



Royal College of
General Practitioners

Urgent Care

**A position statement from the Royal
College of General Practitioners**

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Summary

Until the new GMS contract, introduced in 2004, GPs had 24 hour contractual responsibility for their patients. Responsibility for commissioning out of hours care and training in the relevant competencies now rests with Primary Care Trusts (PCTs) in England. A variety of service models have been set up. Whilst good out of hours care exists in some areas, significant concerns remain about the quality and safety of patient care and variability of services and training. Furthermore, the new PCT arrangement is not being monitored to the same stringent quality standards that were previously applied. These are issues of high public concern and interest. The system is also complex and confusing for patients. This position statement emphasises the important role of general practitioners in urgent care and makes a series of recommendations. It urges PCTs to take action to improve the situation.

Recommendations are made for PCTs, the Department of Health, GP practices, the Healthcare Commission and educationalists. They include: improving the organisation of care and services, configuring care around the needs of patients, monitoring clinical standards, the importance of engaging GP practices through incentivisation, and the promotion of stronger and integrated multidisciplinary teams.

The Ten Recommendations:

For Strategic Health Authorities and Primary Care Trusts

1. Show leadership and champion the cause of urgent care. Develop urgent care networks to foster integration and co-ordination of care between providers (Figure 1)
2. Configure care around the needs of patients with better signposting for access and the promotion of self-care skills
3. Strengthen clinical and educational governance arrangements for urgent care; monitor and enforce quality standards including clinical outcomes; learn from significant events, including complaints
4. Engage local GPs and recognise their pivotal role in leadership, planning and support for out of hours (OOH) services; this should be achieved by incentivising GP practice involvement
5. Promote stronger multidisciplinary urgent care teams whose members have been trained to nationally agreed standards; ensure effective training opportunities in urgent care for GP registrars

For the Department of Health

6. Make urgent care a priority and set a clear national strategy for this, emphasising the necessity for high clinical standards. Ensure that policy is complied with and that sufficient support is given to local health economies to implement better services.
7. Ensure that emergency care practitioners are trained to a defined national standard including an assessment of competence (including English language and communication skills), and work within a robust clinical governance arrangement.

For GP practices

8. Urgent care is an important part of the day-time work of GPs and GP practices. All practices should have a clearly understood system for responding to and dealing with urgent care during surgery hours. Although GPs are no longer contractually responsible for OOH work, they should champion optimal levels of urgent care for their patients. Practices must have systems in place for alerting urgent care providers to patients with complex care needs.

For the Healthcare Commission

9. Given the high level of public concern in this area, the Healthcare Commission should ensure that the quality and safety of urgent care including clinical outcomes is monitored regularly. Based on these findings, the Commission should make recommendations for improvement.

For educationalists

10. Primary care educationalists must ensure that the quality of urgent care training receives a high priority. GPs remain pivotal to urgent care provision. To maintain this quality, a systematic approach to the training of GP specialty training registrars (GPStRs), including practical experience, must be established and appropriately monitored, with organised supervision in a range of urgent care settings. Urgent care competencies should also be incorporated within GP appraisal and CPD.

1. Introduction

- 1.1. There is considerable public and professional concern about the quality of OOH services, most recently confirmed in a report by the National Audit Office¹. Whilst good provision of OOH care exists in some areas, there is confusion about access routes amongst patients, in addition to concerns about inconsistent response and fragmentation of patient experience.
- 1.2. Until the new GMS contract (which was introduced in April 2004), GPs had contractual responsibility for their patients' care 24 hours a day. Responsibility for commissioning OOH care now lies with Primary Care Trusts (PCTs) in England.
- 1.3. In this position statement, the Royal College of General Practitioners (RCGP) explores current concerns about urgent care. The document builds on our national OOH quality accreditation scheme² and considers issues in the context of the community white paper *Our health, our care, our say*³ which has signalled a national review of urgent care.

2. The key issues

- 2.1. The quality of OOH care has been a significant concern for patients and their general practitioners since the change in responsibility for 24-hour care in 2004. In February 2005, Council agreed a motion that requested the College to work at a national level to improve the quality of OOH care. Since then, the College has consistently raised the issue with senior officials and politicians at the Department of Health. Urgent care was mentioned in the RCGP General Election Manifesto and the College's submission to the consultation on the White Paper submission. The previous OOH accreditation scheme was devised by the RCGP and was implemented widely by PCTs until accreditation requirements were changed by the Department of Health in 2004.
- 2.2. Following the motion to Council, a think tank meeting including patient groups was held. The meeting identified the following key issues:
 - 2.2.1. There is public confusion about what to do and which service to access out of hours.
 - 2.2.2. While urgent care was not of a uniformly high standard before the nGMS contract, it would be sensible to learn from past successes of the GP co-operative movement.
 - 2.2.3. A collaborative approach is essential as is the need to keep OOH care high on the agenda.
 - 2.2.4. Provision of care in rural locations poses particular challenges – centralisation can cause worsening of access for rural and remote healthcare communities.
 - 2.2.5. Although standards exist for monitoring OOH services, these are inconsistently applied and there is no clear mechanism for routine national reporting and discussion.

- 2.2.6. There is wide variation in the quality of services.
- 2.2.7. GP specialty training registrars must continue to receive adequate, high quality training in urgent care backed up by robust monitoring and assessment measures
- 2.2.8. There is concern that some nurses and Emergency Care Practitioners (ECPs) may be being exposed to situations beyond their competencies. Adequate monitoring systems are not in place.
- 2.2.9. Patient demands and expectations for urgent care are increasing. There is a need for better patient education and the promotion of self-care policies.
- 2.2.10. Providing comprehensive, high quality, OOH services is costly.

2.3. The meeting identified several themes to be addressed when generating solutions:

- 2.3.1. The organisation of urgent care services needs to improve. Fragmentation of care must be dealt with. This requires the adoption of a 'whole systems approach' to ensure integration of services and the creation of virtual urgent care centres in which different providers work together.
- 2.3.2. Focus on quality and safety of clinical care – by developing, monitoring and enforcing standards and paying due attention to the training of health care professionals to national quality standards.
- 2.3.3. Put the patient at the centre of urgent care services. Empower patients by providing information to make access and navigation easier.

The paper will now consider these issues in greater detail.

3. Terminology

- 3.1. There is confusion about the terminology used by users, providers and commissioners of urgent care. Terms such as unscheduled care, unplanned care, emergency care and urgent care are used interchangeably. This confusion may prevent the development of a fully integrated system based on the needs of patients.
- 3.2. The Department of Health guidance on telephone access to out of hours⁴ sought to clarify commonly used terms:
 - 3.2.1. 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.
 - 3.2.2. A definition of urgent care has since been issued by the Department of

Health in England⁵ :

***‘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’.*

3.3. This definition has been supported by the RCGP in its formal response to the Department of Health consultation. In this paper we adopt the term urgent care and the definition above.

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

4. The underlying principles and values

4.1. It is possible to identify some principles and values that must inform the development of new systems of urgent care. The quality and safety of care is all important given the nature of urgent care work – with the need to promptly diagnose serious clinical conditions such as meningitis or appendicitis. The provision of high quality, safe and responsive urgent care services must be acknowledged as an important and essential function of the NHS and not be regarded as an ‘add on’.

4.2. Patients find the current system for accessing out of hours care confusing. Access to urgent care must therefore be made as simple as possible for patients. Services must be designed around the clinical needs of patients and be responsive to those with particular needs such as end of life care. Patients should expect a consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.

4.3. Urgent care must be differentiated from ‘convenient care’. A request for the issue of a non-emergency prescription might be dealt with quickly when presented in-hours even though an urgent response is not needed, but the same response cannot be expected when requested out of hours. Whilst care must be patient centred and responsive it should not be at the expense of the clinical needs of the individual or other patients.

4.4. The concept of urgency for a patient may be different from that of a clinician. An urgent care system responsive to patients’ needs should be able to handle a clinical emergency, a cry for help or a request for information efficiently and effectively. From a patient’s perspective, all of these may be perceived as a need for urgent care. However the clinical emergency must take priority. Urgent care services therefore need mechanisms for dealing with patients needing reassurance as well as for those requiring formal face-to face clinical assessment and treatment. The response to an urgent care need must take into account the clinical urgency of the situation.

4.5. Although the change of contractual responsibility for out of hours care has, of necessity, shifted urgent care from being purely a GP discipline to a multi-professional system delivered from a variety of locations, we believe that the

number of providers and health care professionals involved must be kept to as few as possible, compatible with delivering a safe level of service. This is because a large number of 'hand-offs' involved in the care of an individual can lead to harm and increase costs. Effective team working and co-ordination of care is also essential when different providers are involved in the provision of urgent care to ensure a coherent patient experience.

4.6. During out of hours the virtues of general practice such as patient centeredness, handling uncertainty and co-ordination of care are as important as during surgery hours. PCTs must apply the lessons learned from previous GP OOH provision to new systems. GPs should be encouraged to offer leadership, support and participation in service delivery. Of necessity patients may need several different providers of urgent care but experienced GPs must be at the centre to ensure the quality of the past is not lost.

4.7. Urgent care must be accorded a priority by primary care trusts: services must be properly organised, and resourced, staff must be trained and competent and there must be high levels of clinical leadership and engagement

5. The organisation of care: urgent care networks

5.1. Better organisation of care will assist patients, and promote the better use of resources. We suggest the creation of urgent care networks. These should be clearly defined and encompass GP practices, walk-in centres and minor injury units working within larger networks of care, including A&E departments, inpatient and specialist units (e.g. stroke units) as appropriate [Figure 1]. No single model will be appropriate for all areas. Local solutions must be developed that offer a well organised, responsive service that is readily understood by patients. The needs of rural as well as urban areas must be considered.

5.2. In urgent care networks, cooperation between health professionals and provider services must be improved. Integrated 'whole system' working will reduce both duplication of services and patients having to repeat their needs and details many times. Such a system must be underpinned by robust and safe electronic patient records and data communication management designed with due regard for patient confidentiality and consent.

5.3. To provide comprehensive 24-hour urgent care cover will need the combination of several providers and professionals. Long-standing barriers between providers and services must be broken down. GPs should not be replaced in this system. The focus must be on the needs of patients and not on those of the providers. This should be supported by multi-professional learning.

5.4. Commissioners must ensure that appropriate principles of continuity – in its broadest sense – are applied to urgent care services. Continuity has been defined as: 'the experience of co-ordinated and smooth progression of care from the patients' point of view'⁶. This includes:

5.4.1. Informational continuity - the use of information on past events and personal circumstances to make current care appropriate for each individual.

5.4.2. Management continuity – a consistent and coherent approach to the

management of a health condition that is responsive to the patient's changing needs.

5.4.3. Relational continuity – an ongoing therapeutic relationship between a patient and one or more providers

5.5. Informational and management continuity can be achieved through the use of shared electronic patient records and individual care plans for patients with long term conditions.

5.6. Access to GPs and continuity is particularly important for certain groups of patients e.g. the terminally ill, older frail patients with multiple and complex medical conditions, and those with mental illness. It is extremely difficult to provide continuity of care at all times and on every occasion, but urgent care services should be tailored to meet the needs of such patients wherever possible.

5.7. While centralised schemes may work well in urban areas, they may diminish access in rural areas. This should be addressed through careful planning and engagement of communities. Arrangements must be tailored to local needs. Better and wider use of technology such as telemedicine can be helpful⁷.

5.8. Concluding remarks: The current system is confusing for patients and fragmented. The organisation of care needs to improve. We agree with the white paper, *Our health, our care, our say* which states that “all health partners should be encouraged to work together in a system-wide approach to developing urgent care services”.

6. Assessment of urgent care needs and the role of NHS Direct (NHSD)

6.1. The Department of Health states that: ‘an appropriate response may include anything from telephone advice and reassurance to self-care, through to face-to-face consultation with a clinician or deployment of a crisis team or admission to hospital in an emergency requiring specialised facilities. Wherever clinically safe, care should be delivered as close to home as possible, within a community setting’. It is important that any problem being assessed as requiring an immediate response utilising validated or robust methods – as defined by the clinical need – should receive this regardless of when and where the episode presents.

6.2. The white paper ‘*Our health, our care, our say*’ stated that urgent care should focus on “ensuring that the skills and experience of NHSD are fully utilised by patients and health care organisations”; “enabling patients to self care where this is appropriate”, and “help to provide better information about local services”. An NHSD Online website and digital TV service have also been introduced⁸.

6.3. The NHSD nurse-led telephone helpline has been widely used by patients; however, capacity⁹ and cost issues¹⁰ as well as use of perceived risk-averse decision support software mean it has not always been popular with GP OOH providers and PCT commissioners¹¹.

6.4. NHSD has worked but not universally or consistently. Well-developed, pre-existing OOH services have not been enhanced by NHSD; however in those areas where such OOH care is lacking, NHSD has proven beneficial. The

Department of Health Exemplar programme of integrating the NHSD telephone service with GP OOH services has also produced equivocal results in terms of demand management¹². In areas where local urgent care services are already delivering high quality care, the added value of NHSD has been questioned⁷. It would therefore be premature to assume that all urgent care should be channelled through the NHSD telephone service as described in the Carson model¹³ arising from the Department of Health's Out of Hours Review¹⁴.

6.5. The 'one size fits all' approach of call handling with nurse assessment of the national NHSD telephone service needs to evolve and adapt to local needs.

6.6. Telephone assessments of urgent care needs must be properly carried out and not done in a 'mechanistic' fashion. Patients with a perceived urgent care need should expect a consistent and rigorous assessment of the urgency of their needs and an appropriate and timely response to them. There is a growing trend for urgency assessment to be carried out by a variety of healthcare professionals but the limits of this must be understood. The skills of experienced GPs in triage must be acknowledged.

6.7. Given the high volume of paediatric urgent care contacts, robust risk assessment needs to be in place when assessing children via telephone contact with a parent or carer. There should be an appropriate threshold for resorting to a face to face contact for the clinical assessment of children.

6.8. Managing risk appropriately has both clinical and resource implications. While generalist GPs are able to consult safely and effectively without the aid of computerised decision support tools, many call prioritisation or 'streaming' systems have a tendency to be risk averse. Future systems must add value to individual patient care without causing unnecessary delays or inconsistencies. Electronic record keeping should support clinical audit and allow more robust data to be collected for quality improvement.

7. Role of walk-in centres, minor injury units, A&E departments

Walk-in centres and minor injury units

7.1 Patients have a variety of options for urgent care provision. Nurse-led minor injury units (MIUs) provide valuable alternatives to A&E for certain patients. Walk-in centres (WICs) are currently in vogue and there is no doubt that they can improve access to healthcare and serve a valuable purpose depending on their location and remit¹⁵. However, under-utilisation, particularly of commuter WICs at London and Manchester rail stations, raises questions about cost effectiveness. Where WIC services are combined with the availability of diagnostics, multi-professional input and co-location with GP OOH services (e.g. Loughborough WIC), the arrangement works well. With the introduction of payment by results, innovative models are being implemented with primary care professionals (GPs & nurses) practising within A&E departments (e.g. Guildford PCT, Surrey).

Accident and Emergency (A&E) departments

7.2 Concern has been expressed about the impact of the change in OOH service provision on A&E attendance. Many PCTs in England have mapped the

utilisation of their urgent care services. A significant proportion of A&E attendances could be dealt with in primary care with appropriate support. The causes of increased attendance at A&E departments remain controversial. In one study of an NHS foundation trust, increased A&E attendance was found to be linked to the change in OOH arrangements¹⁶. Some departments observe increases in A&E workload at weekends and bank holidays. However, the Department of Health has stated that “[it] did not think that increases in A&E attendances were connected to lack of access to GPs”¹⁷. One possible reason that A&E attendance has increased is because A&E has become so much better than it used to be. However, most people do not want to go to A&E but do not know about any alternatives.

7.2.1 The perception that there are excessive referrals to A&E by GPs in hours and by GP OOH services is not supported by the evidence¹⁸. In a study from Croydon PCT, referrals from the GP OOH service, plus that from NHS Direct, a walk-in centre and minor injuries unit together only accounted for 3% of A&E attendances.

7.2.2 Although self-referrals by patients account for the majority of A&E attendances, some patients are advised to attend A&E by other health care professionals. Management of urgent care in general practice and improving access to primary care would be one way of reducing A&E attendances. There remains a perception among some patients that they may be unlikely to get an urgent appointment with their GP even though this may not be true. Mechanisms need to be developed to tackle this.

7.2.3 Patients are often blamed, unfairly in our view, for doing the wrong thing by attending the ‘wrong’ provider of urgent care. This is hardly surprising when they have rarely been empowered to do otherwise – for instance in London the majority of self-referrers to A&E aged 25 to 45 do so because they are infrequent users of the healthcare system and do not know how to get the best out of the system to meet their individual needs¹⁹. They only know A&E so this is where they go. There is an urgent need to provide effective health education and self-care support systems (both electronic and paper-based).

7.3 Social services have important parts to play in urgent care and, in some centres, provide a community triage desk. Senior nurses can be trained to coordinate packages of social as well as medical care and deal with problems immediately rather than wait until social services are available in working hours. An integrated approach to urgent health and social care should be encouraged.

8 The role of GPs

8.1 The majority of urgent care is undertaken in primary care by GP practices during normal working hours. Many GP practices operate a flexible and responsive access system for patients with urgent needs during surgery hours. Some practices do more (daytime) urgent care than others who may need additional support. It must be recognised that the sheer volume and unpredictable nature of this work makes it unrealistic for any single access system to manage all urgent care during surgery opening hours and that an ‘overflow’ system is needed to ensure patient safety.

8.2 GPs voted in a national ballot to opt out of 24-hour contractual responsibility. Nonetheless a significant number of GPs remain involved in OOH provision. GPs have welcomed the flexibility offered by the opt out; 24-hour provision of care was an issue of significant concern to the profession and was not a sustainable arrangement for the future. We believe the opt out has helped GP morale, recruitment and retention.

8.3 The College acknowledges that the change in 24-hour responsibilities remains a difficult issue for the profession. Whilst it has been widely supported by many doctors there is no doubt that it has been viewed negatively by some GPs, the media and patients. The College is cognisant of this and therefore urges PCTs to find ways of engaging GP practices and incentivising their involvement in urgent care. We must emphasise that we do not support contractual change as a way of achieving this. Efforts must be made to engage GPs in out of hours care. Innovative ways of organising care should make it possible to do so, without the burden of the past for these activities, for more GPs and practices who want to participate in urgent care work.

8.4 Urgent care is an important part of the day-time work of GPs and GP practices. All practices should have a clearly understood system for responding to and dealing with urgent care during surgery hours. Although GP practices are not contractually responsible for OOH work, they should champion and influence optimal care for their patients. There must be systems for alerting urgent care providers about patients with complex needs.

8.5 Urgent care provided by GPs and other members of the primary healthcare team should be celebrated and nurtured. Primary health care teams should be supported in their efforts to deliver appropriate urgent care services in the daytime.

8.6 All PCTs must engage GPs and practices and recognise their pivotal role in leadership, planning and support of OOH services; they should incentivise GP practice involvement in urgent care

9 Maximizing the potential of professional skill mix

9.1 It is acknowledged that where it is difficult to recruit GPs to provide urgent care, PCTs resort to assessment and provision of care by other health care professionals such as emergency care practitioners (ECP). This must be done to support GPs; not to replace GPs in the system.

9.2 GPs remain the best managers of clinical risk, particularly of undifferentiated presentation of illness within urgent care. Replacing GPs would be at best a costly diversion and at worst an unsafe destabilising action that would inevitably increase fragmentation of care and reduce the skills pool available to urgent care.

9.3 It may be tempting to employ other professionals who may be cheaper than GPs where possible, but to do so may be a false economy. Use of higher paid professionals can be more cost-effective, especially in triage. GPs have proven expertise in delivering urgent care and must have a strong influence on those providing this care and in conducting triage.

9.4 As experts in urgent care, GPs undertake fewer investigations and have less recourse to high cost referrals to A&E or ambulance services than other groups. They are used to dealing with a high rate of individual contacts (throughput) and their efficiency is reflected by a high 'episode completion rate' per contact. In one study, 97% of GP contacts resulted in resolution of the problem within the OOH period with only 3% being referred on to emergency ambulance or A&E services²⁰. When considering skill mix it is important to take into account the total cost of multiple contacts with health professionals and organisations per individual episode of care rather than just considering the hourly costs of different health professionals.

9.5 The Health Select Committee emphasised this point when it said that it is "vital that [GPs] do not become disengaged from the process of redesigning out-of-hours services during this critical transition phase, and their expertise and local knowledge lost."²¹

9.6 The training of ambulance ECPs is highly variable across the country, as is their deployment. ECPs must be trained to a defined national standard including an assessment of competence with appropriate monitoring. They should work within a proper clinical and educational governance structure under the guidance of a GP, since GPs have the experience of providing comprehensive urgent care and can guide others in these skills. There is therefore a need to have consistent competencies for ECPs across the country and better integration into the wider urgent care service provision.

9.7 The GP is the proven expert in the field of delivering urgent care and must have a strong influence on and educational input to others providing this care. Other health care professionals must not be seen as replacements for GPs. Consistent competencies for ECPs and better integration into the wider urgent care service provision across the country is therefore essential.

9.8 Team working

9.8.1 The expertise required for urgent care must be determined by clinical needs and not simply by the skills available locally. The urgent care system must have pathways whereby patients can access the appropriate healthcare professional in a timely manner. All providers of urgent care must be used for what they do best by maximising the use of skills and existing services. However, the expertise and quality of advice, assessment and care provided must be consistent.

9.8.2 Teams remain the arrangement of choice for people when working in primary health care. However, community nurses – such as district nurses and health visitors are being distanced from existing practice-based teams. The break up of primary health care teams will work against efficient urgent care provision during the daytime.

9.8.3 Integrated primary health care teams can best address the challenges of an aging population who often develop urgent care needs due to an increasing burden of long term conditions and co-morbidity. Primary care organisations must adopt a policy of ensuring that community nursing roles are integrated with existing primary health care teams and primary care practices. Such an arrangement is essential to bring about a much needed improvement in the coordination and integration of care

– an issue repeatedly shown to be of concern to patients and one which is a crucial function of primary care. There is no doubt that close working, physical co-location or virtual teams foster better working relationships than individuals working within professional ‘silos’.

9.8.4 ‘One size does not fit all’ in terms of urgent care workforce models. There needs to be a drive to promote multi-professional teaching and training with a competency based approach. This will ensure consistent quality of care across the entire urgent care workforce.

9.8.5 Staff new to urgent care or with an identified learning need should have specific telephone consultation training to acquire the skills to listen, prioritise, empathise, reassure and give easy, understandable advice. They also need to know how to elicit appropriate information from confused and/or distressed callers. The RCGP has issued a manual on telephone consultations²².

10 Patient involvement and empowerment

10.1 The traditional approach to urgent care provision has been from the service providers’ perspective. This must change to that of the patient. The current ‘call back’ system in both OOH and indeed in-hours services exists simply because this is the way the system has evolved, and it smoothes the peaks and troughs of work in a busy day. However this means that urgent care is not necessarily dealt with quickly enough from the patient’s perspective. Even the notion of ‘right’ and ‘wrong’ choice of provider by the patient or carer is based on the perspective of the service provider.

10.2 Access to the various providers of urgent care outside normal surgery hours must be made simpler. Publicity through patient leaflets and standardised OOH surgery telephone messages telling patients how to access urgent care will improve knowledge in this area. No matter which service is accessed it is essential that the patient’s own GP must be informed rapidly, efficiently and accurately.

10.3 Patients can make appropriate choices for their healthcare needs from a variety of options - from face to face contacts with health professionals, via the telephone and increasingly via the internet and digital TV. Why do patients make the choices they do? Past experience or peer support are commonly the only source of information on which patients can base their decision. Patients are often unfairly blamed for making the ‘wrong’ choice when they have not been empowered to make the right choice. This must be addressed by all urgent care providers giving consistent advice about self care, the most appropriate place to attend, or how to call a doctor, if this is necessary. The College must champion the cause of patient involvement in service redesign.

10.4 Patients must be empowered to use self-care and to access timely and helpful information when needed. Such information can also be provided in the consultation (preferably in writing) so that patients understand what to do next time. Demand flows must be managed from the patient perspective and not the clinicians’. We have to move on with the redesign of the system to promote telephone access directly and efficiently through to the appropriate clinician or provider – particularly in urgent cases. For example Kingston PCT’s newly commissioned Urgent Care (OOH) service involves live call transfer to a GP

for urgent calls, thus ensuring a “real time” clinical response.

10.5 In palliative care, it is good practice for healthcare professionals and carers to be provided with a single local phone number for palliative care advice out of hours. The OOH team should have access to high level palliative care advice from the on-call consultant or specialist team and should carry a list of recommended drugs. This can be facilitated by a ‘special note’ system. Similar systems could also be set up for patients with serious mental health problems.

10.6 Urgent care must be configured around the needs of patients. Successful, effective delivery of urgent care depends upon patient empowerment. The College must champion the patient perspective and involvement with service redesign.

11 The quality perspective

11.1 The monitoring of quality in urgent care services has traditionally been process-led, e.g. measuring the time to call answer or time to visit rather than the clinical outcome. The Out of Hours National Quality Requirements²³ delineate the process-driven targets, although providers are also required to audit the consultations of all those involved in service provision. Such monitoring by PCTs has been highly variable and sometimes hindered by shortcomings in the available software. There is no effective national system for collating this information²⁴. Studies have shown that the highest patient satisfaction in urgent care is achieved by local GP co-operatives²⁵.

11.2 Clinical Audit: To ensure a consistently high quality of urgent care out of hours, the patient experience and quality of the clinical encounter itself must be monitored and audited. The RCGP has developed an OOH clinical audit toolkit²⁶ to provide a consistent framework for organisations to implement or develop routine clinical audit processes for informing, monitoring and continually improving the quality of OOH services. The audit includes:

- ⇒ An assessment of the need for emergency intervention,
- ⇒ Clear identification of main presenting problem,
- ⇒ Recording of past medical history, medication/allergies and a diagnosis,
- ⇒ Evidence of effective decision making with critical appraisal of information,
- ⇒ Consultation displays empowering behaviour and
- ⇒ Instructions in the event of deterioration are recorded

11.3 Monitoring of 24-hour urgent care requires the development of quality standards for both in and out of hours periods. This must include assessments of clinical quality and patient experience as well as measures of process timeliness. It is important to ensure that there is no levelling down of quality as a result of any harmonisation of policy on ‘in hours’ urgent care with ‘out of hours’. The same quality requirements must be applied to all urgent care services and providers e.g. mental health, WICs, MIUs and A&Es to ensure that patients can expect a consistently high quality service wherever they present.

11.4 Robust governance arrangements for providers of OOH urgent care are essential. The development of core quality and governance requirements across different providers in urgent care will promote consistency and integration.

11.5 There has been variable recording of, and learning from, patient safety incidents and other forms of feedback²⁷. Arrangements must be made for learning and dissemination of good practice in urgent care. For example the NAO¹ noted that in some areas there has been considerable improvement and innovation in OOH provision and this provides a useful learning experience for other PCTs. In South West London, informal urgent care learning 'sets' involving frontline practitioners, senior managers, commissioners and providers have been found to be useful conduits for sharing innovation, learning and good practice, as well as developing a strategic view of urgent care²⁸.

11.6 Monitoring the quality of urgent care including clinical outcomes is essential. In view of the importance of urgent care to patients and in consideration of patient safety issues we recommend that the Healthcare Commission should regularly monitor national standards of urgent care.

12 Clinician and patient safety

12.1 Providers of urgent care services must be mindful of the potential risks to clinical professionals when visiting patients or seeing unknown patients. There is a very real danger to clinicians visiting in poorly lit areas and cases of assault on clinicians have been recorded (perhaps because they were perceived to be carrying drugs). Clinicians should not have to place themselves in danger and should be provided with escorts to minimise the risk of assault. Guidelines should be established with the local police to escort clinicians into especially dangerous environments. There must also be effective means of securing urgent help for clinicians threatened by physically aggressive patients in the consulting room, e.g. alarm systems.

12.2 There has been much recent debate about the requirement and provision of chaperones during the examination of patients. The General Medical Council states that, particularly when an intimate examination is to be conducted, a chaperone should be offered to a patient in the form of a friend or other medical professional. However, this can be difficult to arrange in urgent situations particularly in the home of a patient out of hours. The design of urgent care provision systems must take into account the need to provide chaperones and to provide patients with their preferred gender of clinician if at all possible. Patients must be advised that chaperones may not always be available when a clinician visits a patient's home and that, if necessary, a patient should arrange for a friend or relative to be present during the consultation. National guidelines on chaperones have been issued²⁹.

13 Training future GPs in urgent care

13.1 The opportunity for GPs to opt out of the nGMS contract may adversely affect the training of future GPs. For example in some areas, such as South London, many training practices have opted out. Some GP registrars may therefore lose the opportunity to develop critical skills in risk management and

clinical decision making. Consideration must be given to GP registrars who do not undertake the same amount of OOH care in training as previous generations of GPs.

13.2 To maintain quality, appropriate training and experience must be ensured for all GP registrars. A systematic approach is needed to ensure organised supervision in urgent care to achieve all competencies expected, including an understanding of the 'bigger picture' of urgent care through exposure to different services. New training models must be explored (e.g. the Urgent Care Practitioner Training scheme at Croydon for GP registrars for Croydon, Kingston, and Sutton & Merton PCTs) to ensure that GPs acquire the necessary confidence to tackle urgent care. Some categories of patient deserve specific attention such as older people with acute problems, children, the mentally ill and patients requiring palliative care.

13.3 There is a risk of deskilling GPs if they are not exposed to sufficient urgent care work. GPs' urgent care skills should be reviewed as part of their individual appraisal.

13.4 Primary care educationalists must ensure that training in urgent care receives a high priority. GPs remain pivotal to urgent care provision. To maintain this quality, a systematic approach to the training of all GP specialty registrars must be ensured with practical experience and organised supervision in a range of urgent care settings.

14 Getting improvement: the potential of Practice Based Commissioning (PBC)

14.1 Financial constraints are reported by both service providers and commissioners as a barrier to achieving National Quality Requirements. The National Audit Office¹ recently reported that "shortfalls in funding were leading PCTs to let contracts that were largely driven by cost" and "that this focus on cost was not allowing [providers] to spend money on any spend-to-save measures, such as experimenting with skill mix, upgrading facilities or innovative integration pilots". As a measure of "Quality" more emphasis now must be given to clinically and cost effective innovative service redesign. This may mean other essential services, such as diagnostics, become more available for the management of urgent care.

14.2 Creating improvements will depend on service redesign and integration. This is a complex task involving multiple NHS organisations. Some areas have been more successful than others in doing this. Strong clinical leadership, particularly from GPs, is essential. To redesign urgent care services responsive to patients requires a redistribution of resources from secondary to primary care: PBC potentially offers a vehicle to achieve this. PBC's potential to improve urgent care should be explored.

14.3 With the advent of Payment by Results (PBR) there is a need to redesign access to A&E departments to improve both value for money and clinical effectiveness. The link between A&E attendance and clinically inappropriate out-patient referrals and admissions is increasingly being made. There is therefore a need for primary care services to exert greater control on the "gateway" into A&E. One way of doing this is to develop a "primary care front end to A&E" staffed by GPs.

14.4 PBC, with unified practice or locality budgets might become the major driver of service redesign. This will mean that practices might wish to influence quality of care by: offering better services or access themselves, joining up into local groups to offer services or exerting control on OOH providers via commissioning tools.

14.5 The majority of care for long term conditions (LTC) is provided within primary care during the day time. Responding to the urgent needs of those with LTC often means a home visit and a complex consultation. With an aging population there will be increasing demands in this area. GPs need extra support to manage patients at home and in the community where appropriate. This may require innovative approaches such as community multidisciplinary specialist teams. Often problems are more about ethics and end of life care than clinical issues. Judgements are difficult, and experienced doctors are needed to formulate and amend care plans. The idea of increased community triage is worth exploring as a way of reducing inappropriate hospital admissions – however it must be remembered that inpatient treatment is a necessary and valuable option for many acutely ill patients and sufficient bed capacity must be available where this option is requested by a GP.

15 Conclusion

15.1 Significant concerns exist about the quality and safety of patient care in the OOH period. The PCTs responsible for commissioning such services must take strong action to improve the situation. The advent of practice based commissioning may afford opportunities to achieve significant improvements in OOH services. Models of good practice already exist in many areas. The term “urgent care” should be used as the umbrella term to include unscheduled care, unplanned care, and emergency care to ensure a single recognisable identity. The change of responsibility for urgent care has, of necessity, shifted urgent care from being purely a GP discipline to a multi-professional system delivered from a variety of locations within primary, secondary and community care 24 hours a day. However, despite their changing role, GPs cannot be replaced in urgent care. From our analysis on the issues we make ten recommendations (shown on Page 2/3).

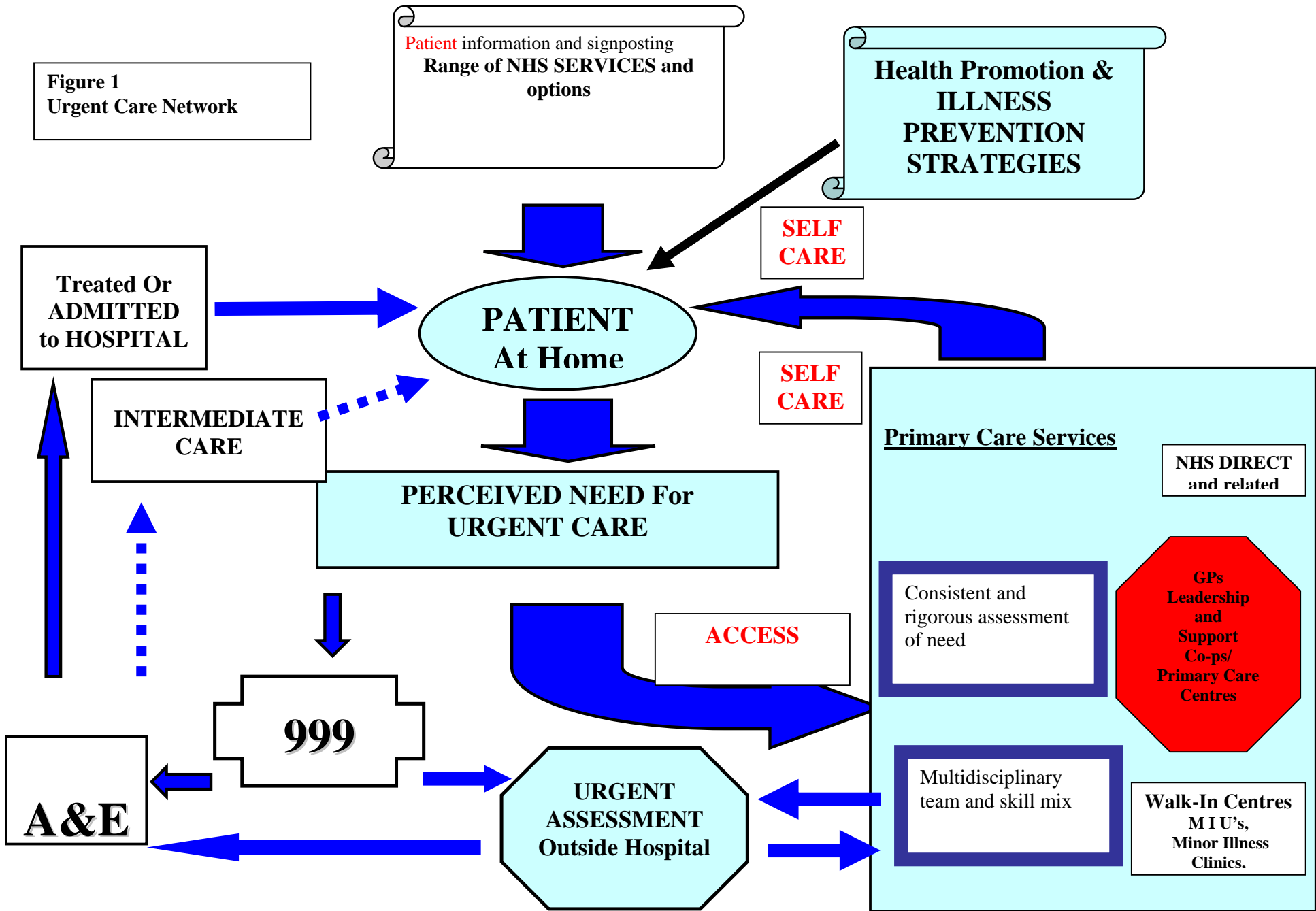
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Figure 1
Urgent Care Network



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