced in A&E and ambulance services and over the next year will be developed for other components of urgent and emergency care. These will work with the new NHS Outcomes Framework and NICE quality standards to encourage and demonstrate improvements. Locally organisations will be demonstrating the quality of their care. Clinicians will also need to demonstrate the quality of their care for their regulatory bodies. This toolkit has been developed to support clinical audit across the range of urgent and emergency care settings from out–of–hours GP services to ambulance services to emergency departments. As such, it is well–placed to support greater consistency and reliability of care across these different settings. Greater consistency and reliability of care is required if we are to deliver more efficient urgent and emergency care that also delivers continuously improving quality and a better experience for patients.

I hope that many organisations will utilise this toolkit as an important component of the work to continuously improve their clinical care.

Professor Matthew W Cooke, National Clinical Director Urgent and Emergency Care, Dept of Health

Regular and well conducted clinical audit helps clinicians improve services. Provided we close the audit loop by introducing changes, where required, and then undertaking a re–audit, the care of patients is improved. Undertaking audit in urgent and emergency care is particularly challenging given the number of organisations potentially involved and the short time each patient is in contact with each service. The Royal College of Paediatrics and Child Health has experience recently of undertaking a study of how parents with a febrile child try to navigate through the various options for urgent and emergency care and this certainly reinforced the fact that the public find advice confusing and sometimes contradictory. Providing a ready made audit toolkit to help clinicians undertake clinical audit in urgent and emergency care will be very helpful particularly as the National Health Service is envisaged as having an increasing number of competing providers. We know that a quality service is one which is safe, effective and as good an experience as possible for the patient and their carers, and audit can address all three elements of a good quality service.

Professor Terence Stephenson President, Royal College of Paediatrics and Child Health

This report comprises the evaluation of a six month project undertaken by the Royal College of General Practitioners (RCGP) and The College of Emergency Medicine (CEM). RCGP and CEM have worked closely with a wide range of Urgent Care providers and representatives throughout the course of the project.

The overarching aim of the project has been to work towards the creation of a universal clinical audit toolkit, applicable across a wide range of urgent and emergency care situations, and one which supports the implementation of a system of routine clinical audit along all urgent care pathways. Current urgent care provision pathways are often fragmented and complex, resulting in confusing care journeys for the many patients experiencing them. This situation is further complicated by the increasing plethora of organisations offering urgent care, and the wide range of professionals involved in the provision of that care. Specifically, the toolkit aims to provide:

- Practical guidance on the implementation of clinical audit in urgent and emergency care provider service settings.
- A framework for assessing the quality of individual provider–patient interactions, to include written records and/or audio/video recordings, conducted as either telephone or face–to–face consultations.
- Exemplars that demonstrate how clinical audit contributes to the overarching clinical governance and educational agendas, thereby improving patient safety and the quality of the care.

The evaluation details the development and piloting of the audit toolkit conducted across a range of different urgent care settings, to include:
Walk–in Centres, NHS Direct, Ambulance Service, Out of Hours Doctors, Urgent Care Centres, GP Medical Practices and Hospital Emergency Departments.

Draft Toolkit Design
The Project Reference Group met on ten separate occasions and during this time developed and refined the Urgent Care Audit Toolkit, a final draft of which was produced at the end of April 2010. The toolkit comprised, in part, the amalgamation of several existing audit tools, drawing on those aspects found to be most consistently applicable and relevant to practice. This process involved incrementally building audit tool upon audit

tool, mapping variation and consistency to the point where consensus was reached on a 'universally' acceptable audit tool. A guidelines framework completed the toolkit.

Following the final drafting of the toolkit by the reference group, the toolkit was piloted in April 2010.

The draft toolkit was piloted over an eight week period, commencing April 2010. The original plan had been to conduct the pilot over a three week period; however this proved impracticable for a number of reasons. Urgent and Emergency Care sites throughout the country were busy conducting audits and surveys during this period, particularly the National Patient Satisfaction Survey. This put significant limitations on the ability of sites to commit resources to undertaking the pilot within such a short time frame.

The aim of the pilot was to evaluate the 'usability' of the audit tool, and the 'usefulness' of the toolkit. We were particularly interested to elicit views on clarity, relevance and ease of use of the audit in the urgent care environment being audited.

We did not set out to test the effectiveness of the tool in practice. This would have required measuring the reported increase or decrease in the quality of consultations of repeated audits in the same clinical settings.

Audit criteria were developed from current best practice guidelines within the different Urgent and Emergency Care services. Their content is not being evaluated. However the applicability of each criterion to all the Urgent and Emergency Care services within a generic tool was evaluated as part of the pilot.

Pilot Site Selection
Pilot sites were proposed and recruited by members of the Toolkit Reference Group, and through advertisements in national urgent care bulletins. Collaborating sites signed a Service Level Agreement with RCGP to promote consistency across and within different sites and clinical specialities. The initial selection of thirty pilot sites was revised down to twenty two sites as a result of sites not being able to commit to the duration of the project due to other workload responsibilities. The twenty two sites involved in piloting the audit toolkit represented a range of eight different urgent care settings (see Table 1–Types of Urgent Care Providers).

Type of Urgent Care Provider	Number of Sites
Out of Hours Doctor	2
Emergency Department	6
Walk–In Centre	4
Medical Practice	5
BASICS (Pre–Hospital Emergency Care Doctors)	2
NHS Pathways	1
NHS Direct	1
Ambulance Service	1

Table 1: Types of Urgent Care Providers

Urgent Care Audit Toolkit drafts were distributed to all pilot sites and sites were linked up to RCGP by teleconference to facilitate inter–site and Reference Group representation discussions and standardisation of procedures.

Following the teleconference, the pilot sites agreed to complete fifty audits using the audit tool, over a period of eight weeks.

Pilot Site Data Collection Methods
Pilot sites were asked to evaluate the audit toolkit using a self completion questionnaire. These were completed by the auditor and comprised a series of open ended and closed questions to gather both quantitative and qualitative data. The questionnaire was designed to collect information from pilot site auditors on six key themes. All but one of these themes related directly to the audit in terms of its structure, composition, content, applicability and user friendliness. Information was also sought from auditors on the length of time taken to complete individual audits and whether they would recommend the use of the audit toolkit for their clinical area.

Due to the inherent differences in audit methods between and across services, the pilot sites were given flexibility in how they undertook the audit. Sites were given freedom in terms of choosing the structure of their audit team, which inevitably impacted on the evaluation as the evaluation team had no control over individual team skill sets and competences. It was therefore important to factor analyse the data to take into account the type of audit they conducted i.e. retrospective from clinical notes, retrospective from audio recordings.

All but one evaluation form was returned to the RCGP electronically. Once stored, local identifying data were coded

and anonymised. The quality, breadth and nature of the in–depth open–ended data rendered the need for separate focus groups unnecessary.

Data Analysis
Data were analysed using SPSS software to cross–tabulate data across and within pilot sites. Qualitative data were analysed using comparative analysis techniques.

In addition to the data collected during the pilot, secondary data on the pilot sites were collected from various public bodies, including the 2009 Care Quality Commission data.

Audit Data
Seventeen of the sites conducted retrospective clinical notes audits. The Out of Hours doctors, NHS Pathways, and NHS Direct, used a combination of notes and retrospective audio recording to conduct the audit.

Sites were asked to record the length of time taken to complete each audit. 72% of the pilot sites took less than 15 minutes to conduct one audit, and no sites took more than 20 minutes. 50% of sites that undertook the audit using retrospective clinical notes–thought the audit took too long to complete. It was noted by the Ambulance Service that the tool was 'very quick to fill' if the consultation was straightforward; however the length of time to complete the audit increased where any extra note taking became necessary.

Audit Team Composition
As this was only a pilot study most sites were unable to provide a full 'audit team' as recommended in the toolkit. The exceptions to this were the two Out of Hours and NHS Direct sites, which routinely audit individual clinicians and were able to use their audit teams already in place. In all other providers the audit was conducted by an individual, usually a lead doctor or regular audit lead. The variation in team composition should be taken into account when reading the findings of the pilot study.

The Toolkit Defined–Context and Application

In the summer of 2010, the coalition government published a white paper "Equity and Excellence: Liberating the NHS"[1], which sets out the Government's strategy for the NHS, with the intention to create an NHS which is more responsive to patients, achieves better health outcomes, with increased autonomy and clear accountability at each level.

The White Paper 'Equity and Excellence" [1] includes a commitment to develop a coherent 24/7 urgent care service, incorporating GP out–of–hours services, in every area of England. This will be supported (subject to pilot evaluation) by a single telephone number–111–helping patients access all urgent care services. The aim behind this is to make it easier for patients to get the right care, in the right place, at the right time.

On 17 December, the Secretary of State announced the introduction of two sets of clinical quality indicators from April 2011[2]. One, for A&E services, replaces the four hour waiting time standard. The other, for ambulance services, replaces the Category B, 19 minute response time target. The purpose of the clinical quality indicators is to provide a more balanced and comprehensive view of the quality of care. This includes outcomes, clinical effectiveness, safety and service experience, as well as timeliness. The clinical quality indicators also aim to stimulate a more sophisticated discussion and debate about quality of care to support a culture of continuous improvement.

At the same time the Quality, Innovation, Productivity, Prevention (QIPP) initiative is being applied at national, regional and local levels to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements. QIPP is engaging large numbers of NHS staff to lead and support change. At a regional and local level there are QIPP plans which address the quality and productivity challenge, and these are supported by the national QIPP workstreams which are producing tools and programmes to help local change leaders in successful implementation.

In the light of these developments, making an effective universal clinical care audit tool available is important because it constitutes the single most important method, which any healthcare service provider can use to understand the quality of the service that is being provided. It is also a powerful mechanism for ongoing quality improvement, identifying weaknesses or delivering clinical and cost effectiveness. It is anticipated that this Universal Urgent and Emergency Clinical Audit Toolkit will help in measuring both within and across urgent and emergency care service providers, the quality of patient care and encourage quality and continuous improvement.

What is Urgent and Emergency Care?
There is often confusion about the terminology used by users, providers and commissioners of urgent and emergency care. Terms such as unscheduled care, unplanned care, emergency care and urgent care are used interchangeably. The Department of Health guidance on telephone access to out of hours sought to clarify commonly used terms[3].
- **Emergency Care**=immediate response to time critical healthcare need.
- **Unscheduled Care**=services that are available for the public to access without prior arrangement where there is an urgent actual or perceived need for intervention by a health or social care professional.
- **Urgent Care**=a response before the next in–hours or routine (primary care) service is available.

The Department of Health in England[4] has since issued a definition for urgent care:

'Urgent care is the range of responses that health and care services provide to people who require–or who perceive the need for–urgent advice, care, treatment or diagnosis. People using 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'.

Conducting Routine Clinical Audits–A Discussion About Resources
The ability of providers to conduct routine clinical audit has been limited by a number of factors, including the immaturity of IT systems, the lack of a consistent audit tool and concerns about costs. Routine audit in Urgent and Emergency Care services has largely concentrated on areas of organisational performance rather than on the quality of individual patient contact. The exception being in response to a patient complaint or clinical incident.

However, some providers recognise the critical role of routine clinical audit in improving service quality and have included the associated costs within their contracts. In accurately identifying those costs, a range of options need to be considered to ensure that clinical audit is adequately resourced. These might include:
- The pooling of resources between providers to perform the audit function more cost effectively;

- Funding from primary care organisations (consortia), extra–contractually where possible;
- The use of other existing primary care organisations (consortia) resources (e.g. within the clinical governance team) especially where the provider is a primary care organisation (consortia);
- Absorbing the costs in year with inclusion in contract negotiations when these next come up for renewal.

Given that Urgent Care service provision is a contestable arena, most viable providers can solve any resource gap by working closely with their primary care organisations (consortia).

The cost of routine clinical audit will vary between providers and services and where it is embedded with other quality measures, the overlap in functions can make it very difficult to estimate its real cost. In instances where a new, routine clinical audit is planned, the following factors need to be considered:

- The need for a senior clinician to act as an accountable lead for clinical audit, and educational support for feedback and to address outliers in clinical performance;
- The need for an audit team, the size of which will be dependant on the size of the provider and the numbers of personnel whose patient contacts are routinely reviewed;
- Time for the assessment of a minimum of 1% or 4 examples of each individual's calls/consultations per quarter (for both call handlers and clinicians) as a recurring routine audit sample. A further 4 calls of individuals identified as having 'calls for concern', and 2% or 8 calls/consultations for new staff members early in their employment; with more extensive call reviews in response to adverse patient or practice feedback or complaints;
- Using a simple but effective audit tool, an average assessor (doctor, nurse or other professional) can expect to review up to 10 Call Handler calls (including documentation) per hour and up to 6 clinician calls/consultations per hour (including documentation);
- Administrative support to retrieve audio recordings and electronic documentation. Paper based systems will always be more labour and resource intensive.

IT support to randomly identify calls/consultations, maintain databases of individual performance and for the generation of both individual and organisational reports. The Urgent Care software supplier needs to be encouraged to develop the necessary standard reports.

Who Should Use This Toolkit?

This toolkit is for all providers of urgent and emergency care, including clinicians and non–clinicians. Out of Hours Doctors, Emergency Departments, Walk–In Centres, GP Medical Practices, BASICS (Pre Hospital Emergency Care Doctors), NHS Pathways, NHS Direct, Ambulance Service and Urgent Care Centres.

Why Use This Toolkit?

Now more than ever, there is increased pressure to improve clinical effectiveness and reduce unnecessary cost associated with healthcare provision. Each year, urgent and emergency care services are provided to millions of people in England and demand is increasing. The average cost of urgent and emergency services to the NHS runs in billions of pounds every year. The complex nature of the patient pathway and the variety of different types of care workers (clinicians and non–clinicians) with direct patient contact means that such services face particular challenges in ensuring continued monitoring of clinical standards for consistency and quality improvement. Effective clinical audit constitutes the single most important method which any healthcare provider can use to understand and improve the quality of the service that is being provided, and it is one of the key methods by which all organisations providing services to NHS patients can deliver clinical and cost effectiveness.

In September 2008, The Healthcare Commission published the report 'Not Just a Matter of Time: a review of urgent and emergency care services in England'[5] and published the following findings:

- During 2007/2008, there were 19.1 million attendances at accident and emergency departments (A&E) and urgent care centres compared to 14 million A&E attendances in 2002/03. The total cost of these services is around £1.3 billion a year (or £25 per person);
- During 2007/08, The Ambulance Services received 7.2 million 999 calls, they responded to 1.8 million Category A (life–threatening) incidents, and made 4.3 million journeys to hospital. Between 2001/02 and 2006/07. The number of emergency calls increased from 4.7 million to 6.3 million. The total cost of these services is around £1.1 billion a year (or £23 per person);
- In 2007/08, Out–Of–Hours GP services received 8.6 million calls and completed 6.8 million medical assessments (there is no good national data on the long–term trend in the use of these services, but these levels are broadly similar to those in 2006/07). They carried out 2.9 million assessments by telephone, 0.9 million assessments on home visits and 3 million assessments where the patient attended a primary care centre. Around 1.5% of the calls they deal with are

classed as 'life–threatening' and 15% are classified as 'urgent'. The total cost of these services is around £400 million a year (or £8 per person);

- In 2007/08, 4.9 million calls were answered by NHS Direct's main 0845 service, down 3.3% from 2006/07;
- Each year around 290 million consultations take place with GPs and practice nurses, many of which are of an urgent nature. Between 1995 and 2006, the number of consultations grew at the rate of 3% each year. Over this same period, there was also an increase in the proportion of telephone consultations (up from 3% to 10% of contacts) and a decrease in the proportion of home visits (from 10% to 4% of contacts, although this is largely linked to the reorganisation of out–of–hours GP services);
- Around 750 million prescription items are dispensed each year by local pharmacy services, many of which also relate to urgent care.

What Does This Toolkit Do?
The aim of this toolkit is to provide an audit tool which comprises a framework for applying relevant, pre–defined audit criteria across all urgent care environments. I

This toolkit will aim to support all urgent and emergency service providers in providing routine clinical audit by:
- Providing the practical guidance on how clinical audit may be implemented for urgent care service providers;
- Providing the framework and criteria (audit tool) for 'routinely' assessing the quality of individual patient interactions (from written records, or audio (video) recordings) in telephone or face to face consultations;
- Illustrating how clinical audit can contribute with other clinical governance and educational aspects to improve patient safety and the quality of the care being given by those individuals with direct patient contact;
- Providing a generic approach and audit tool that can span all stages of the urgent and emergency care patient pathway; allowing for benchmarking between health workers (clinicians and non–clinicians) and urgent care services; to improve both the consistency and quality of the urgent and emergency care response by different individuals and providers.

This toolkit is not intended to be prescriptive; local implementation will be determined by individual local factors ranging from the size and complexity of the organisation to the available resources.

Using This Toolkit: Potential Outcomes
We hope that by using this toolkit, any provider of urgent and emergency services will:
- Improve the quality of individual consultations along the journey of the patient with urgent and emergency care needs;
- Strengthen and develop the needs of the workforce, contributing to an improved patient experience for urgent and emergency care services;
- Develop strategies and their implementation for continuous quality improvement and improvement in productivity (QQUIP)[6;]
- Information from the audit can also be used to support doctors' appraisal, certification and revalidation competencies.

How to Use the Toolkit
This Universal Toolkit has been developed to support all urgent and emergency care providers in delivering effective clinical audit. It set out seven steps which will enable them to maximise the opportunities the audit provides for continuous improvement in the quality of the service they provide:
Step 1: Identify the role of the clinical audit within the organisation
Step 2: Define the patient pathway
Step 3: Define the audit criteria
Step 4: Define the audit tool
Step 5: Conduct the audit
Step 6: Incorporate learning from other aspects of the service
Step 7: Repeat the audit cycle

See Figure 1 (Page 12)

The audit tool is a two page workbook comprising 14 criteria–**9 universal criteria, 5 additional criteria**. The workbook can be completed electronically or printed out. The 9 universal criteria are relevant to all urgent care settings and providers and should be applied in all health care settings. The 5 additional criteria are optional and may be relevant to some organisations more than others. You are encouraged to review this at a local level. In line with the National Outcomes Framework, the National Quality Indicators sent out by the National Institute of Health and Clinical Excellence[7] (NICE) also form part of this Toolkit. These are **10 case–specific criteria** (Appendix 6) which should be used where they are relevant to the consultant being audited (face to face, retrospective patient notes or telephone consultations).

Each criterion has a set of questions, which should be used as prompts to score each criteria. Please note that some questions may be more relevant to some organisations than others. The universal criteria, however, remain relevant across the board and should be scored against the scoring scale (0–2).

Currently, some services (for example, emergency departments) do not routinely conduct audits of individual consultations with patients. It is hoped that the use of this toolkit will contribute to a better understanding of how clinical and non–clinical staff interact with patients, thereby providing evidence on which to build improved patient experiences. You are encouraged to use this toolkit at individual personal development meetings (clinical and non–clinical staff), directorate meetings or use as an input in organisational level audits.

How to Use the Toolkit

Step 1
- Clinical audit process
- The audit team
- Resources

Step 2
- Generic pathway
- Safeguarding along the patient pathway
- The data pathway

Step 3
- The core criteria
- Additional criteria
- Setting the standard
- Local Adaptation
- Clinical quality and outcome indicators

Step 4
- Using the tool

Step 5
- Information gathering
- Sampling strategy
- Feedback
- Confidentiality
- Timescale
- Acting on findings

Step 6
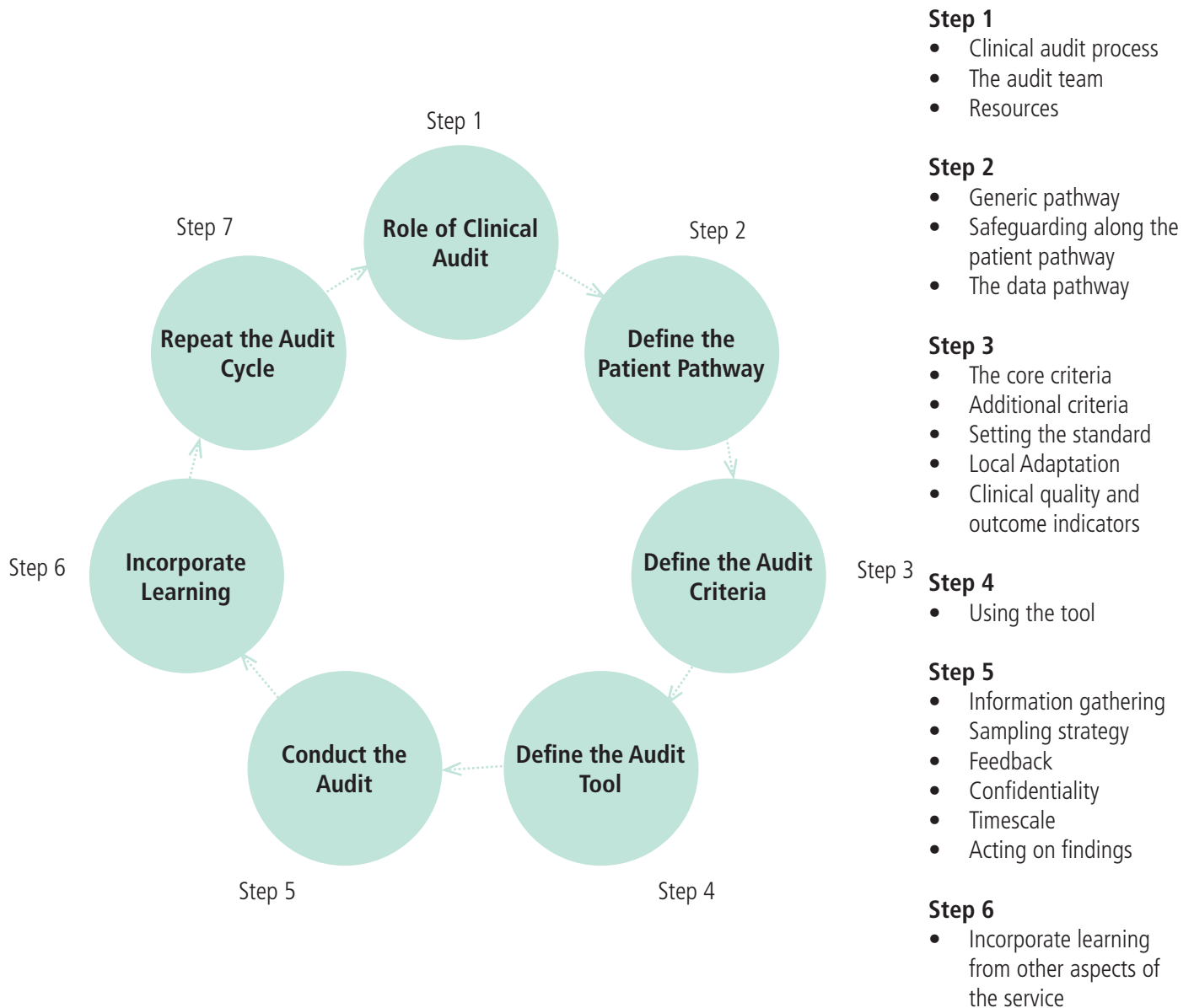- Incorporate learning from other aspects of the service

Figure 1: How to use the Toolkit

Step 1: Identify the Role of Clinical Audit Within the Organisation

The Clinical Audit Process
Clinical audit involves reviewing the delivery of health care in order to improve quality and performance. To achieve this the clinical audit process generally consists of four critical stages:
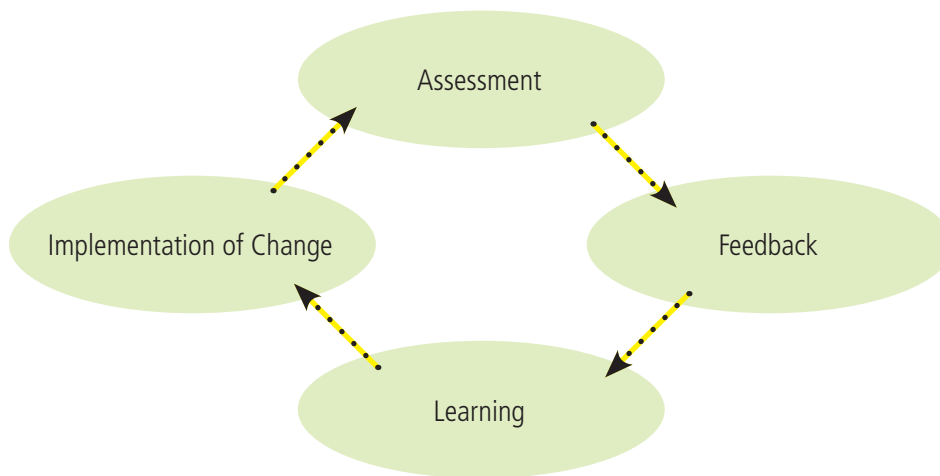

Figure 2: The Clinical Audit Process

The beneficial outcomes of clinical audit are equally applicable at an individual, as well as organisational level. This is illustrated in Figure 3, below:
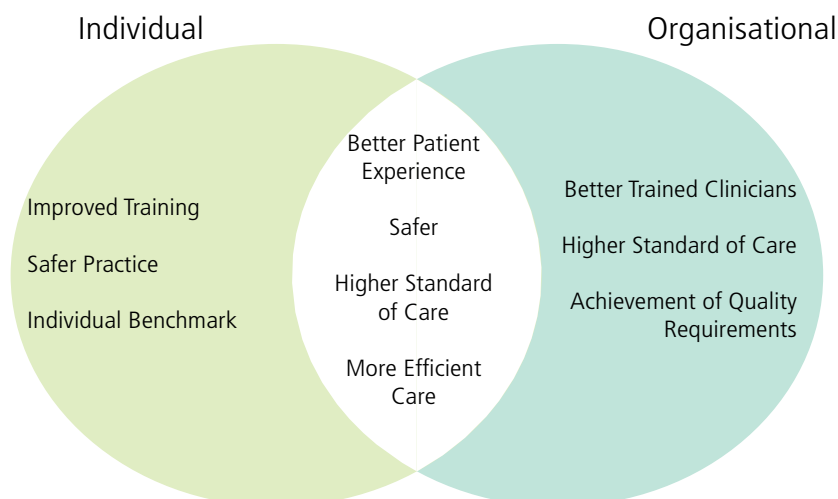

Figure 3: Individual and Organisation Outcomes

The Audit Team

An effective clinical audit should be administered by an audit team who is formally recognised by the health care provider's management structure, at Board or Director level. This increases the likelihood of outcomes being achieved.. For smaller organisations e.g. GP practices the equivalent, accountability structure can apply in terms of the 'Partnership' and different lead roles within the practice, often already in place to deliver the 'Quality and Outcomes Framework'.

Team Member	Key Responsibilities
Audit Lead	• Overall management and coordination of the audit
(Senior Clinician)	• Reporting of information to senior management • Coordination of feedback to individuals • Identification of outliers in clinical performance
Education Lead	• Provision of educational support to enable progressive feedback • Integration of feedback into professional development programmes
IT Lead	• Randomly identify calls/consultations • Maintain databases of individual performance • Generate individual and organisational reports

Table 2: The audit team

An audit team generally consists of an experienced audit lead responsible for the overall implementation of the audit, with the appropriate level of authority to progress performance issues if required. The Audit Lead will usually be supported by an education lead capable of advising on training methods and processes and able to escalate implications of findings to facilitate individual and organisational learning and update training requirements. As most data is now stored within computer systems, an IT lead is also needed to extract and collate appropriate data or clinical records and audio recordings. However in some services, paper records are still extensively used and the mechanism for their retrieval for routine audit processes needs to be considered. How these roles and responsibilities will be delivered in practice

will vary from organisation to organisation, however key responsibilities are identified in Table 2 above.

Resources

The audit team should be equipped with the appropriate resources, and each provider will need to agree with its primary care organisation (consortia) precisely what these resources are and where they can be found. While many providers will want to take sole responsibility for audit as the costs associated will be identified explicitly within the contract, others may wish to draw on resources that may exist elsewhere within the Primary Care organisation (consortia) e.g. clinical governance team.

Step 2: Define the Patient Pathway

Generic Pathway

The fundamental pre–condition for an effective clinical audit is a thorough understanding of the patient pathway within and between providers. The detail of individual local pathway will vary, but a detailed look at a number of pathways for the key urgent care services; including NHS Direct, Ambulance Service, Emergency Departments and Out of hours GP (See Appendix 1) show common features that can be extracted and mapped onto generic pathways, applicable in most urgent care settings.
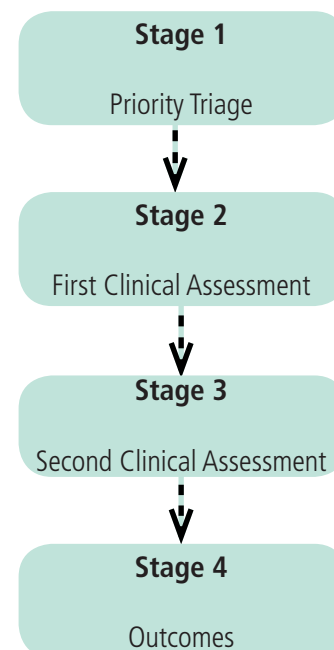

Figure 4: Generic urgent and emergency patient pathway

Stage 1	Priority triage
Staff role	E.g. Call handler, receptionist
Consultation	This stage is usually performed by a call handler or receptionist who will do the following: • Take initial information (including demographics) • Prioritise the severity of the call (including the identification of an immediately life–threatening condition • Pass the call to the next stage of the pathway or stream the call to another service
Outcome	Patient is progressed to the next stage within the service or is transferred to priority triage in another service

Stage 2	Primary Clinical Assessment
Staff role	E.g. Triage Nurse, Front Line Ambulance Staff
Consultation	A definitive clinical assessment usually conducted by a doctor or nurse although in some services this could be a pharmacist, or an Emergency Care Practitioner (ECP)
Outcome	The patient may be discharged if it is deemed that no further action needs to be taken, transferred to another clinician for further assessment (or called in to see the clinician if initial primary assessment is conducted over the telephone), or referred to another service

Stage 3	Secondary Clinical Assessment
Staff role	E.g. GP face–to–face consultation, Clinician in Referral Service
Consultation	Following a primary clinical assessment the patient is given either; • A telephone consultation • A face to face consultation, or is referred to another service • (e.g. advised to attend A&E or to see their GP)
Outcome	The final decision is made during a telephone consultation or face to face episode

Stage 4	Outcome
Outcome	Admitted, Discharged, Referred to Correct Service

Table 3: Generic urgent and emergency patient pathway

The generic patient pathway can easily be mapped to local service provision and in this way, the key audit points related to initial access to the service and the different stages in the pathway can be easily identified (see Appendix 1 and 2). There are a multitude of providers offering different services within the urgent care system, and therefore a number of different entry points. An urgent care episode is triggered when a patient (or representative) calls an urgent care service, turns up at a walk–in service or an emergency department. The patient pathway thereafter will usually consist of three decision–making processes which are connected by the passing of information either electronically, on paper or by word of mouth.

Ensuring Safeguarding Along the Patient Pathway
Staff should be aware of safeguarding issues when consulting all patients; however safeguarding is of particular importance in children and vulnerable adults. Whilst services may vary in their approach to identifying those at risk, appropriate training should be given to all staff along the patient pathway. Staff with access to appropriate computer databases (e.g. Child Protection Plan) should ensure that concerns relevant to a patient's care are explored, recorded, and appropriate action is taken.

During clinical audit, one of the difficulties is not knowing if a safeguarding issue has been missed or not recorded. This is a particular problem with Emergency Departments and Walk–In–Centres, where past histories are not available, and clinical audit is done with retrospective patient notes. A possible solution could be that for each individual clinician the auditor looks at a cross–section of patients where children and elderly are seen (the most vulnerable groups). For example, x number under 1, under 5 and under 16, then over 70. The risk associated with this is missing the age group in between where there is domestic violence, mental health issues, and drug abuse or where children are at risk. The auditor could also consider focusing on patients where safeguarding has been an issue and assess the clinical care provided.

It is up to the organisation to ensure that mechanisms are in place for ensuring that safeguarding issues are not missed. The ability of clinicians to recognise and act upon concerns for the well being and safety of patients and record appropriate data is key to effective safeguarding. Learning the lessons of safeguarding cases is also important.

The Data Pathway
Whilst most urgent and emergency care providers use IT extensively, some services such as the emergency departments

may have paper records. Both paper and IT based/telephony records for audit purpose are acceptable and will be equally effective. In order to audit retrieval for routine audit processes needs to be considered. How these roles and responsibilities will be delivered in practice will vary from organisation patient pathways, it is necessary to consider each of the points where decision–making and data transfer takes place. Each organisation must define its local protocol for accessing the audit data along the patient pathway.

Step 3: Define the Audit Criteria
An audit tool comprises a selection of criteria against which different staff groups, organisations and modes of patient contact can also be assessed. Whilst there are different audit tools used by different urgent and emergency care providers, there is value in having a universal audit tool, with universal criteria applicable to all organisations. The application of some of the universal criteria will vary, but by using a single set of universal criteria, it is possible to achieve a consistent interpretation when looking at the patient journey along the patient pathway, especially when patients are passed from one provider to another.

In developing the universal audit criteria, the clinical consultation model was followed[8,9,10,11,12].

Review of Existing Audit Tools
An audit tools comparison exercise was carried out using the listed audit tools currently in use across all urgent and emergency care service organisations. Each criterion was mapped across generic expected outcome and interpretation. The exercise found a lot of similarities across the audit tools, rather than differences. The only differences were the variation in the audit process itself, rather than the audit tools and the interpretation or expected outcomes. See Appendix 1 for more details of the comparison analysis.
• NHS Pathways–Competency Call Review Tool
• NHS Direct–Health Advisor Call Review Tool
• NHS Direct–Nurse Advisor Call Review Tool
• London Ambulance Service–Emergency Care Practitioner (ECP) Review Tool
• RCGP Out of Hours Toolkit

The following Urgent Care providers have been involved in the development of the criteria against which performance can be audited, using evidence from well established audit tools and standards currently in use. See Appendix 3 Universal Clinical Care Audit Tool.

Providers	Evidence based
• NHS Pathways • NHS Direct • The Ambulance Service • GP Out of Hours • Emergency Departments	• The GMC's Good Medical Practice • The Nursing & Midwifery Councils Code of Professional Conduct • Standards for Better Health • The RCGP's criteria for 'Summative Assessment and MRCGP Video Consultation Assessment • The Out of hours Quality Requirement • Examples of current good practice

Table 4: Urgent and Emergency Care Providers and Existing Tools

There are no published evidence–based audit tools available or in use in any urgent and emergency care service organisations, except for the RCGP Out of Hours Clinical Audit Tool published in 2007[21].

The Core Criteria
This audit tool utilises a selection of core criteria against which staff groups, organisations and modes of patient contact (from face–to–face interactions to those on the telephone) can all be assessed. While it would be possible to develop different criteria for each, there is value in having a single set of criteria which can be used for all staff groups and for all kinds of consultations:
• Standardisation: Standards are comparable between staff groups and organisations.
• Benchmarking across providers: This generic Urgent Care Audit Tool has been designed to review the quality of individual patient journeys through the urgent care system as a whole. For example, the same four calls or episodes can be reviewed across all the relevant providers to allow for consistent benchmarking against the audit criteria for good clinical care.
• Efficiency and cost saving: a single auditor can apply the same tool to multiple staff groups, without having to develop a new tool for every situation. Primary Care organisations (consortia) may want to develop clinical audit capability across organisations and the standardisation of the audit can deliver efficiency and cost savings.

By using a single set of criteria it is possible to achieve a consistent interpretation when looking at the patient journey

along the whole patient pathway, including those occasions where patients are passed from one provider to another[22,23]. See Appendices 4 and 5, with detailed notes on the rationale and guidance on using the audit tool.

Additional Criteria

As well as the Universal Criteria which can be used by all providers, the Urgent and Emergency Care audit tool also contains five additional criteria that can be used if the auditor feels they are appropriate. During the pilot phase of the tool some providers noted that not all the additional criteria are relevant for all audit settings and it was agreed that providers will need to review each additional criteria and adapt or use as appropriate to suit the local audit environment. See Appendices 4 and 5 with detailed notes on the rationale and guidance on using the audit tool.

Case–Specific Criteria–National Quality Indicators (NICE)

These are case–specific criteria setting out the quality of the clinical outcome, as dictated by NICE guidelines (Appendix 6). These quality indicators are designed to ensure appropriateness of treatment, advice for specific health issues, and ensure a high level of patient safety. You are encouraged to use these case–specific criteria where appropriate for the patient consultation, or retrospective notes being audited. See National Quality Indicators (NICE)[7].

Setting the Standard

Individual organisations should calculate an average score for each criterion against which clinicians within the organisation can be bench marked against each other. The standard set for each criterion is the mean for the individual organisation and a scoring system can then be used to benchmark this mean score for each criterion as part of a formative approach to improving clinician performance. This is a developmental approach in improving staff (clinicians and non–clinicians) performance by providing feedback to simulate reflection and improvement either in the core, additional or case–specific criteria.

Local Adaptation

There may be circumstances in which local health organisations want to modify or add to the core criteria set out here–e.g. because of the use of paper–based or electronic protocols or algorithms. In particular, when staff are recruited from outside the UK, additional criteria that enable the assessment of their language skills, and their understanding of the local health economy and the local practice of medicine may also be necessary. However

the principle of a consistent approach across a health community should not be lost. The core criteria are provided in the generic audit tool and further explanations and guidance on their use is given in Appendices 4 and 5.

Although all criteria are relevant to Urgent Care, there are some criteria that are more important to clinicians working in particular settings. For example, clinicians dealing with a life–threatening case in an Emergency Department need to clearly identify the main reason for contact, but may not be able to give a good explanation of the process to the patient. Additionally, providers may also use different auditing techniques. Audits may be done using retrospective audio and/or visual recordings, face–to–face, or using retrospective clinical notes. Auditors should be able to apply the universal criteria in the audit tool to all types of audit technique, and the additional criteria have been provided for use if they are considered appropriate.

Step 4: The Audit Tool

The Universal Clinical Care Audit Tool in Appendix 3 is intended to be simple and intuitive. It is designed to capture the main components of patient contact with Urgent Care services while providing a framework to examine and develop the quality of calls and consultations using established educational approaches for good practice.

Using the Tool

There are fourteen criteria (nine core criteria, and five additional criteria) and the 10 case–specific–National Quality Indicators. Each criterion has a series of questions that provide the prompts relating to that criterion. It is particularly important to emphasise that these questions are not intended to promote a 'tick box' approach to the audit. Rather, they are included to provide an explanation for determining if a particular criterion is in fact being met. Thinking through the extent of compliance with these different subsidiary components will make it much easier to explain the basis for a 'Call or Consultation to Reflect'.

The marking schedule allows individuals to benchmark their performance against the criteria in relation to the organisation's mean score for any individual criterion. This is both to aid reflection and to enable an individual to monitor their progress. It is also one of the mechanisms that Urgent Care providers can use to monitor different elements of the quality of contact it has with patients.

The marking schedule has been devised for simplicity and ease of use and there are three possible scores for each of the criteria:

- 0–criterion not met
- 1–criterion partly met [or acceptable–minimally safe and can be improved]
- 2–criterion largely or fully met

In addition to the composite score it is recommended that any elements of concern should lead the assessor to designate it a **Call or Consultation to Reflect upon (CtR)**. In most cases these will be minor but nevertheless worthy of reflection by the individual, and will aid learning for all (as in the sharing of information about significant events). A small number will be considered major, requiring immediate intervention and/or education (e.g. incorrect prioritisation or streaming by a call handler, ignoring an algorithm where these are used, failure to recognise a serious condition in face–to–face contact).

In terms of the most effective targeting of additional educational support, it would make sense to focus on those with low average scores (e.g. the bottom 10%) and/or those with several CtRs (3 per annum or if more than 10% of an individual's calls/consultations are identified as CtRs if many calls/consultations reviewed). This will lead in turn to a proactive approach, providing the learning from CtRs is shared with appropriate groups of staff clinicians or call handlers. Scores from the clinical audit involving patient contacts on the telephone or face–to–face can be collated for feedback to individuals and summarised in an organisational report at least quarterly, either in a paper–based or electronic form.

Audit Report Templates

The following audit report templates are available in Appendices 7, 8 and 9. These templates have been adapted from the RCGP Out of Hours Clinical Audit Toolkit[21], however reporting template can be adapted for different services e.g. Urgent Care Settings, GP Out of Hours and NHS Direct.

1. Quarterly Clinician Audit Report e.g. for use in emergency departments, out of hours services, etc.
2. Quarterly Call Handler Audit Report e.g. for use in telephone based services, call handlers, etc.
3. Quarterly Urgent Care Provider Organisation Audit Report.

Step 5: Conducting the Audit

Information Gathering–Paper Records, IT systems and Telephone Calls,

In order to review the performance of an individual working across the Urgent Care spectrum, it will be necessary to collate information from a number of sources. Some urgent care service providers will access data from telephone records or IT systems, others such as the emergency departments will be using paper records with process information held electronically, and you are encouraged to use existing means of data available to the organisation.

Some of these data sources are:
1. Paper records
    - Clinical records not held on computer
2. Electronically held clinical records
    - Consultation records
    - Prescribing information
    - Use of IT tools (PILs, Decision support etc.)
    - Outcome data
3. Productivity Data
    - Average consultation times
    - Average triage times
    - Calls triaged per hour/shift
    - Face to face consultations per hour/shift
4. Outcome Data Percentage of dispositions:
    - Where an immediate life threatening condition (ILTC) is identified
    - Admitted or discharged to another agency (A&E, 999 ambulance, District Nurse, etc.)
    - Streamed to another agency
    - Resulting in telephone advice
    - Resulting in home visit
    - Resulting in base visit
5. Voice Records
    - Voice recordings of calls
6. Feedback from patients
    - Complaints
    - Compliments
7. Feedback from colleagues
8. Significant Events
9. Serious Untoward Incidents (SUI's)

Sampling Strategy

Sampling arrangements must ensure that a random sample of the consultation records (face to face, telephone or patient notes) are systematically reviewed for each and every individual working within the organisation who contributes to clinical care. A minimum standard would be to ensure that at least 1% or 4 examples (whichever is the larger) of each individual's consultations (face to face, telephone or patient notes) are reviewed. Should the results of this baseline audit identify any

areas of concern about an individual's performance, then a further 4% of that person's consultations should be sampled. Organisations will develop their own regular audit cycle for their staff, however providers may wish to carry out early audits for new members of staff, where a larger sample (perhaps 2% or 8 calls/consultations) may be desirable. Equally, where doubts are raised about an individual's performance (perhaps in a complaint, or in feedback from the patient's own practice), then a prompt and more extensive audit may be necessary.

Feedback

Feedback is a process by which information collected about an activity is used to influence the performance of an individual or organisation; it should recognise excellence but also differentiate unsatisfactory calls. Constructive feedback can improve motivation and correct mistakes providing there is reinforcement of what has been learnt and steps are taken to help learners or organisations reach their goals[24]. Reflection on feedback– at both an individual and organisational level–can be used to influence training procedures and organisational processes that will produce a gradual or immediate change[25,32].

A variety of different techniques for communicating effective feedback have been developed in both medical and business education–see Pendleton[8]; Ende[24]; Hewson[26] and Kurtz (1998)[27] for examples.
Regular feedback is important to ensure that any proposed changes are implemented and correctly adhered to. Audit reports allow for benchmarking and monitoring of performance, however motivated continual improvement will only be achieved if appropriate reflection time is given. It is also important to acknowledge that feedback is a two–way process that may require staff to talk to more senior colleagues regarding their performance, and this should be facilitated by a clear management structure. Practical guidelines for giving feedback are provided in Appendix 10.

Confidentiality

Feedback regarding the audit review should be given confidentially. However in situations where issues of performance have been raised, information may be shared as part of the performance management process[31].

Timescale

Clinical Audits should be conducted on a quarterly basis, as this will allow for comprehensive coverage of staff, many of whom may only work part time. Organisational reports can be compiled from an amalgamation of individual staff audits. A sample

organisational report is set out in Appendix 7.

There is much to be gained by providing summaries of the reports of audit findings across the organisation to all staff groups to further facilitate learning and benchmark progress. Findings can be reported to the management board of the Urgent Care provider via the clinical governance group, who should meet on a quarterly basis. Targeted educational activity can be organised for specific staff groups where further progress is required.

Acting on Audit Findings at Individual and Organisational Levels

In order to provide an effective feedback mechanism it is important that the links between individual audit and organisational response are recognised.
recording facilities which are either electronic or paper based. There is also a need for routine mechanisms for collating and reporting on Individual action:
- Individuals identified in the audit as having development needs can be managed using feedback and action plans involving reflection and planned review.

Organisational actions:
- Developmental needs of individuals can be supported by the Urgent Care provider. Resources can be made available for appropriate feedback, and a learning plan can be developed that includes a planned review to monitor progress. Where there are specific areas to address in multiple individuals, group educational activities can be organised.

Where environmental or operational factors are identified as being responsible (in whole or in part) for criteria not being met, appropriate changes can be made e.g. better rostering, amenities, etc.

Persistent poor performer

Such an individual may be identified in a number of ways–e.g. by numerous complaints, staff feedback or a failure to improve after educational input, as evidenced by a follow–up audit. Individual services will have their own processes for managing serious performance issues. However, before any decisions are made, there must be proper consideration of what other factors might have led to this poor performance–e.g. personal pressures (home, relationship, elderly parents, heath issues), or the situation at work (pressure of work, expectations, values, bullying) the attributes of the individual (extraversion, resilience, previous medical education, culture, values).
The individual who is being referred should be informed as to the

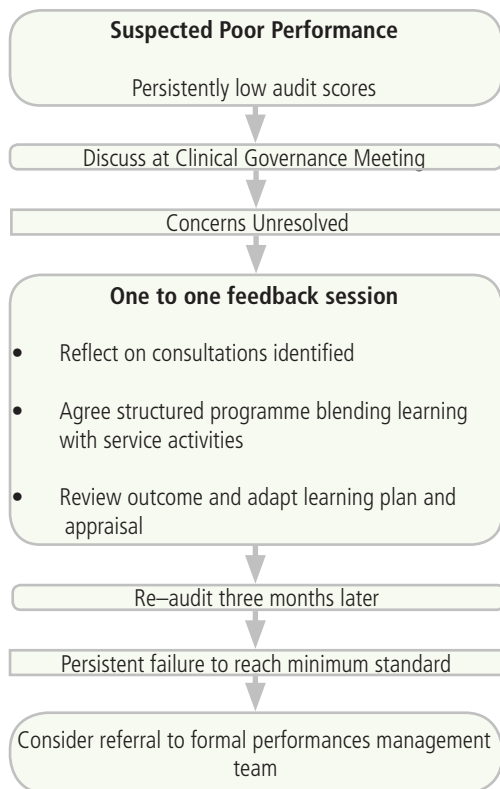reasons for the referral and what the expected outcome will be.

Figure 5: Action on audit Finding

Step 6: Incorporate learning from other aspects of the service

Every Urgent Care service will have access to data that can provide invaluable additional information about the quality of the service that is being delivered. These data may include:

- The routine auditing of performance against the other Quality Indicators e.g. National requirements of Out of Hours services;
- Reports of Serious Untoward Incidents and Significant Events which have been investigated and which result in appropriate remedial action (where necessary).
- Feedback from those who use the service (patients and their carers) through questionnaires or other methods of understanding the patient experience of the service, including complaints and compliments.

Effective clinical governance is achieved by establishing rigorous policies and processes to record and collate this data. All staff should be expected to record significant events, with easily accessible recording facilities which are either electronic or paper based. There is also a need for routine mechanisms for

collating and reporting on these entries, with dissemination of the learning (and any actions arising) to all staff in the

Figure 6: The Clinical Governance Committee Meeting

A multi–disciplinary and multi–agency governance group including patients and commissioners will act as an effective means of ensuring that there is organisational reflection across the entire service. Such a group should hold quarterly meetings to review, learn, and plan for any actions that may arise, including the identification of particular learning needs for individual members of staff and subsequent organisational training updates (see Figure 6).

Step 7: Repeat the Audit Cycle

As the processes for routine clinical audit of Urgent Care Contacts become embedded, it will become apparent how audit can routinely inform both appraisal and performance review to drive the cycle of Continuous Professional Development (CPD)[28,29]. As the diagram below illustrates, performance review may be triggered by the results of clinical audit itself or by other events such as a Serious Untoward Incident (SUI) or by a complaint from a patient. The end result is likely to be one–to–one feedback with the call handler or clinician, and an educational or action plan formulated. This will inform continuous medical or other professional education to address individual development needs[30].

Routine clinical audit has a key role to play in CPD, both in the accepted cycle of annual appraisal and formulation of a Personal Development Plan (PDP) as well as the faster route of performance review[29,30]. Clinical audit conducted quarterly with feedback to OOH organisations and the individual creates the opportunity to inform PDPs more frequently. When used in this way, performance review can be seen as nonthreatening and a means of benefiting both the individual and the organisation.
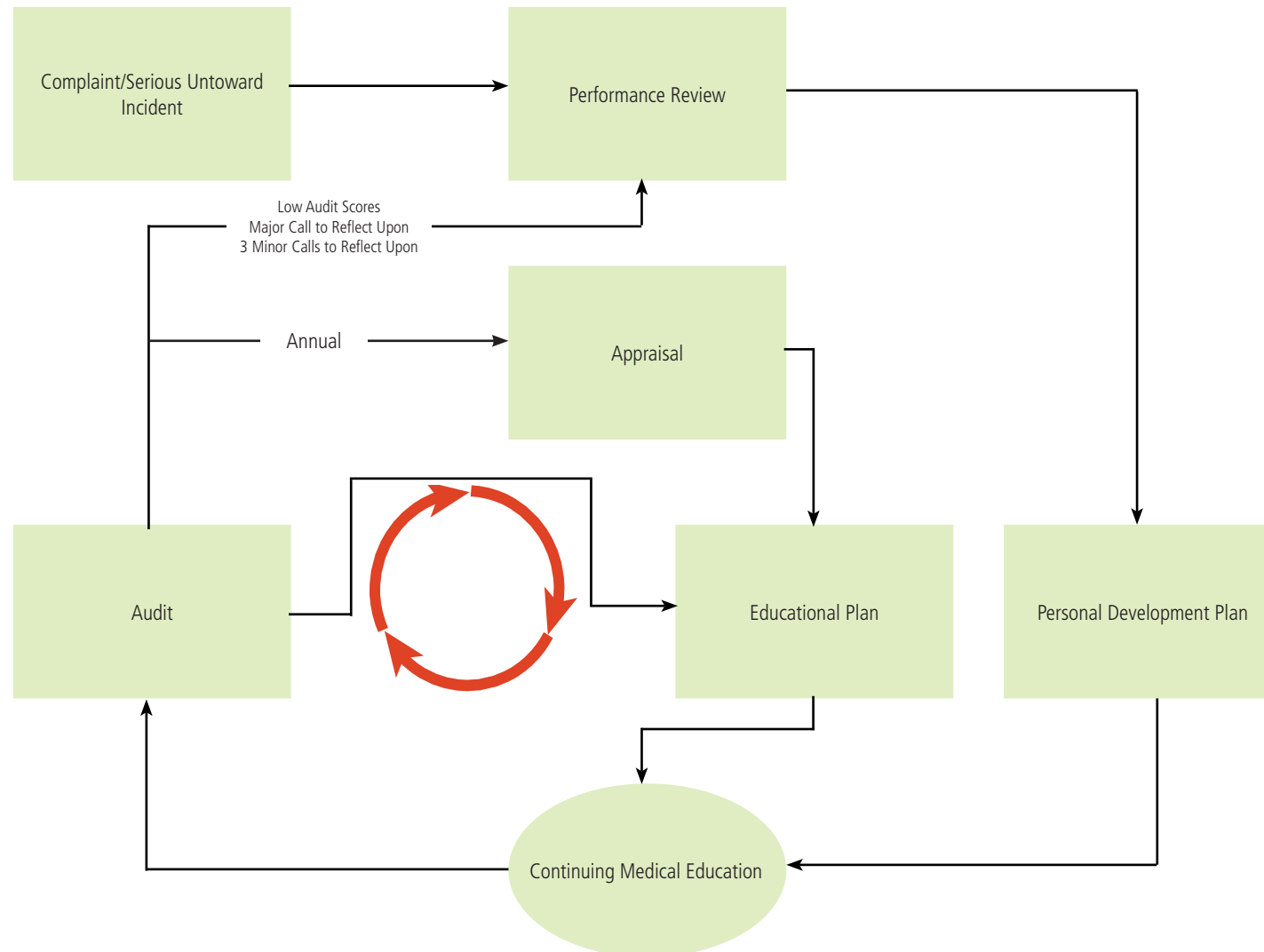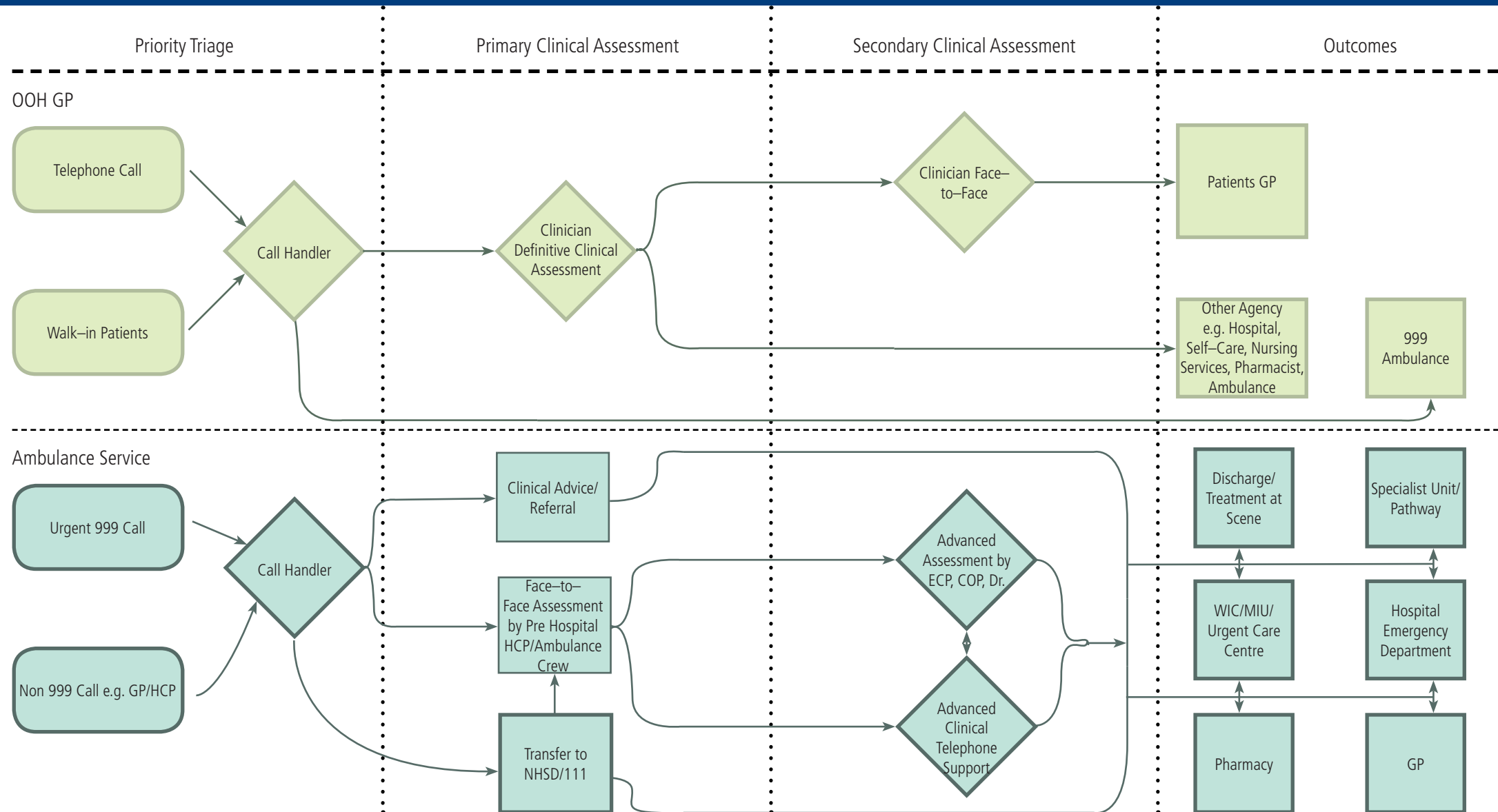
Figure 7: Routine clinical audit driving Continuing Professional Development
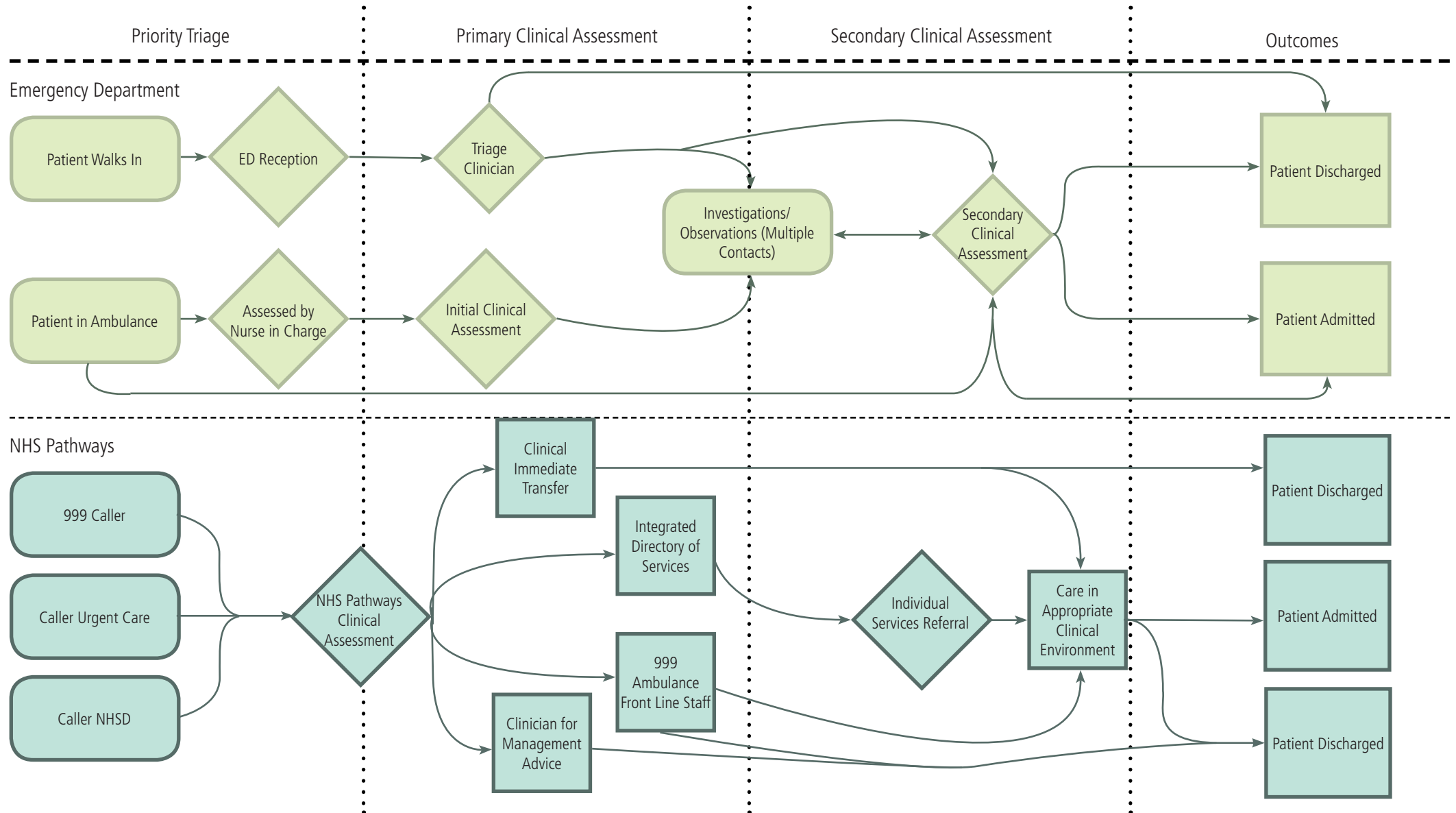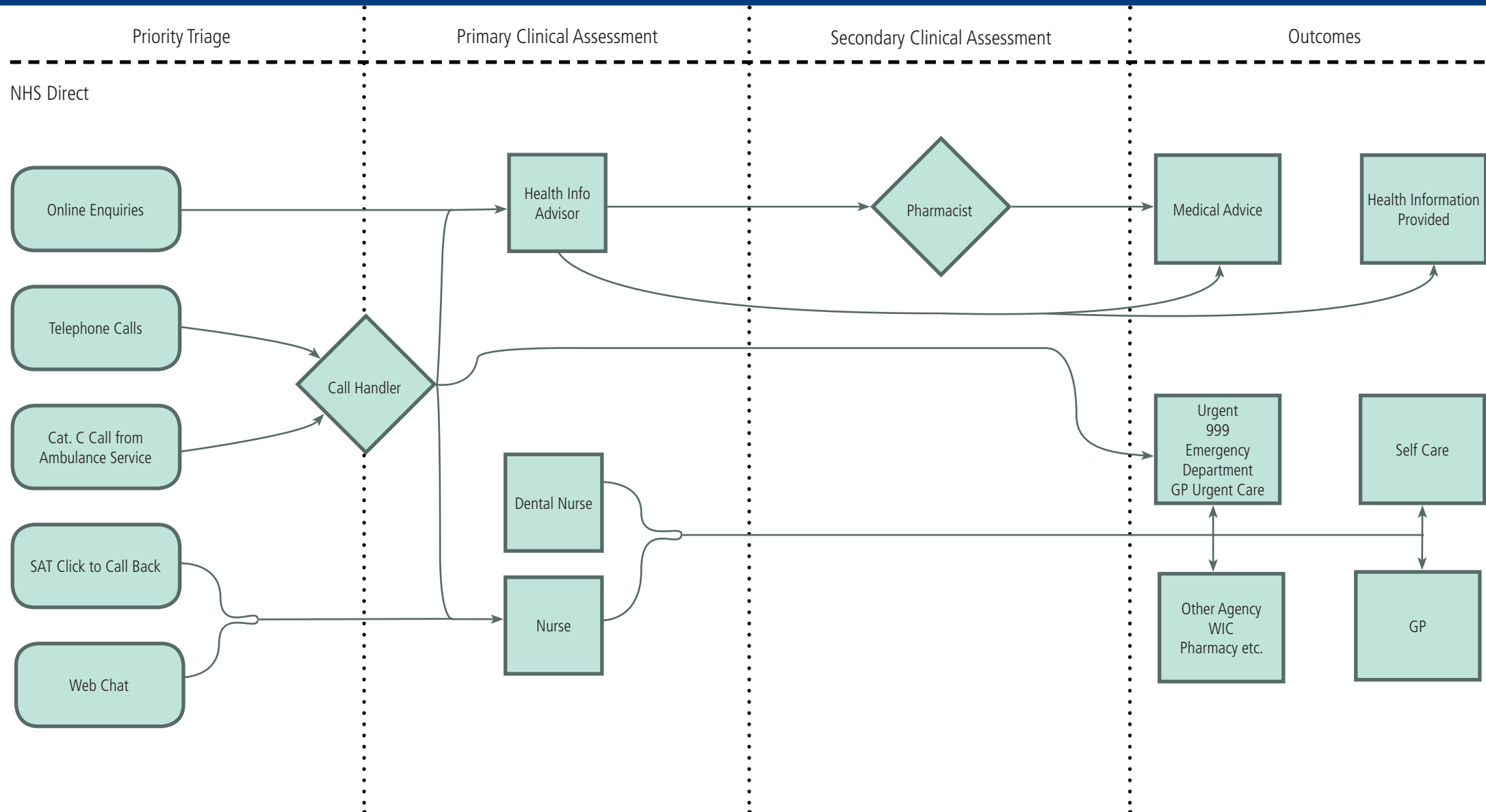
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Appendix 1–Comparison of Patient Pathways

Priority Triage	Primary Clinical Assessment	Secondary Clinical Assessment	Outcomes

OOH GP

- Telephone Call
- Walk–in Patients
- Call Handler
- Clinician Definitive Clinical Assessment
- Clinician Face–to–Face
- Patients GP
- Other Agency e.g. Hospital, Self–Care, Nursing Services, Pharmacist, Ambulance
- 999 Ambulance

Ambulance Service

- Urgent 999 Call
- Non 999 Call e.g. GP/HCP
- Call Handler
- Clinical Advice/Referral
- Face–to–Face Assessment by Pre Hospital HCP/Ambulance Crew
- Transfer to NHSD/111
- Advanced Assessment by ECP, COP, Dr.
- Advanced Clinical Telephone Support
- Discharge/Treatment at Scene
- Specialist Unit/Pathway
- WIC/MIU/Urgent Care Centre
- Hospital Emergency Department
- Pharmacy
- GP

Royal College of General Practitioners

Priority Triage · **Primary Clinical Assessment** · **Secondary Clinical Assessment** · **Outcomes**

Emergency Department

Patient Walks In → ED Reception → Triage Clinician

Patient in Ambulance → Assessed by Nurse in Charge → Initial Clinical Assessment

Investigations/Observations (Multiple Contacts) ↔ Secondary Clinical Assessment

Patient Discharged

Patient Admitted

NHS Pathways

999 Caller

Caller Urgent Care → NHS Pathways Clinical Assessment

Caller NHSD

Clinical Immediate Transfer

Integrated Directory of Services

Individual Services Referral

Clinician for Management Advice

999 Ambulance Front Line Staff

Care in Appropriate Clinical Environment

Patient Discharged

Patient Admitted

Patient Discharged

Priority Triage	Primary Clinical Assessment	Secondary Clinical Assessment	Outcomes

NHS Direct

- Online Enquiries
- Telephone Calls
- Cat. C Call from Ambulance Service
- SAT Click to Call Back
- Web Chat

Call Handler

Health Info Advisor

Dental Nurse

Nurse

Pharmacist

Medical Advice

Health Information Provided

Urgent 999 Emergency Department GP Urgent Care

Self Care

Other Agency WIC Pharmacy etc.

GP

Appendix 2–Audit Tools and Associated Criteria

Out of Hours Toolkit	NHS Pathways Competency Call Review Tool	NHS Direct Health Advisor Call Review Tool	NHS Direct Nurse Advisor Call Review Tool	London Ambulance Service (ECP Review Tool)	Urgent Care (Update of OOH tool, criteria updates bold)
Elicits reason for call/visit A. Clearly identifies main reason for contact B. Identifies patients concerns [health beliefs] C. Accurate information e.g. demographics in call handlers	Effective Call Control Call Handler & Clinician Indicators: • Makes effort to speak to patient • Explains process to caller effectively • Greets caller effectively • Controls flow of information • Paces call according to clinical urgency, caller's needs and service demands • Maintains call flow by effective multi–tasking	Call Control • Use the conversation cycle to control the call • Identifies key elements of caller's symptoms to focus on • Gives a good explanation for the assessment process • Appropriate adaptation of the speed for the caller's needs • Positively manage the caller's expectations		• Conducts themselves in a PROFESSIONAL MANNER. • Communicates well with patients and other agencies	Elicits REASON for call/visit • Clearly identifies main reason for contact • Identifies patient's concerns [health beliefs] • Accurate information e.g. demographics in CH's • Gives a good explanation of the process
Identifies EMERGENCY or SERIOUS situations: A. Asks appropriate questions to exclude [or suggest] such situations	Skilled QUESTIONING: Call Handler and Clinician Indicators: • Accurately conveys the clinical meaning of questions • Recognises where to probe • Phrases questions in a way that callers can understand • Ensures every question is answered adequately Clinician Indicator: • Synthesises information from validation screen to form effective summary questions	PATIENT SAFETY: • Rapidly check ABCs • Deals with 3rd party and intermediary calls appropriately • Gives clear worsening instructions at call closure • Interim care instructions given where clinically indicated • Transfers effectively and timely to 999 emergency services • Advises patient on current call back time or transfers call onward	Opening and PATIENT SAFETY: • Access the correct patient record from the queue • Opens the call • Quickly establishes the need for any emergency intervention • Quickly identifies correct call reason/where multiple symptoms identified critical symptom		Identifies EMERGENCY or SERIOUS situations • Asks appropriate questions to identify or exclude [or suggest] such situations • Appropriate use of ILTC protocols • Phrases questions in a way the caller can understand. • Quickly establishes the need to respond to a serious or emergency situation and acts accordingly

Out of Hours Toolkit	NHS Pathways Competency Call Review Tool	NHS Direct Health Advisor Call Review Tool	NHS Direct Nurse Advisor Call Review Tool	London Ambulance Service (ECP Review Tool)	Urgent Care (Update of OOH tool, criteria updates bold)
Appropriate HISTORY taking (or algorithm use): A. Identifies relevant PMH/DH [including drug allergy] B. Elicits significant contextual information (e.g. social history)	Active LISTENING: Call handler and clinician indicators: • Picks up accurately on verbal cues/nonverbal cues/relevant background noise • Recalls information given • Demonstrates active listening to caller		ALGORITHM use: • Selects the correct algorithm based on primary/critical presenting symptom. • Uses the algorithm effectively with critical thinking. • Uses the relevant PMH within the assessment and on delivery of decision	Takes appropriate HISTORY, using the clerking model & completes the PRF	Takes an appropriate HISTORY (or uses algorithm appropriately) • Elicits significant contextual information (e.g. social history) • Identifies relevant PMH/DH [including drug allergy]
Carries out appropriate ASSESSMENT: A. Face–to–face settings: appropriate examination carried out B. Clinician on telephone–targeted information gathering or algorithm use to aid decision making		PROTOCOL SELECTION: • Identifies correct call reason based on information received • Selects correct category • Selects appropriate symptom based or HI protocol based on correct call reason • Is able to take P4QC calls to completion using approved sources		Demonstrates a THOROUGH EXAMINATION and recognises normal findings considering differential diagnosis, linking findings to history	Carries out appropriate ASSESSMENT • Face–to–face settings–complete examination of all relevant body regions documented • Clinician on telephone–targeted information gathering or algorithm use to aid decision making • Links findings to history.

Out of Hours Toolkit	NHS Pathways Competency Call Review Tool	NHS Direct Health Advisor Call Review Tool	NHS Direct Nurse Advisor Call Review Tool	London Ambulance Service (ECP Review Tool)	Urgent Care (Update of OOH tool, criteria updates bold)
Draws appropriate CONCLUSIONS: A. Clinician face–to–face/ telephone–makes appropriate diagnosis or differential/or identifies appropriate 'symptom cluster' with algorithm use B. CH–makes appropriate prioritisation C. CH–streams call appropriately	Skilled Provision of INFORMATION AND ADVICE: Call handler and clinician indicators: • Provides all necessary information and advice • Information given is clear and without jargon, accurate, clinically sound and concise • Responds appropriately to caller requests for information	Navigates CSPT using CRITICAL THINKING: • Navigates the CSPT competently and logically • Use of critical thinking evident • Reaches an appropriate priority or streamed end point		Instigates appropriate testing and INTERPRETS RESULTS	Draws CONCLUSIONS that are supported by the history and physical findings • Constructs appropriate diagnosis or differential based on the history and findings to date/or identifies appropriate 'symptom cluster' with algorithm use • CH–makes appropriate prioritisation • CH–streams patient appropriately
Displays EMPOWERING behaviour: A. Acts on cues/beliefs B. Involves patient in decision–making C. Use of self–help advice [inc. PILs]		ACTIVE LISTENING: • Reflect back and confirm understanding of the caller's response. • Use verbal nods appropriately. • Allow the caller time to respond • Picks up/responds to nonverbal cues.			Displays EMPOWERING behaviour • Acts on cues/beliefs • Involves patient in decision–making • Use of self–help advice [inc. PILs] • Responds appropriately to caller requests for information

Out of Hours Toolkit	NHS Pathways Competency Call Review Tool	NHS Direct Health Advisor Call Review Tool	NHS Direct Nurse Advisor Call Review Tool	London Ambulance Service (ECP Review Tool)	Urgent Care (Update of OOH tool, criteria updates bold)
Makes appropriate MANAGEMENT decisions: A. Decisions safe B. Decisions appropriate (e.g. face–to–face or A&E)	Practices according to designated ROLE REQUIREMENTS: Call handler and clinician indicators: • Adheres to local policy/ guidelines/code of conduct. • Practices in accordance with service aims and relevant code of conduct (clinicians) • Seeks help appropriately. • Documentation is: clear, concise, accurate, no abbreviations or diagnosis.	POLICY AND GUIDANCE: • Adheres to policy, procedure, and guidance relevant to the call handling • Works within scope of role and responsibility • Where issues arise during a call, escalates appropriately • Demonstrates an awareness of own practice issues			Makes appropriate MANAGEMENT decisions following assessment • Decisions are safe • Decisions conform to relevant clinical guidelines (with any exceptions clearly and correctly justified • Practices in accordance with relevant code of conduct
Appropriate PRESCRIBING behaviour: A. Generics used [unless inappropriate] B. Formulary–based [where available] C. Follows evidence base or recognised good practice				Determines and INSTIGATES APPROPRIATE TREATMENT, referral and/or discharge plans including use of PGDs where appropriate	• Appropriate PRESCRIBING behaviour: • Generics used [unless inappropriate] • Formulary–based [where available] • Follows evidence base or recognised good practice

Out of Hours Toolkit	NHS Pathways Competency Call Review Tool	NHS Direct Health Advisor Call Review Tool	NHS Direct Nurse Advisor Call Review Tool	London Ambulance Service (ECP Review Tool)	Urgent Care (Update of OOH tool, criteria updates bold)
					Did the clinician address any potential SAFEGUARDING issues? • Do the notes demonstrate an awareness of safeguarding issues (where relevant)? • If safeguarding issues were suspected was the patient referred to the appropriate service? • If an injured child; Did the clinician explore the possibility of intentional injury?
Displays adequate SAFETY−NETTING: A. Gives clear and specific advice about when to call back B. Records advice fully (worsening instructions)	Delivers a SAFE AND EFFECTIVE OUTCOME for the patient: Call handler and clinician indicators: • Manages all aspects of the call safely Call handler: • Recognises and comprehends the clinical essence of the call. • Conveys an appropriate disposition to the caller • Uses adequate worsening advice Clinician: • Demonstrates clinical level of understanding commensurate with the role • Uses sound judgement in reaching disposition • Manages all aspects of the call safely		SAFE AND EFFECTIVE PATIENT OUTCOME: • Correct outcome reached for the patient, referral clinically indicated • Worsening advise given, general or specific • Appropriate care advice given based on symptoms and disposition	Demonstrates knowledge in abnormal physiological findings and acts accordingly	Displays adequate SAFETY−NETTING • Clearly documents advise given about when to return/call back • Records advice given (worsening instructions)

Out of Hours Toolkit	NHS Pathways Competency Call Review Tool	NHS Direct Health Advisor Call Review Tool	NHS Direct Nurse Advisor Call Review Tool	London Ambulance Service (ECP Review Tool)	Urgent Care (Update of OOH tool, criteria updates bold)
		DOCUMENTATION: • Correct demographics collected • Correct data protection processes followed to verify record • Completes Clinical Summary where appropriate. • Uses only approved abbreviations and annotations. • Completes P4QC data correctly • Correct documentation of the call reason/symptom/duration/ severity.	DOCUMENTATION: • Best practice in documentation and record keeping is documented throughout		Correctly fills in appropriate DOCUMENTATION • Documents information clearly and legibly, following correct procedures and processes • Correct documentation and information given to the patient
Develops RAPPORT: A. Demonstrates good listening skills B. Communicates effectively [includes use of English] C. Demonstrates shared decision making	EFFECTIVE COMMUNICATION: Call handler and clinician indicators: • Demonstrates a polite and professional manner • Adapts approach according to callers needs • Establishes rapport and treats caller with respect and sensitivity • Conveys empathy appropriately • Negotiates where appropriate and does so effectively • Avoids jargon	RAPPORT: • Mirrors tone and pace of caller. • Reflects caller's language appropriately • Treats caller as an individual • Gains cooperation of caller by keeping them informed • Shows interest in caller • Validates or educates caller on their actions where appropriate • Reassures caller • Uses humour appropriately APPROACH: • Positive and confident attitude and language • Demonstrate willingness to help and a 'can–do' attitude • Polite and courteous • Demonstrate sensitivity and a non–judgmental approach to the caller's need • Be honest			Develops RAPPORT • Demonstrates good listening skills • Communicates effectively [includes use of English] • Demonstrates shared decision making • Conducts themselves in a professional manner

Out of Hours Toolkit	NHS Pathways Competency Call Review Tool	NHS Direct Health Advisor Call Review Tool	NHS Direct Nurse Advisor Call Review Tool	London Ambulance Service (ECP Review Tool)	Urgent Care (Update of OOH tool, criteria updates bold)
Makes appropriate use of IT/ Protocols/Algorithms: A. Adequate data recording B. Face–to–face/phone/CH Use of IT tools where available/ appropriate C. Clinician on telephone– appropriate use of support tools or algorithms	Skilled use of the pathways functionality: • Allows system to drive assessment • Actively uses supporting information • Takes an appropriate route through the system • Moves through each aspect of the system logically and efficiently Clinicians: • Ability to efficiently return to questions asked by the call handler if a discrepancy in information becomes apparent		Effective use of decision support software: • Exhibits competence in navigating the decision support software	CONSIDERS REFERRAL to other LAS agencies and or third party	• Makes appropriate use of IT/ Protocols/Algorithms • Adequate data recording • Face–to–face/phone/CH Use of IT tools where available/ appropriate • Clinician on telephone– appropriate use of support tools or algorithms • Identifies discrepancies in information passed between clinicians if needed • Appropriate referral to another service if required
Satisfies ACCESS criteria where appropriate [info available]:					

UNIVERSAL URGENT AND EMERGENCY CARE CLINICAL AUDIT TOOL		
CRITERION SCORING: Criterion fully met = 2 ; Criterion partially met = 1 ; Criterion not met = 0 Score (0–2) for each criterion based on scoring rationale sheet, or note N/A	Date:	
	Reference No:	

Universal Criteria		SCORE
1	Elicits REASON for call/visit	
	A. Clearly identifies main reason for contact B. Identifies patient's concerns [health beliefs] C. Accurate information e.g. demographics taken by Call Handlers D. Gives a good explanation of the process	
2	Identifies EMERGENCY or SERIOUS situations	
	A. Asks appropriate questions to identify or exclude [or suggest] such situations B. Appropriate use of ILTC protocols C. Phrases questions in a way the caller can understand D. Quickly establishes the need to respond to a serious or emergency situation and acts accordingly	
3	Takes an appropriate HISTORY (or uses algorithm appropriately)	
	A. Elicits significant contextual information (e.g. social history) B. Identifies relevant PMH/DH [including drug allergy]	
4	Carries out appropriate ASSESSMENT	
	A. Face–to–face settings–complete examination of all relevant body regions documented B. Targeted information gathering or algorithm use to aid decision making C. Links findings to history	
5	Draws CONCLUSIONS that are supported by the history and physical findings	
	A. Constructs appropriate diagnosis or differential based on the history and findings to date/identifies appropriate 'symptom cluster' with algorithm use B. Prioritises appropriately C. Streams/Refers patient appropriately	
6	Makes appropriate MANAGEMENT decisions following assessment	
	A. Decisions conform to relevant clinical guidelines (with any exceptions clearly and correctly justified) B. Practices in accordance with relevant code of conduct C. Decisions are safe	
7	Correctly fills in appropriate DOCUMENTATION	
	A. Documents information clearly and legibly, following correct procedures and processes B. Correct documentation and information given to the patient	
8	Appropriate PRESCRIBING behaviour	
	A. Generics used [unless inappropriate] B. Formula–based [where available] C. Follows evidence base or recognised good practice	
9	Displays adequate SAFETY–NETTING	
	A. Clearly documents advice given about when to return/call back B. Records advice given (worsening instructions)	
SCORE:		

Additional Criteria if Applicable		SCORE
10	Did the clinician address any potential SAFEGUARDING issues?	
	A. Do the notes demonstrate an awareness of safeguarding issues (where relevant)? B. If safeguarding issues were suspected was the patient referred to the appropriate service? C. If an injured child; did the clinician explore the possibility of intentional injury?	
11	Makes appropriate use of IT/Protocols/Algorithms	
	A. Adequate data recording B. Face–to–face/Call Handler use of IT tools where available/appropriate C. Clinician on telephone–appropriate use of support tools or algorithms D. Identifies discrepancies in information passed between clinicians if needed E. Appropriate referral to another service if required	
12	Displays EMPOWERING behaviour	
	A. Acts on cues/beliefs B. Involves patient in decision–making C. Use of self–help advice [inc. Patient Information Leaflets] D. Responds appropriately to caller requests for information	
13	Develops RAPPORT	
	A. Demonstrates good listening skills B. Communicates effectively [includes use of English] C. Demonstrates shared decision making D. Conducts themselves in a professional manner	
14	Satisfies ACCESS criteria where appropriate [info available]	
	TOTAL SCORE:	

Appendix 4–Rationale For Using The Universal Urgent and Emergency Care Clinical Audit Tool

Universal Criteria		Not Met (0)	Partially Met (1)	Fully Met (2)
1	Elicits REASON for call/visit	Clinician does not identify reasons or concerns accurately	Clinician identifies reason	Clinician accurately identifies all
	A. Clearly identifies main reason for contact B. Identifies patient's concerns [health beliefs] C. Accurate information e.g. demographics taken by Call Handlers D. Gives a good explanation of the process	CH does not record reason or concern accurately	CH accurately records details or problem	CH accurate both details & problem
2	Identifies EMERGENCY or SERIOUS situations	No: Does not exclude an emergency	Questioning adequately excludes	Excludes emergency well, acts appropriately
	A. Asks appropriate questions to identify or exclude [or suggest] such situations B. Appropriate use of ILTC Protocols C. Phrases questions in a way the caller can understand D. Quickly establishes the need to respond to a serious or emergency situation and acts accordingly			
3	Takes an appropriate HISTORY (or uses algorithm appropriately)	Does not elicit relevant history	Elicits basic history without contextual information	Elicits full history including contextual
	A. Elicits significant contextual information (e.g. social history) B. Identifies relevant PMH/DH [including drug allergy]			
4	Carries out appropriate ASSESSMENT	No appropriate examination nor information gathering nor algorithm use	Adequate examination, information gathering or algorithm use	Good–appropriate actions
	A. Face–to–face settings–complete examination of all relevant body regions documented B. Targeted information gathering or algorithm use to aid decision making C. Links findings to history			
5	Draws CONCLUSIONS that are supported by the history and physical findings	No: does not draw appropriate conclusions in respective setting	Adequately draws appropriate conclusions in respective setting	Draws appropriate conclusions well in respective setting
	A. Constructs appropriate diagnosis or differential based on the history and findings to date/or identifies appropriate 'symptom cluster' with algorithm use B. Prioritises appropriately C. Streams/Refers patient appropriately			
6	Makes appropriate MANAGEMENT decisions following assessment	Decisions neither safe nor appropriate	Decisions either safe or appropriate	Decisions safe and appropriate
	A. Decisions are safe B. Decisions conform to relevant clinical guidelines (with any exceptions clearly and correctly justified) C. Practices in accordance with relevant code of conduct			

No.	Criterion	(Insufficient Evidence / Needs Further Development)	(Competent)	(Excellent)
7	**Correctly fills in appropriate DOCUMENTATION** A. Documents information clearly and legibly, following correct procedures and processes B. Correct documentation and information given to the patient	Appropriate documents are not completed.	Appropriate documentation is filled in adequately.	All documentation is completed to a high standard
8	**Appropriate PRESCRIBING behaviour** A. Generics used [unless inappropriate] B. Formulary–based [where available] C. Follows evidence base or recognised good practice	Prescribing unsafe or involves none of the features	Appropriate with either one or two of the features	All 3 features are present
9	**Displays adequate SAFETY–NETTING** A. Clearly documents advice given about when to return/call back B. Records advice given (worsening instructions)	Neither clear call back advice nor full recording of worsening advice	Either of the 2 features present	Both of the 2 features present
	Additional Criteria if Applicable			
10	**Did the clinician address any potential SAFEGUARDING issues?** A. Do the notes demonstrate an awareness of safeguarding issues (where relevant)? B. If safeguarding issues were suspected was the patient referred to the appropriate service? C. If an injured child; did the clinician explore the possibility of intentional injury?	No: Does not ask appropriate questions regarding safeguarding, and does not act on evidence	Adequate information gathering and referral if necessary	Good information gathering. Issues are fully explored and linked to history Appropriate referral if necessary
11	**Makes appropriate use of IT/Protocols?Algorithms** A. Adequate data recording B. Face–to–face/Call Handler use of IT tools where available/appropriate C. Clinician on telephone–appropriate use of support tools or algorithms D. Identifies discrepancies in information passed between clinicians if needed E. Appropriate referral to another service if required	Poor documentation, the use of IT system, use of decision support tools or of algorithms	Adequate records, use of IT, decision support tools or algorithms	Good records, use of IT, & decision support tools and aids
12	**Displays EMPOWERING behaviour** A. Acts on cues/beliefs B. Involves patient in decision–making C. Use of self–help advice [inc. Patient Information Leaflets] D. Responds appropriately to caller requests for information	No: does not act on cues/beliefs nor involve patient nor use self help	At least one of the features	At least 2 or 3 of the features
13	**Develops RAPPORT** A. Demonstrates good listening skills B. Communicates effectively [includes use of English] C. Demonstrates shared decision making D. Conducts themselves in a professional manner	Neither listens nor is understandable nor shares decisions	Two of these features present	All four of these features are present
14	**Satisfies ACCESS criteria where appropriate [info available]**	None of QR access criteria satisfied	1 or 2 of the QR access criteria satisfied	All of the QR access satisfied

Appendix 5–Guidance on using the Universal Urgent and Emergency Care Tool

(A) The key distinguishing features of this Tool

- The same set of minimum criteria is used for both call handlers and clinicians (e.g. doctors, nurses, etc.) although they may interpret them differently.
- The same set of minimum criteria are used for different settings e.g. on the telephone or face–to–face (e.g. a call handler or clinician on the telephone and a clinician face–to–face).
- The same set of minimum criteria are used along the patient pathway involving the three main decision points–(a) prioritisation/streaming, (b) definitive clinical assessment/triage by a clinician, (c) clinical consultation on the telephone or face–to–face.
- The same set of minimum criteria can be used by different providers involved in telephone or face–to–face contacts.
- The success measure for each criterion is outcome rather than process based as the marking schedule shows.

(B) Clinicians (e.g. Doctors, Nurses, ECPs, etc.)

For providers whose clinicians use decision–support systems or algorithms (on the telephone or face–to–face) without the traditional clinical consultation markers outlined in Appendix 2, the core criteria can still be applied given that the audit tool is outcome–based. The aim is that compliance with each criterion is inferred from: the algorithm that was used, the questioning within the algorithm, and the outcome or end point both in terms of clinical rationale and disposition. A 'diagnosis' is not an end point in some systems, even though the symptom cluster may point to one, hence the term 'draws appropriate conclusions' is used in criterion 5. Compliance with this criterion is demonstrated if the appropriate algorithms are used, provided that each stage within the algorithmic structure includes an appropriate rationale. All other criteria should map across easily to clinicians, whether or not they use decision–support software.

It is clear that ten of the fourteen criteria that have been selected have been in general use with many urgent and emergency care providers for some time, albeit in different combinations and applied in different ways. It is also clear that there is now a much wider understanding of what full compliance with Quality Requirement 4 means in Out of Hours Services. However two of the criteria (displays 'empowering behaviour' and 'develops rapport') may be less well known. When mapping the audit criteria to the consultation (Appendix 2) it becomes apparent that empowering behaviour is a key part of a good consultation, and it can be inferred from the subsidiary components in that criterion. While it is much easier to assess compliance with the criterion 'develops rapport' in telephone–based consultations or observed face–to–face contacts, it may be possible to infer rapport from the extent to which the clinical notes demonstrate shared decision–making. The audit tool sets out the minimum core criteria which will enable providers to deliver consistent and effective clinical audit, but some providers may wish to add further subsidiary components depending on the particular ways in which urgent care is delivered in their local health community.

(C) Call Handlers/Receptionists

Both the audio recording of telephone contacts, and the documentation generated by the call, will be used for the audit. The audit could either be conducted live, with the reviewer sitting with the call handler as they take calls or, retrospectively, with access to the audio recording and supporting documentation (electronic or paper based). Apart from criterion 10 which relates to prescribing, all the other criteria are relevant to call handlers. A call handler can be expected to:

- Note the reason (1) for a call.
- Identify a life threatening condition or emergency (2) using appropriate protocols.
- Take initial details of a patient's history (3) (e.g. 'Breathless', 'known heart patient', lives alone, etc.).
- Take details of the patient's condition in terms of a simple assessment (4) (e.g. not well and bed bound, house key with neighbour).
- Working from appropriate protocols (electronic or paper–based), draw appropriate conclusions (5) in terms of prioritisation times to definitive clinical assessment (20 minutes or 60 minutes) or stream the call–e.g. to a district nurse.
- Empowering behaviour (12) may include: calming the patient down; giving simple first aid advice until the clinician or ambulance crew make contact; providing reassurance that the patient is not being a bother and that clinical advice is needed.
- Safe or appropriate overall management decisions (6) in terms of prioritisation times chosen, live call transfer to a clinician, or streaming to the appropriate professional or service.
- Advice on calling back or calling an ambulance if the

condition worsens before definitive clinical assessment can begin is an essential part of safety netting (9).

- Listening to the recording of the telephone contact quickly establishes whether rapport (13) is established with the patient–e.g. introductions, listening, the patient understanding the call handler's language, etc.

- In organisations where the call handler uses decision support software or algorithms (for prioritisation or streaming) the appropriate use of these IT tools/protocols/algorithms (11) can be established using both the audio cues and the electronic records. In organisations that do not use such decision–support systems, the appropriate use of software and paper based protocols can be reviewed. Most providers are using paperless systems which greatly facilitate the audit processes. Those providers still using largely paper–based systems need to be encouraged to migrate to more effective electronic recording systems.

- The main access criteria (14) relating to call handlers are Quality Requirements 8 and 9–relating to access to the service (abandonment rate) and the identification of a life threatening call respectively. Although the access to the service may be an organisational issue, individual behaviour can affect compliance. Listening to the audio recording of a call can reveal how long the patient was held once connected. Also, listening to the ongoing scripted message or how long there was before a ringing tone provides further evidence of the time call answering was delayed. However the latter features will depend on individual providers' telephone systems.

Appendix 6–NICE Quality Indicators

Quality Indicator	On the Telephone	Face to face	CRITERION SCORING: Criterion fully met = 2 Criterion partially met = 1 Criterion not met = 0 Score (0–2) for each criterion for an individual either face to face/telephone
Acutely Ill Feverish Child Under 5:	Patient has Temp/headache/non–blanching rash/neck stiffness/light hurts eyes/floppy Child distressed/high temperature/very unwell • Alertness • Rash • Neck stiffness • Fontanelle records temperature • Adheres to NICE Guidance	• Alertness • Rash • Neck stiffness • Fontanelle • Records temperature • Records heart rate • Records respiratory rate • Capillary refill • Records diagnosis or suspected diagnosis • Adheres to NICE Guidance SPECIFIC WORSENING INSTRUCTIONS	
Acute Asthma:	Patient having severe breathlessness sufficient to prevent speech • Ability to speak • Audible wheezing • Respiratory rate And/or • Use of accessory muscles • Respiratory effort	• Respiratory rate, • Was a peak flow rate done? • Was oxygen saturation taken? Adherence to local protocols for 1. Life threatening asthma 2. Moderate/Severe asthma And/or • Use of accessory muscles, • Respiratory effort SPECIFIC WORSENING INSTRUCTIONS	
STROKE	Patient has sudden weakness,paralysis (stroke) (Face Arm Speech Time to call 999) Patient has sudden loss of vision (This can be done by clinicians or call handlers): • FAST	• FAST • Stroke: diagnosis and initial management of acute stroke and transient ischaemic attack (TIA) • Appropriate dispatch • Relevant transfer to unit • Local management protocol • Time to CT/MRI • Time to treatment	
Safeguarding	• NICE–consider/suspect guidance in child consultation • Share concerns with other professionals on a need to know basis • If referral to another provider e.g. ambulance service required, practitioner shares concerns • Refers any suspected concerns with relevant agency–e.g. social services • Documents an accurate factual account • Takes into account any special patient alert notifications • If a child; Did the clinician explore the possibility of the child being on the child protection plan or ask if the child had a social worker?	• NICE–consider/suspect guidance in child consultation • Share concerns with other professionals on a need to know basis • If referral to another provider e.g. ambulance service required, practitioner shares concerns • Refers any suspected concerns with relevant agency–e.g. social services • Documents an accurate factual account • Takes into account any special patient alert notifications • If a child; Did the clinician explore the possibility of the child being on the child protection plan or ask if the child had a social worker?	
Depression	• Low mood • Suicidal intention/ideation	• Depression • Vulnerable • Suicidal intention/ideation/plan	

Quality Indicator	On the Telephone	Face to face	CRITERION SCORING: Criterion fully met = 2 Criterion partially met = 1 Criterion not met = 0 Score (0–2) for each criterion for an individual either face to face/telephone
COPD	• Patient having severe breathlessness sufficient to prevent speech • History of COPD • Respiratory effort/rate	• Respiratory effort/rate • History–what is normal? • Oximetry • Local treatment protocol SPECIFIC WORSENING INSTRUCTIONS	
PAIN	• Severity of pain recorded • Advised re analgesia according to local guidelines	• Severity of pain recorded • Patients in severe pain (pain score 7 to 10) should receive appropriate analgesia, according to local guidelines • Patients with moderate pain (pain score 4 to 6) should be offered or receive analgesia, according to local guidelines • 90% of patients with severe pain should have documented evidence of re–evaluation and action within 30 minutes of receiving the first dose of analgesic • 75% of patients with moderate pain should have documented evidence of re–evaluation and action within 60 minutes of receiving the first dose of analgesic REDUCTION IN PAIN SCORE	
Fractured Neck of Femur	• Patient had fall now leg/hip pain • Relevant prioritisation • Appropriate urgency	• Relevant urgency • Relevant examination • Relevant dispatch • Relevant transfer to unit • Time to pain management • Time to operation • Time to home • Patients re–admitted as emergencies within 7 days following discharge	
Head Injury	• History • Consciousness level • Associated features • Adheres to NICE Guidance on head injury	• Triage, assessment investigation and early management of head injury in infants, children and adults • Patients presenting with head injury should be assessed for features of high risk brain and/or cervical spine injury by an A&E clinician within 15 minutes of triage or arrival, whichever is the earlier • Discharged patients should receive written head injury advice • Adheres to NICE Guidance on head injury SPECIFIC WORSENING INSTRUCTIONS	
Diarrhoea and vomiting in children–diarrhoea and vomiting caused by gastroenteritis	• If child follows NICE guidance for managing D&V in children 5years	• Diagnosis, • Assessment and • Management in children younger than 5 years • If child follows NICE guidance for managing D&V in children,5 years	

Appendix 7–Quarterly Clinician Audit Report Template (Locally Tailored to Individual Urgent Care Settings)

Name:

Period:

Activity:

Urgent Care

Productivity: (Mean = Average of Organisation)

	Base Visits Face to Face		Home Visits Face to Face	
	Clinician	Mean	Clinician	Mean
Consultation/Hour				
Average Consultation Time				

Outcomes:

Face to Face		Admitted		Discharged		Onward Referral		Advised ED		Advised Ambulance	
Clinician	Mean	Clinician	Mean	Clinician	Mean	Clinician	Mean	Clinician	Mean	Clinician	Mean

Audit:

Consultation

Complaints

Serious Untoward Event

Compliments

Average Scores:

	Reason	Emergency	History	Assessment	Conclusions	Management	Documentation	Prescribing	Safety–Netting	Safeguarding	IT	Empowering	Rapport	Access	Overall Average
Clinician															
Average for Organisation															

NICE Quality Indicators:

Acutely Ill Feverish Child Under 5	Acute Asthma	Stroke	Safeguarding	Depression	COPD	Pain	Fractured Neck of Femur	Head Injury	D&V in Children

Care should be taken in interpreting the data contained in this report. Many factors outside the control of the individual can influence these figures. Factors such as the type of shifts worked (visiting, triage only, etc.) or the timing of shifts (overnight, Bank Holidays, etc.) will particularly affect productivity and activity data.

Appendix 8–Quarterly Call Handler Audit Report (Locally Tailored to Individual Urgent Care Settings)

Call Handler Name: [   ]

Period: [   ]

Productivity: (Mean = Average of Organisation)

Calls Per Hour		Average Consultation	
Call Handler	Mean	Call Handler	Mean
[ ]	[ ]	[ ]	[ ]

Outcomes:

Primary Prioritisation

If Life Threatening Condition		If Life Threatening Condition (within 3 mins)		Disposition Times < 20 Minutes		Disposition Times < 60 Minutes	
Call Handler	Mean	Call Handler	Mean	Call Handler	Mean	Call Handler	Mean
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Primary Prioritisation

999 Ambulance		Emergency Department		Other	
Call Handler	Mean	Call Handler	Mean	Call Handler	Mean
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Audit:

Consultation	[ ]	Serious Untoward Event	[ ]
Complaints		Compliments	

Average Scores:

	Reason	Emergency	History	Assessment	Conclusions	Management	Documentation	Prescribing	Safety–Netting	Safeguarding	IT	Empowering	Rapport	Access	Overall Average
Call Handler															
Average for Organisation															

NICE Quality Indicators:

Acutely Ill Feverish Child Under 5	Acute Asthma	Stroke	Safeguarding	Depression	COPD	Pain	Fractured Neck of Femur	Head Injury	D&V in Children

Care should be taken in interpreting the data contained in this report. Many factors outside the control of the individual can influence these figures. Factors such as the type of shifts worked (visiting, triage only, etc.) or the timing of shifts (overnight, Bank Holidays, etc.) will particularly affect productivity and activity data.

Appendix 9–Quarterly Urgent Care Provider Organisation Audit Report Template

Organisation Name:

Period:

Clinical Audit:

No. of Calls Reviewed		Serious Untoward Incidents	
No. of Clinicians Reviewed		Calls to Reflect	
No. of Call Handlers Reviewed		Complaints Received	
Patient Questionnaires Received		Compliments Received	

	Reason	Emergency	History	Assessment	Conclusions	Management	Documentation	Prescribing	Safety–Netting	Safeguarding	IT	Empowering	Rapport	Access	Overall Average
Call Handler/Clinician															
Average for Organisation															

NICE Quality Indicators:

Acutely Ill Feverish Child Under 5	Acute Asthma	Stroke	Safeguarding	Depression	COPD	Pain	Fractured Neck of Femur	Head Injury	D&V in Children

Patient Experience Feedback–Key issues:

1.

2.

3.

Appendix 10–Guidelines for Feedback

Setting the Scene
- Create an appropriate environment
- Clarify your ground rules with the health care professional– which part of the results of the call audit i.e. from the 14 criteria or other sources of information (complaint, patient feedback or SUI) you will concentrate on, and when you will interrupt
- Agree a teaching focus
- Make notes of specific points

Giving Feedback–Do's
- Establish the health care professional's agenda
- Get them to start with what went well in the consultation– the positive
- Teacher starts positive if prompting is needed–however difficult it may seem
- Comment on specific aspects of the consultation–i.e. in history taking
- Active listening (eye contact, stance etc.)
- Use of silence
- Clarifying
- Responding to cues (verbal, nonverbal, psychosocial)
- Summarising
- Empathising
- Move to areas 'to be improved' (avoid the term 'negative'!)–follow the health care professional's agenda first
- Ask individual to comment, but remind them there is 'No criticism without recommendation'
- Offer own observations & constructive criticisms
- Be specific
- Always offer alternatives
- Begin with:
  - '…I wonder if you had tried…'
  - '…perhaps you could have…'
  - '…sometimes I find…helpful…'
- Distinguish between the intention and the effect of a comment or behaviour

- Distinguish between the person and the performance– ('What you said sounded judgmental'–rather than 'You are judgmental')

- Discuss clinical decision making
- Be prepared to discuss ethical and attitudinal issues if they arise

Giving Feedback–Don'ts
- Don't forget the receiver's emotional response
- Don't criticise without recommending
- Don't comment on personal attributes (that can't be changed)
- Don't generalise

*Goodyear–Smith F, Whitehorn M, McCormick R. General Practitioners' Perceptions of Continuing Medical Education's Role in Changing Behaviour. Educ Health 2003; 16: 328–38.