



Centre for
Commissioning

Guidance for commissioning integrated **URGENT AND EMERGENCY CARE** A 'whole system' approach



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Foreword

Providing out-of-hours, urgent or emergency care is a serious business; patients accessing it are usually doing so at their most frightened and vulnerable, and we have a duty of care to ensure that the system is as seamless and uncomplicated to navigate as possible.

The key to providing this seamless service is integration. It makes good clinical, financial and practical sense for GPs, our secondary and specialist colleagues, local authorities and the third sector to work together in designing, providing and maintaining services that ensure our patients receive the highest quality care possible.

This can all be achieved through good commissioning, which is where this guide comes in. Commissioning with a 'whole system' approach to care pathways is the way forward to achieving a truly joined-up health service which provides the best possible quality of care to patients when and where they need it the most.

I want to acknowledge the excellent work of Dr Agnelo Fernandes, RCGP Lead for Urgent Care, in producing this guide, and hope that healthcare commissioners use the information contained within to improve their own commissioning practices for the benefit of their patients and communities.

Dr Clare Gerada, RCGP Chair of Council

Commissioners need to know that 5% of accident and emergency attendances, 30% of acute inpatient bed occupancy, and 30% of acute readmissions are mental health related (RCPsych, 2004). Without the commissioning of onsite psychiatric liaison services in acute settings, wider support from out of hours and community mental health services, and an integrated approach to care which recognises the intertwined relationship between many physical and mental health conditions, patient care and health and social care outcomes will be significantly compromised. The Royal College of Psychiatrists therefore welcomes this new guide for commissioners, endorses its aims and objectives, and urges existing and future commissioners to take note of its recommendation to consider mental as well as physical health. The Centre for Commissioning is also formally working to develop guidance on commissioning around mental health and learning disability issues through its collaboration with the Joint Commissioning Panel for Mental Health(<http://www.jcpmh.info>)

Professor Sue Bailey, Royal College of Psychiatrists

Children and Young People comprise around 22% of the population in England and over 25% of attendances at emergency departments; concerns about children under 10 comprise 13% of calls to out of hours services. It's vital that the needs and behaviours of young people and families are actively considered in any commissioning process and that services, and information about services, are accessible and designed to deliver the best possible outcomes as close to home as possible. The RCPCH supports its members through development of clinically-led evidence based standards for children's health services and it is important that commissioners take account of these in service design. We are therefore very pleased to support this document as a useful and important guide for commissioners during a period of extensive reform to the NHS in England, and look forward to a continued association with the RCGP Centre for Commissioning in their continuing programme of work.

Professor W.Hamish Wallace, Registrar, RCPCH

The College of Emergency Medicine welcomes this important guidance. The axis between commissioners and the Emergency Department is fundamental. Urgent and emergency care must be an absolute priority on the commissioning agenda, with active involvement of the local Emergency Medicine clinical lead to ensure discussions are optimally informed. Better access to primary care for extended periods throughout the week combined with a truly joined up ED / urgent care facility, with common training and governance, will ensure a simpler, cohesive system with clinical and cost benefits, providing consistent high quality safe patient care 24 / 7. Tariffs must drive improvements in the ED , particularly much more EM Consultant and senior clinician provided care recognising the challenges of the case mix of the majority of patients attending. For the public, urgent and emergency care is the shop window of the NHS – we must deliver the care they expect and deserve.

Mr John Heyworth, President The College of Emergency Medicine



Executive Summary

The establishment of Clinical Commissioning Groups (CCGs) under current healthcare reforms presents an ideal opportunity to look differently at the urgent and emergency care pathway.

Until now, much of the focus has been Emergency Department (ED), Accident and Emergency (A and E), out of hours services and ambulance services. Despite high profile cases in the media, change has predominantly focused on timeliness, driven by national targets, rather than on improving quality and the patient experience.

“Silo” thinking has to change if we are to capitalise on the interdependencies between health, social care, self-care and the third sector to provide an urgent and emergency care system that is more joined up and seamless for patients.

Going forward, new clinical commissioners need to have an overview of the commissioning processes as a “whole system” and what this means in practice so that they can develop strategies which ensure: a coherent 24 hour seven day urgent care service with greater consistency, improved quality and safety, improved patient experience, greater integration and better value for the taxpayer.

This commissioning guidance draws on many discussions with pathfinder Clinical Commissioning Groups, current commissioners and experts to build a picture of the “whole system” impacting on urgent and emergency care, including health, social care, self care and the third sector.

This guidance deliberately places greater emphasis on demonstrating the interdependencies between services to illustrate the “bigger picture” rather than on specific “how to” guidance on commissioning processes.

It describes what urgent and emergency care is, why it is important to commissioners, our knowledge of the activity in current services and what the system looks like at present. Case studies bring it to life by drawing on experiences of patients which powerfully illustrate the need for change.

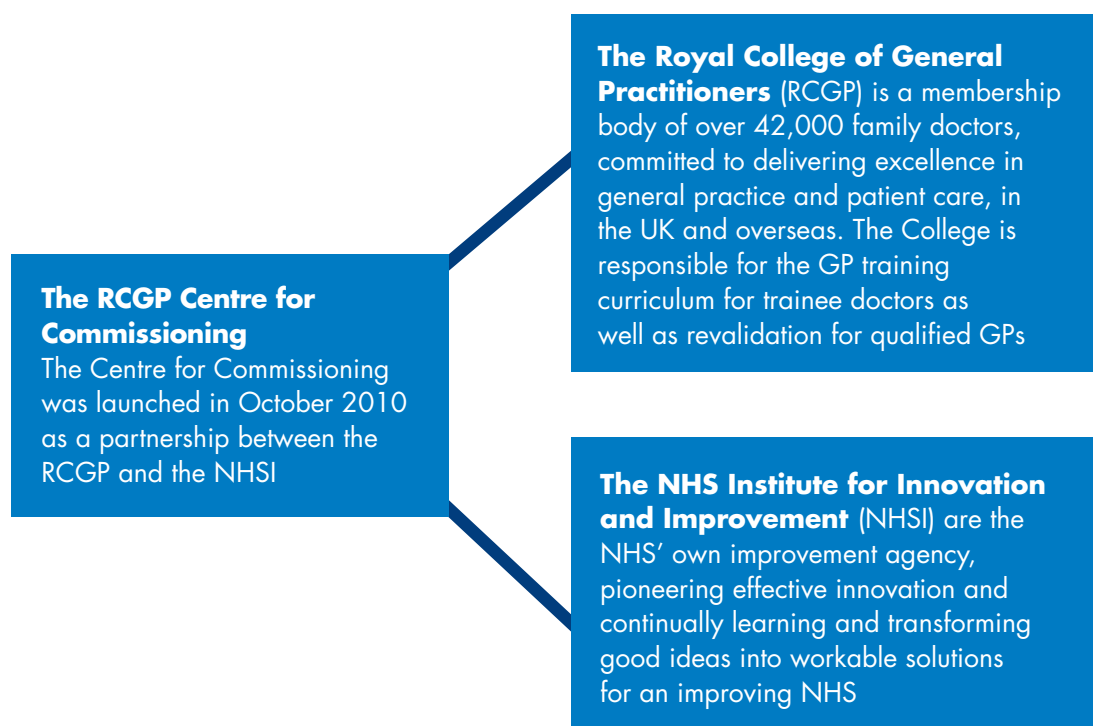
Using the Clinical Commissioning Cycle, the guidance describes what a good urgent and emergency care service looks like based on local and national evidence. It shows how to redesign services leading to more integrated care pathways and draws on the Quality, Innovation, Productivity and Prevention (QIPP) programme and other measures to deliver the required efficiency savings.

More detailed information on specific aspects of the urgent care system and how these can support commissioning plans are provided in the Appendices, including urgent care in general practice in hours, the ambulance service, NHS Pathways-Capacity Management System, ED (A and E) and a public health perspective of programme budgeting for urgent care.

The RCGP Centre for Commissioning

The Royal College of General Practitioners (RCGP) launched the RCGP Centre for Commissioning in October 2010 in response to the government's healthcare reforms, set out in its 2010 White Paper, Equity and Excellence: liberating the NHS. ^[1]

Set up in partnership with the NHS Institute for Innovation and Improvement, the Centre aims to equip GPs and GP practices^[2] with the skills, competencies and expertise required to deliver effective healthcare commissioning which ensures patient-focused and high quality healthcare, leading to improved health outcomes.



Our Mission

We support those involved in clinically-led commissioning to continually improve health outcomes by developing the required skills and knowledge.

Our Vision

Through effective collaboration between clinicians and other professionals, we will contribute to improving commissioning that will ensure local communities receive the healthcare they need.

Our Values

- Achieving excellence
- Improving outcomes
- Effective collaboration
- Empowering communities
- Commitment to caring.

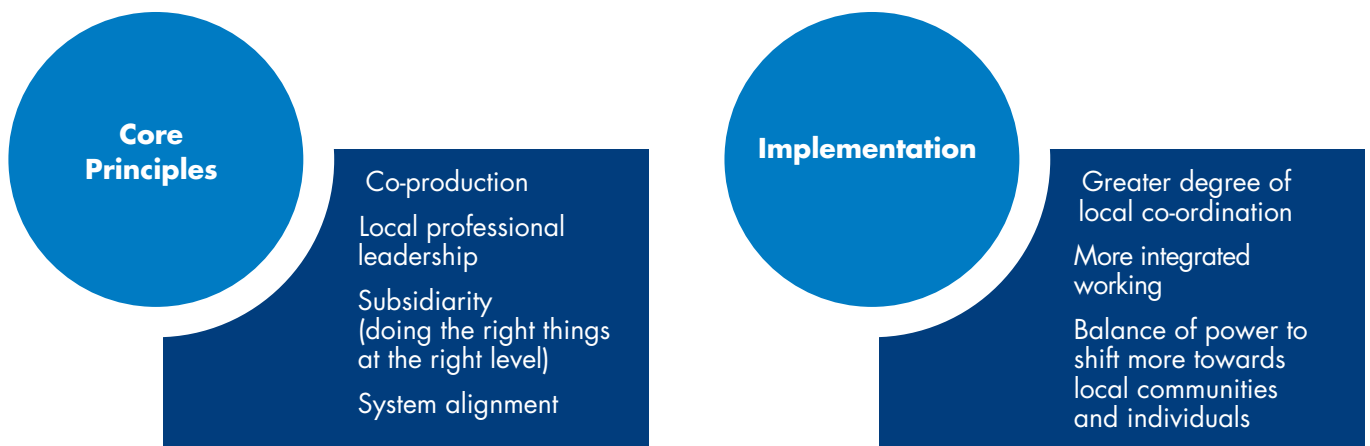
Introduction

The RCGP Centre for Commissioning is developing a range of learning resources on clinically-led commissioning (visit: www.rcgp.org.uk/commissioning) ^[3]

This guidance considers urgent and emergency care and gives an overview of the key issues for those commissioning urgent and emergency care services. Using the Clinical Commissioning Cycle developed by the Centre, the guide draws on a wealth of available evidence to enable commissioners to effectively review and redesign their urgent and emergency care services to be more responsive to the needs of their local populations.

The changing face of the NHS

The government's approach to delivering a new NHS is based on a set of core principles and their aim is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level. ^[1]



What is commissioning?

Good commissioning places patients at the heart of the process. It is about improving people's lives and providing high quality services that are designed around the individual.

We have defined commissioning as:

"A continual process of analysing the needs of a community, designing pathways of care, then specifying and procuring services that will deliver and improve agreed health and social outcomes, within the resources available."

Clinical Commissioning Groups, local authorities and others need to work together to plan and deliver better integration of local services ^[2] to ensure that communities enjoy the highest quality, responsive, affordable and personalised services that are also shaped directly by the people who use them. The National Commissioning Board must also ensure that the services that it commissions support local service integration.

The Principles of Effective Commissioning

Core Principles

The Centre believes effective commissioning should be based on the following core principles:

- Community focussed
- Clinically-led
- Adopting a collaborative approach
- Ensuring comprehensive engagement.

For a truly joined-up system, physical and mental health, together with social care, must be better integrated in order to meet the needs of patients.

For urgent and emergency care, we need to look at the patient journey and patient experience, and more importantly "service experience" along the whole urgent and emergency care pathway and not just focus on ED (A and E), ambulance or GP out of hours services.

Service experience includes:

- Patient Satisfaction
- Patient Reported Outcomes (PROMS)
- Patient Reported Experience Measures (PREMS) (being developed by the Royal College of Paediatrics and Child Health (RCPCH) for children in urgent and emergency care
- Patient Improvements, eg asking patients about how they can improve the service
- Staff satisfaction surveys
- Staff Improvements, eg canvassing ideas for improvement from staff.

We also need to ensure services which support urgent and emergency pathways are involved, such as acute hospital wards and referrals to mental health services, including psychiatric liaison services.

In order to meet the needs of patients and their carers, a whole pathway approach is required for integrated care across ED



(A and E), community-based health services and health and social care.

To date, many emergency and urgent care pathways have been designed simply to meet the immediate clinical needs of patients. However, as demographics change and the number of older people, especially those with complex and long-term conditions increases, the impact of people's social circumstances will become more apparent.

For older people, it is often their social circumstances which can both precipitate an emergency or, indeed, prevent it. For example, in some areas, the numbers of older people who present directly to an A and E or as an emergency is exceptionally high.

This guidance is an opportunity to tackle the health and social care implications of poorly designed pathways and behaviours. A collaborative approach towards commissioning integrated care provides an opportunity to do this with better outcomes for the patient as well as ensuring better local partnerships.



This guidance is intended to support commissioners in developing a “strategic oversight” of their urgent and emergency care system, and identifies the following key principles of a good service when reviewing and re-designing urgent and emergency care services:

- No confusion of what to do, who to call or where to go
- A joined up and co-ordinated system
- Safe, responsive and a high quality service
- Self-care, prevention, anticipatory care and patient empowerment
- Patient and public involvement
- Monitoring of urgent and emergency care services
- Knowledge to influence spend on services
- Integrated mental and physical health care for all.

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 often used interchangeably.

The previous Department of Health guidance on telephone access to Out of Hours services unsuccessfully tried to clarify commonly used terms as follows ^[5,6]:

“Emergency Care is an immediate response to time critical health care need. Unscheduled care involves 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 is the response before the next in-hours or routine (primary care) service is available.”

The current Department of Health definition (2011) for urgent care face-to-face is:

“Urgent and emergency care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly.” ^[7]

“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” ^[8].

Definitions for urgent and emergency response are often different for mental health commissioning. Mental health response times need to be commissioned as part of urgent and emergency care pathways to both ensure equity of care for mental health problems, and to address the significant number of crisis mental health presentations in primary and acute secondary care settings.

CASE STUDY

Tom is 68 years old. He developed sudden numbness in his right arm and weakness in his right leg so that he could hardly stand up. His wife Lilly had seen the adverts for “FAST” and knew that the right thing to do was to dial 999 for an ambulance. The ambulance was there in minutes and took Tom to a stroke unit 10 miles away rather than the local hospital.

Lilly thought the doctors and nurses at the stroke unit were brilliant and they really worked hard with Tom who was soon well enough to be transferred to the local hospital and rehabilitation team before going home with little to show for the effects of the stroke.

Integrated “whole system” approach

If we are to make a difference with commissioning urgent and emergency care we need to adopt a strategic approach which is:

- Needs led
- Patient and public centred
- Commissioner led
- Developed in conjunction with providers
- Supports innovation
- Focuses on improving clinical outcomes through “service integration”.

What do we mean by integration?

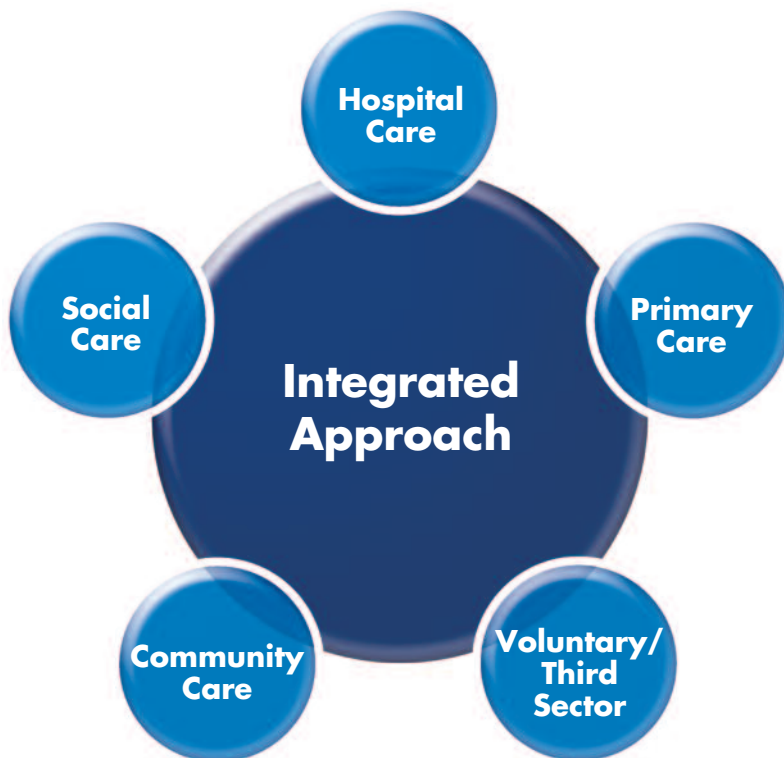
Integration means ensuring patients do not see the joins between services and that information is available at every stage rather than having to take patient details many times. Then, when it is the right thing to do, to hand over responsibility of care to other services or professionals, ensuring that the barriers are removed.

What does good urgent and emergency care look like?

Good urgent and emergency care is:

- Patient-focussed
- Based on good clinical outcomes, eg survival, recovery, lack of adverse events and complications
- A good patient experience, including ease of access and convenience
- Timely
- Right the first time
- Available 24/7 to the same standard.

Given the complex nature of patient flows across different services, urgent and emergency care services cannot be commissioned in isolation and the process requires a “whole system” and “multidisciplinary” approach across acute, primary and community-based services and social care. “Collaboration” between services is key.



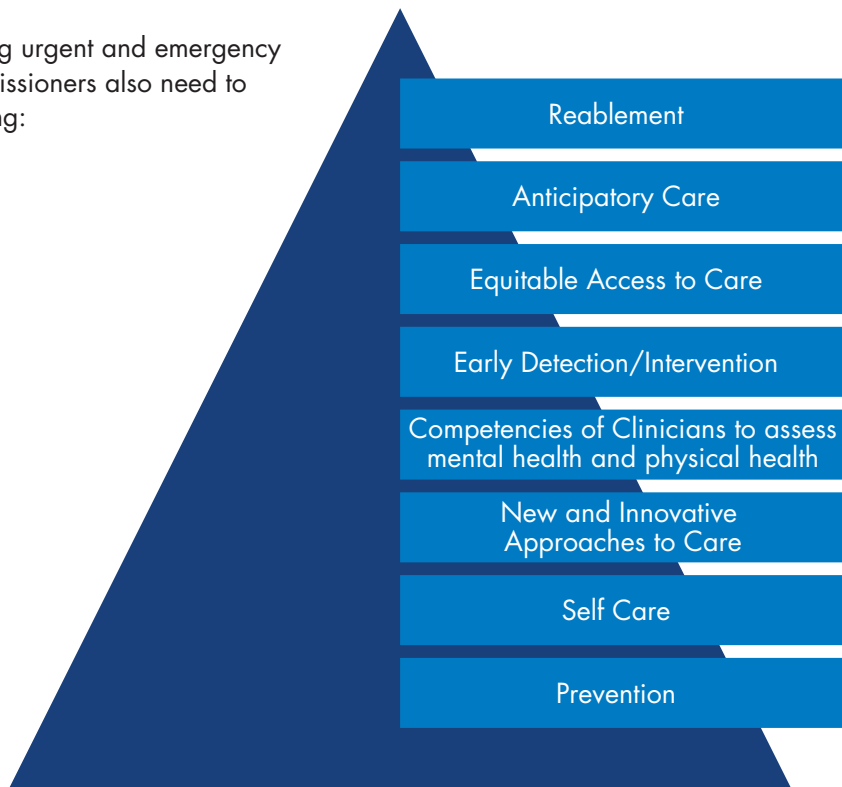
All care pathways for delivering physical healthcare should always have a mental health component. There should be a counterpart pathway for commissioning practice to ensure services are in place to deliver this ^[115, 116, 120].

- Primary mental health presentations account for 5% of ED attendances ^[122]
- Alcohol-related problems account for 13-30% attendances ^[119, 124]
- Mental health presentations account for at least 20-25% primary care attendances ^[120]
- Self-harm is one of the most common reasons for acute medical admission ^[118],
- Mental health problems occur in 30-40% of unscheduled medical and surgical admissions ^[118]
- Mental health problems are especially common in frequent attenders to primary and secondary care.

On site liaison psychiatry services are needed in acute hospitals and crisis response mental health services are needed to support community pathways.

The input of mental health services to emergency departments and acute wards is a vital element of the delivery of a modern responsive and integrated service to patients. ⁽¹¹⁵⁾

When commissioning urgent and emergency care services, commissioners also need to consider the following:



Adopting such an approach is more likely to lead to integrated and seamless services for patients, which avoid duplication and fragmentation and shift care from more expensive settings such as hospitals to the community, making best use of available resources.

This can be achieved in a number of ways, depending on local circumstances and with a strong focus on a partnership approach to improve the patient experience and outcomes.

All social service authorities are signed up to the Quality, Innovation, Productivity and Prevention (QIPP) programmes and will be interested in any activity which avoids unnecessary hospital admissions as this can help to avoid high cost admissions to residential and nursing homes.

Why is urgent and emergency care important to commissioners?

Key Drivers

Urgent and Emergency care has particular significance to commissioners due to:

- Clinical safety issues [30-32]
- The changing expectations and experience of patients as a result of a 24/7 culture [11, 12]
- The unacceptable variation in quality and availability in some services [13-21, 126]
- The volume of the work and high visibility to all [9]
- The increasing demand for some services [22-27, 118, 125]
- The duplication in the system [28, 29]
- The complexity of service provision, including primary care, acute hospitals, ambulance services, mental health services, pharmacies, social services and third sector
- Escalating costs [9, 24, 25, 26]
- The challenge to make efficiency savings in the NHS [32, 33,34]
- High profile and press and media interest [29, 30, 31]
- The changing political context [10].

The King's Fund report "Managing emergency activity – urgent care" May 2011 [25], summarised some of the key reasons why urgent and emergency care is important to commissioners:

- Urgent care services are currently often highly fragmented and generate confusion among patients about how and where to access care
- Poor sharing of information as patients move between different providers of care in an emergency is a cause of many significant failures of care
- The quality of out-of-hours care is highly variable, particularly in terms of continuity of care, leading to variable patient experiences
- The growth of new forms of urgent care has failed to reduce A and E attendances. For example, emergency attendances in England rose by 46% between 2003/04 and 2009/10

(however, from 2004 the data also included Walk In Centres & Minor Injury Centres with ED (A&E) attendances increasing around 6% per annum and Emergency 999 calls over 8 million in 2010/11 with demand rising at 4% per annum)

- Walk-in centres do not appear to have led to shorter waits in general practice or lower admission rates at other health care providers
- Emergency admissions have also grown rapidly. The number of emergency admissions in England rose by 11.8% between 2004/05 to 2008/09 – resulting in around 1.35 million extra admissions.

24/7 coherent urgent care service – vision for implementation

The government is committed to the idea of a 24/7 urgent care service. This is reiterated in its White Paper, Equity and excellence: Liberating the NHS, that has led to the current health reforms [1]

...“The government will develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care. This will incorporate GP Out of Hours services and provide urgent medical care for people registered with a GP elsewhere. We will make care more accessible by introducing, informed by evaluation, a single telephone number for every kind of urgent and social care and by using technology to help people communicate with their clinicians...”

This 24/7 vision of a coherent Urgent Care Service should have the following key aims:

Greater consistency Consistent, high quality integrated care led by Clinical Commissioning Groups delivering the best outcomes and experience 24/7, with no noticeable differences during or out of normal office hours.

Improved quality and safety Services which are clearly focused on meeting the clinical needs of the patient, with less variation across the country and ingrained in a culture of continuous improvement.

Improved patient experience
A simply designed and rationalised system supported by easy telephone and web access, with a greater focus on patient feedback.

Greater integration Services working together to provide a seamless service, irrespective of the provider organisations which operate them.

Better value Reducing inappropriate use of NHS services, to deliver better value for the taxpayer.

“Liberating the NHS” and revised operating framework ^[32]

Subject to pilot evaluation this commitment to develop a coherent 24/7 urgent care service will be supported by a single telephone number (111) helping patients access all urgent care services. ^[35] The aim is to make it easier for patients to get the right care, in the right place, at the right time from the right care professional.

The NHS Operating Framework 2011/12

The A and E Clinical Quality Indicators in England were updated to reflect changes to the landscape of urgent and emergency care for both commissioners and providers. ^[36, 37] Time targets that had skewed the response of



providers were reviewed and changed during 2010, with ambulance targets changed to Clinical Quality Indicators.

Clinical Quality Indicators (CQIs)

The purpose of 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. These indicators remove the isolated focus on achieving faster care at the expense of higher quality care.

In April 2012, the “four-hour standard” – by which a patient should be seen and admitted, transferred or discharged within four hours of arrival at the ED (A and E), minor injury units and walk-in centres – was replaced by a set of CQIs. ^[36-40]

There are eight Clinical Quality Indicators:

- Ambulatory care
- Unplanned re-attendance rates
- Total time in the A and E department
- Left without being seen rate
- Service experience
- Time to initial assessment (for ambulance cases)
- Time to treatment
- Consultant sign-off.

Elements of five of the indicators have been included as headline measures in the NHS Operating Framework for 2011/12, with the remaining indicators included as supporting measures.

For ambulance services^[41] the Category B, 19 minute response target was removed as part of this emphasis on “outcomes” rather than “process targets” to provide a more balanced and comprehensive view of the quality of care.

The new indicators include:

- Time to answer call (999)
- Time to treatment
- Service experience
- Outcome from stroke
- Calls closed with telephone advice or managed without transport to A and E
- Call abandonment rate



- Outcome from cardiac arrest – return of spontaneous circulation (how many patients in cardiac arrest have a pulse/heartbeat on arrival at hospital following resuscitation)
- Re-contact rate following discharge of care
- Category A eight-minute response time to life-threatening calls
- Outcome from cardiac arrest to discharge from hospital
- Outcome from ST elevated myocardial infarction (a common type of heart attack)
- Category A 19-minute response time to serious but not life-threatening calls

These ambulance Clinical Quality Indicators^[41] will give a better indication of patient care and experience.

Timeliness of care will still be an important factor – but not the only factor. Importantly, the ambulance CQIs will improve the quality and safety of care by focusing on groups of patients “with the most acute needs” instead of “who needs the most urgent care”. Further developments are in progress.

The 24/48 hour targets for access to see a GP were also reviewed and the target to be able to see a GP within 48 hours was removed, with the emphasis instead focusing on GP practices to provide the appropriate level of access for their particular patient populations.^[42]

The Department of Health has plans to develop a set of indicators to apply to urgent care services (both telephone and face-to-face) and the intention is that these will replace the National Quality Requirements for out-of-hours services^[43]. There are also plans to identify indicators which can be used to measure performance of the whole urgent and emergency care system as part of a 24/7 urgent and emergency care service and development of the national Quality, Innovation, Productivity and Prevention (QIPP) programme.

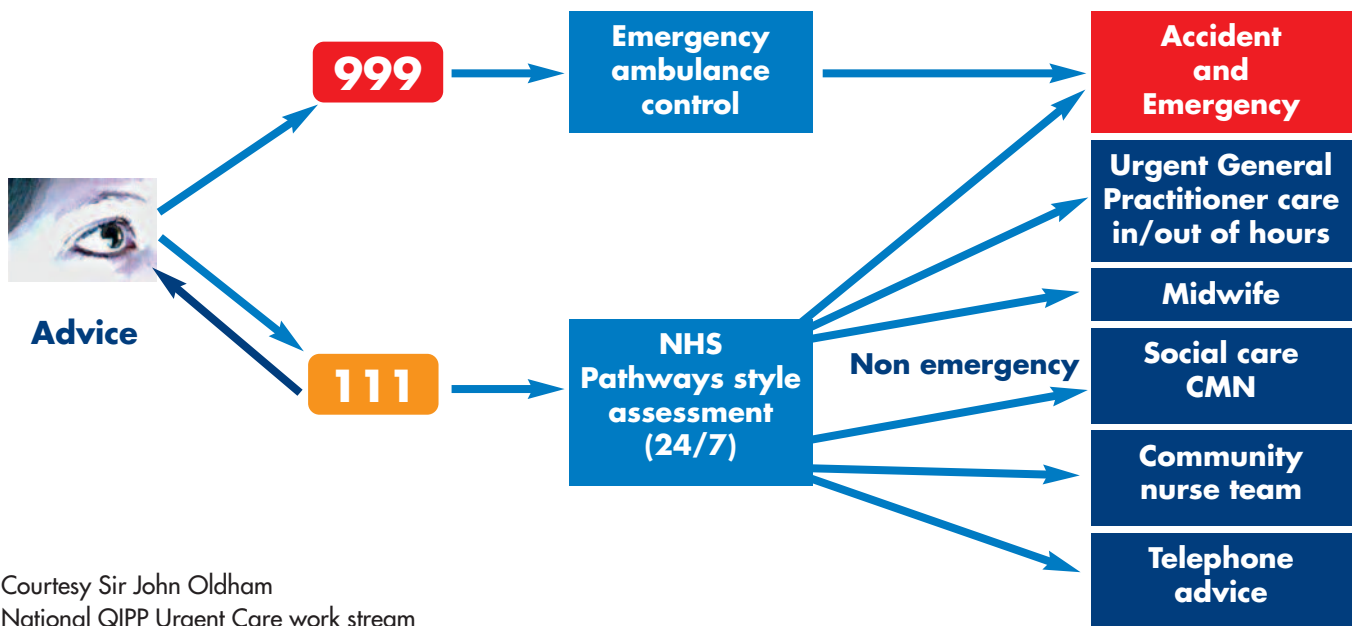
Quality, Innovation, Productivity and Prevention (QIPP)

The QIPP programme^[33, 34, 44] is about ensuring that each pound spent is used to bring maximum benefit and quality of care to patients. The NHS needs to achieve up to £20 billion of efficiency savings by 2015 through a focus on quality, innovation, productivity and prevention.

This QIPP initiative is being applied at all levels to support clinical teams and NHS organisations, to improve the quality of care they deliver while making efficiency savings

Patients eye – urgent care

“I need some help now”



Courtesy Sir John Oldham
National QIPP Urgent Care work stream

that can be reinvested in the service to deliver year-on-year quality improvements.

The QIPP Urgent Care initiative aims to achieve a 10% reduction in the number of patients attending ED (A and E) with associated reductions in ambulance journeys and hospital admissions. This will require significant changes and a major service redesign, as activity has been growing rapidly each year.

The QIPP Urgent care work stream involves:

- A single point of entry
- Local directory of services
- Commonality of offer
- GP dashboard

There are also related QIPP workstreams, on long term conditions, end of life care, and right care (reducing variation), which will have a significant impact on the urgent and emergency care system.

The QIPP Urgent Care workstream aims to maximise the number of instances when the right care is given by the right person at the right place and right time for patients. The workstream starts from a perspective that rather than ‘educating’ patients about where

it is appropriate for them to go, it should focus on designing a simple system that guides them to where they should go.

High profile quality investigations

Urgent and emergency care services receive considerable media attention, eg the Care Quality Commission (CQC) investigations into the out of hours provider “Take Care Now” and the enquiry into Mid Staffordshire NHS Trust. The quality of out-of-hours care is highly variable, particularly in terms of continuity of care, leading to variable patient experiences [14, 15, 16, 46 47]. In light of this, the role of commissioners will continue to be scrutinised to ensure commissioned services are safe, high quality, consistent, effective, seamless and provide a good patient experience.

Links to the Joint Strategic Needs Assessment (JSNA) and public health

The JSNA [48, 49] is developed jointly by local health and social care organisations in England. It is a tool to identify the health and wellbeing needs and inequalities of a local population to inform more effective and targeted service provision. The core data set for the JSNA includes “domains and sub

domains” on the “burden of ill health”, hospital admissions and causes of death. Other sub domains include people with long-term conditions due to the demand they create for urgent and emergency care services. eg diabetes, cardiovascular disorders (coronary heart disease or stroke), COPD, mental illness, cancer and arthritis, as well as trauma, accidents, falls and injuries.

Services to effectively meet the needs of end of life care pose particular challenges. Strategies need to be implemented to provide co-ordinated, timely and seamless care, especially to ensure that careful planning enables patients to die in a place of their choice, rather than in hospital by default.

Enhanced recovery ^[50] schemes aim to maximise patients’ health and fitness prior to planned hospital admissions. Reablement schemes ^[51, 52] support patients’



independence and recovery at home, following a recent illness, disability or after a period in hospital or residential care. Both these approaches are critical for better outcomes, better patient experience and better value to commissioners.

For many illnesses, the need for urgent and emergency care is a failure of “health and wellbeing”. Prevention of an acute, avoidable episode is as important as service provision to address it.

The proposed “Health and Wellbeing Boards” ^[53] led by local authorities has the potential to bring together a range of public service interdependencies, including health, social care, public health, housing, education, older people and children’s services to support the commissioning of health and wellbeing of which urgent and emergency care is a key component.

Such integration is essential in developing joined-up and effective urgent and emergency care services in response to the increase in long-term conditions, dementia and frailty, attendances to ED (A and E) and hospital admissions.

4

What do we know about the current urgent and emergency care system?

The additional resources provided to the NHS in the previous decade, coupled with national performance targets for different urgent and emergency services, has made a difference in improving patient safety, reducing waiting times and patients' experience of the NHS. However, confusion persists with patients, the public and health professionals about what to do, who to call or where to go for urgent and emergency care.

The urgent and emergency care system still appears fragmented and needs to be more joined-up to make the care provided seamless, more efficient and effective, and offering greater value to commissioners.

There is a wealth of local data and evidence available to commissioners about how their current urgent and emergency care system is operating which can help commissioners take a more strategic view.

Although much of the focus has been on hospitals, most urgent care takes place in the community.

As a result of "system gearing" small changes in primary care, which includes general practice, can give rise to a much greater effect on the activity in hospitals (secondary care).

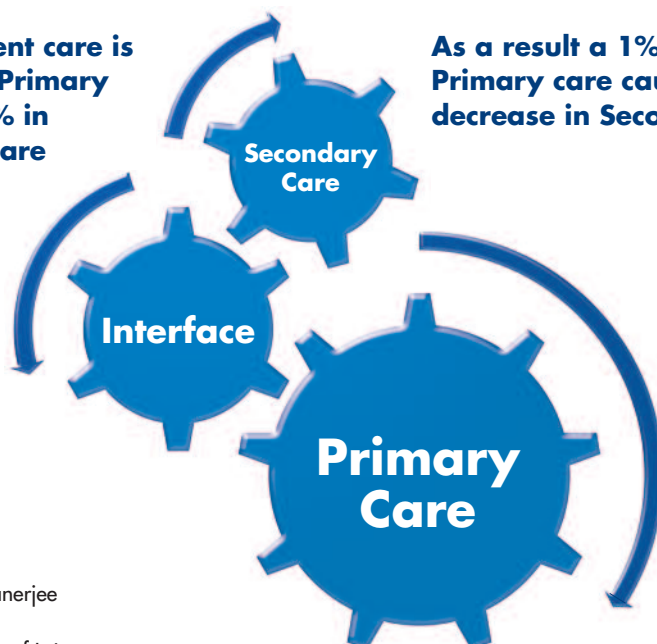
General practice provides the majority of urgent care and small changes to improve overall access and a consistent approach to urgent care requests, especially to older people, is likely to have a significant effect both on ED (A and E) attendance and hospital admissions. [107-111, 13, 21, 25, 69] Improved access to timely integrated health and social care services in the community is also likely to have a significant impact on hospital admissions, length of stay, discharge and re-admission rates. [51, 52]

Although more recent statistics are available [54] for ED (A and E) activity, the detailed Healthcare Commission report 'Not Just a Matter of Time: a review of urgent and emergency care services in England' 2008, [9] provided an important comparative insight of patient contacts and activity across a number of urgent and emergency care services during a specified period.

System Gearing

95% of Urgent care is accessed in Primary care with 5% in Secondary care

As a result a 1% increase in Primary care causes a 20% decrease in Secondary care



Courtesy Dr Jay Banerjee
Consultant
University Hospitals of Leicester



ED (A and E)

During 2007/08, there were 19.1 million attendances at accident and emergency departments and urgent care centres, compared to 14 million attendances in 2002/03 ^[149].

- The total cost of these services is around £1.3 billion a year (or £25 per person)

This means that on average, we go to an accident and emergency department every 2.5 to three years and each visit/case costs £68. But the real cost is in admissions, eg non-elective admission for DVT or diabetes with hypoglycaemia cost £2K or for heart failure with complications cost £4K.

(Source: Henry Clay, Primary Care Foundation).

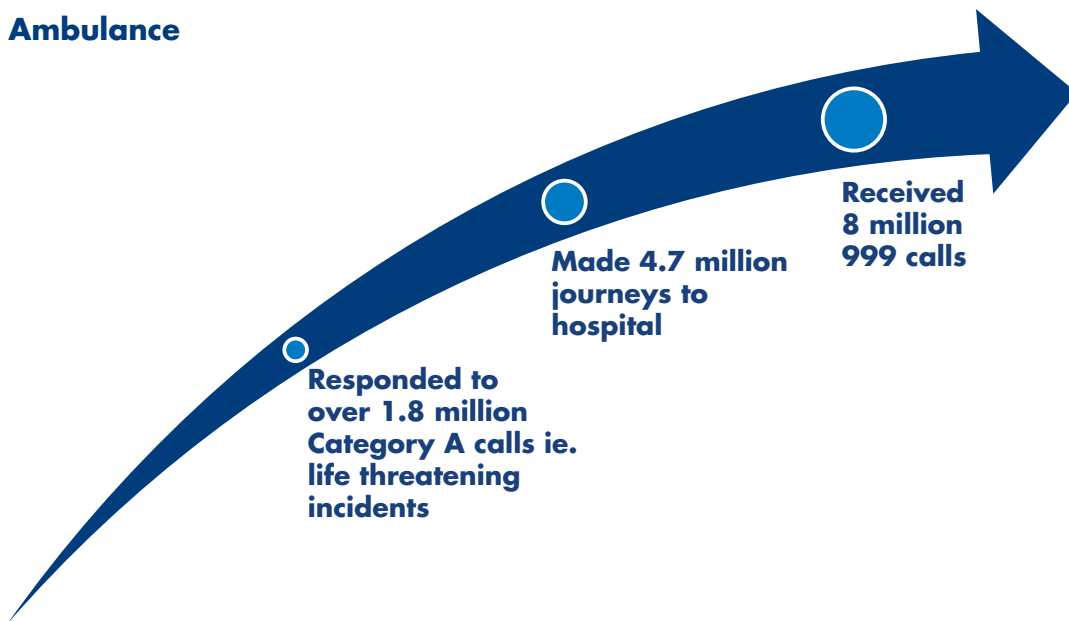
- Primary mental health issues account for around 5% of A and E attendances ^[129]
- Self-harm presentations to EDs show an increase of 11% in the last three years ^[118, 125]

- Up to 70% of night time attendances and 40% of daytime attendances are caused by alcohol ^[128]
- Mental health problems, including somatoform disorder, are common in frequent attenders, with a significant proportion being linked to psychosocial exacerbations of underlying conditions ^[129]
- Early intervention is a key aim of the current Mental Health Strategy (2010). First presentations of mental illness and substance misuse occur in the ED (which needs to be equipped to provide early intervention strategies and rapid access to appropriate mental health assessments) ^[117, 120]
- Patients with depressive disorder are twice as likely to use ED services as those with a long term condition alone, without depression. ^[122]

Ambulance

- 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 to the ambulance services increased from 4.7 million to 6.3 million and in 2010/11, calls topped 8 million with 4.7 million journeys – an increase of 4% per annum since 2007/08
- The total cost of these services is around £1.1 billion a year (or £23 per person). The Audit Commission report (2011) suggested a cost of £200 per 999 ambulance journey
- Early results of the impact of the new ambulance indicators (2011) suggest great variation. Low transport rates may be associated with higher recall rates, so apparent savings from not transporting may not be true, although the data is still being validated.

Ambulance



This means that on average, we only go to hospital in an ambulance once in every 12 years, or that we call the service once every eight years and that the average cost of such a call (including all of the back up associated with responding to and treating patients in an emergency) is approximately £175.

(Source: Henry Clay, Primary Care Foundation).

GP out of hours services

- In 2007/08, out of hours GP services received 8.6 million calls and completed 6.8 million medical assessments
- They carried out 2.9 million assessments by telephone, 0.9 million assessments on home visits and three million assessments where the patient attended a primary care centre
- Around 1.5% of the calls GPs 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).

This means that on average, we call the out of hours service once every six years and that the cost per case is, on average £58. (Source: Henry Clay, Primary Care Foundation).

- Out of hours services are set to be redefined (2011) as part of a 24/7 urgent care service and the data reporting will change.

GP in-hours services

- 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).

NHS Direct

- In 2010/11, NHS Direct undertook 12.5 million assessments through its core service. Of these, 4.5 million were calls to the national 0845 4647 service and over 8 million assessments were completed using the online service; 8% of all calls in the traditional out of hours period were dental problems.
- Of the assessments completed, 55% were completed by NHS Direct, with patients not needing to seek face to face contact
- In 2007/08, 4.9 million calls were answered by NHS Direct's main 0845 service In June 2011, NHS Direct also launched mobile 'apps' for patient assessment, and they have been used over 200,000 times a month.



Pharmacy services

- Around 750 million prescription items are dispensed each year by local pharmacy services, many of which relate to urgent care
- There are 1.8 million visits per day to community pharmacies for health-related reasons
- The number of prescription items dispensed by community pharmacies in England increased by 43.5 million from 842.5 million in 2008 to 886 million in 2009, an increase of 5.2%. Many of these prescriptions are related to urgent care
- Community pharmacies are easily accessible – 99% of the population can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. 100 hour pharmacies provide extended hours access often when other healthcare services are closed
- Provision of medicines is, however, still a problem for some patients in the out of hours period, eg elderly people having to travel further or unable to travel, palliative care medicines though available during the day, arrangements are not always consistent out of hours. ^[45]

Mental health

- Mental health problems arising in acutely admitted patients usually fall outside the remit of community-based mental health services. Urgent and emergency care therefore needs to include commissioning on site liaison psychiatry services in order to provide rapid, appropriately skilled assessment ^[123, 127, 129, 130]
- Self-harm is one of the top five reasons for acute medical admission (NICE 2004) ^[126, 125]
- 13-20% of all hospital admissions are alcohol-related (British Society of Gastroenterology, 2010) ^[119, 122]
- Mental health problems occur in 30% of acute inpatients (45% of the elderly) and 30% of acute readmissions (RCPsych and BAAEM, 2004) ^[129]
- Mental health problems are especially common in frequent attenders and those frequently admitted both due to somatoform disorder and complex psychological factors impairing self-care ^[117, 120]
- The relative neglect of mental health problems compared to physical health problems is most evident in ED (A and E) facilities and the medical and surgical inpatient wards of acute hospitals. Among people with a physical illness or injury serious enough to require admission, a high proportion have a mental health problem, frequently masked or overlooked. ^[115]

The Role of Carers

- The work of all carers (family, friends and neighbours) involved in looking after patients at home has an economic value, saving the economy a staggering £119 billion per year. ^[147] This is considerably more than the annual cost of all aspects of the NHS – £98.8 billion – in the year 2009-2010, and is equivalent to £2.3 billion per week

Multiple contacts with urgent and emergency care services

CASE STUDY

Adam is five years old and the youngest of four children. He is a typical child in that he gets colds, coughs and temperatures, which his mother usually treats herself. On this occasion Adam developed a cough and a cold and had a temperature – so his mum wanted to get him checked out.

She got an emergency appointment with her GP, who examined Adam and diagnosed a viral illness and advised his mum to continue with what she was already doing. That night, Adam's temperature was still high and so in the morning, Adam's mum tried to get another appointment with her GP but was told that there were no appointments available. She therefore took Adam to the walk in centre and saw the nurse practitioner who carefully examined Adam and confirmed what her GP had said the previous day about a viral infection and told her to carry on with temperature control and fluids.

That evening Adam started vomiting and his temperature was very high so his mum took him to an A and E department, where he began to perk up. He was examined and told that he had a viral illness and that he would get better. Adam didn't get better overnight so his mum called the out of hours doctor who saw Adam and examined him and said the same thing as other doctors had said.

However, the next morning, Adam's mum was beginning to get really worried as she felt there was something more than a virus that was wrong with Adam so she saw her own GP as an emergency appointment. Her GP had no record of Adam having been seen at the walk in centre or A and E department, but he did have notes from the out of hours doctor service. On examining Adam again the GP said that he noticed a change from the last time he examined Adam and that he may have pneumonia. Adam was referred to the paediatric on-call team at the hospital and the full history and contacts with different services explained. A chest x-ray was done which confirmed that Adam had pneumonia. He was consequently given the right treatment to make him better.

- The cost of multiple contacts with different urgent care services is largely unknown as patients' urgent care needs have either failed to be delivered on first occasion or due to patients shopping around between services.
- Rolling up-to date data is available about ED (A and E) attendances ^[54]
- Ambulance services cost around £1.5 billion each year but have an impact on around £20 billion of NHS spend on emergency and urgent care. ^[26, 55] Therefore, it is essential that the commissioning models for ambulance services are right. The potential of ambulance services is still not well understood, as it is viewed by many as fundamentally a transport service, whereas the majority of interventions are for urgent (as opposed to life-threatening) calls
- Reduced conveyance to hospital may lead to reduced A and E attendance and potential admission
- Greater use of NHS Pathways and a Directory of Service can lead to less duplication.

CASE STUDY

Tom is a 28-year-old labourer who was rarely ill. At 10 pm on a Sunday evening, he started to have toothache. He did not have any painkillers, so he went to a 24-hour petrol station and got some tablets for his pain. During the night, his toothache became unbearable and he phoned his GP surgery number and was put through to the out of hours service. The receptionist took his details and said the doctor would phone him back. The doctor phoned him back nearly three hours later, but said that he wasn't a dentist and so Tom would need to phone his dentist in the morning. In the meantime Tom was advised to take more painkillers.

Later in the night his pain increased to the point of being the worst he ever had, so he rang NHS Direct. A kind nurse phoned him back in two hours and advised him to continue the painkillers or to go to an A and E department for something stronger as the out of hours doctor couldn't help. His pain continued to get worse, so Tom went to A and E. The doctors saw him in half an hour and said that he needed to see a dentist but he would give him stronger painkillers. He got through the night, still in severe pain despite the stronger painkillers. Tom rang his dentist at 9am the next morning only to be told all the emergency appointments had gone and he would have to wait three days to be seen.

Tom rang NHS Direct to find out if he could get an appointment with any other dentists, but they were not able to assist. He also phoned three other dentists, but they all said they did not have any appointments. It was now Monday afternoon (almost 20 hours since the onset of his symptoms) and Tom was still in tremendous pain. He went back to the A and E and after waiting nearly four hours, was told that they couldn't give him any more painkillers and that he would have to wait to be seen through the hospital's emergency dental service which started at 7.30pm.

There were a lot of other patients waiting ahead of Tom, so he eventually saw a dentist at 9pm. Tom was told he had a dental abscess and that he needed antibiotics. Suffering pain and light-headedness (caused by his painkillers) Tom had forgotten to take his wallet with him to the hospital and so could not pay for the antibiotics and took the prescription with him instead. He went home to get his money and then went to the late night pharmacist to get his antibiotics – only to find that it had closed at 10pm. He rang NHS Direct again to find out if there were any other nearby pharmacists open. Although there was one open until 11pm it was nearly 15 miles away and Tom did not want to drive in his condition. So he went home, and still in pain, he didn't sleep for the second night in a row. Tom eventually got his antibiotics from his local pharmacist the next morning and started to feel better about six hours after starting his treatment.

Confusion of what to do, who to call or where to go

- Numerous reviews and reports on out of hours GP services and other urgent and emergency care services have highlighted that the service to patients is fragmented and that patients and the public are confused about what to do. ^[9,14,15,25]
- There is a public perception that all ED (A and E) departments can do everything and that out of hours services may not exist in their area
- Lack of urgent care mental health services mean people default to ED (A and E). Often they are not appropriate for secondary care “home treatment teams”, who tend to be the default out of hours contact for mental health issues
- Other than 999 for an emergency ambulance there is no easily remembered telephone number for patients and the public to phone when they need advice or urgent and emergency care
- Currently, patients and the public have to navigate their way through the system with multiple telephone access points, from NHS Direct ^[56] available nationally, to a myriad of different telephone numbers for local services out of hours and GP surgeries in-hours
- With a continually changing landscape of local service provision combined with additional outlets such as urgent care centres, walk in centres and equitable access GP-led health centres, the only constants in the public psyche remain 999 for an emergency ambulance, ED (A and E)s for actual and perceived urgent or emergency situations and GP surgeries, with community pharmacies available to support urgent self-care and NHS Direct for general health advice
- The provision and access to emergency NHS dental services is also variable in different areas. In an emergency patients often default by going to ED (A and E) or GP out of hours services.
- It is no wonder that the public, patients and indeed health professionals themselves are confused about what to do and who to call or where to go – despite multiple attempts to clarify in different parts of the country with “choose well” campaigns ^[57,58]
- New immigrants, eg from EU countries or those whose first language is not English, with urgent care needs often call 999 or go to ED (A and E) because they are not aware of the different NHS services. ^[59,60,61] Commissioners have sometimes made this worse by commissioning Minor Injury Units (MIUs) that only have x-ray available some of the time, or by establishing services that have doctors there for part of the time and not other times so that the range of services varies (sometimes unpredictably).



The current system for urgent and emergency care is not joined-up or co-ordinated

- From a patient perspective the “health and social care” systems are not as joined-up as they could be, so the default position for many older people with urgent and emergency care needs is an ambulance journey, attendance at ED (A and E) or hospital admission

CASE STUDY

A wife returns from work one evening to find her 50-year-old husband experiencing lower abdominal and back pain which he describes as coming in waves and increasing in intensity. He is sweating profusely. She rings her GP out of hours service and the staff advise her that they will have a doctor call back. The wife waits for half an hour – meanwhile the waves of pain her husband is experiencing become unbearable. She then phones 999 and her husband is taken to hospital as a high priority/urgent case (with blue lights flashing). At hospital, her husband is diagnosed as having kidney stones and is given painkiller injections.

Once the kidney stone is passed, her husband is discharged with an appointment for a CAT scan and instructions that if his condition deteriorates he should return to A and E for further treatment.

A day later, his condition deteriorates and he returns to A and E as instructed. He is told by the receptionist that there is a 4.5 hour wait and is advised that the best thing to do is to go to the out of hours service nearby, where a doctor will see him and refer him to A and E to be seen immediately.

His wife manages to get her very anxious husband back into the car and takes him to the out of hours service – she goes to the reception area and explains the situation. She is told that it is an appointments only situation and that the service does not take walk-ins and that the hospital should not have advised her to come to the service. The wife is advised to take her husband home and ring to make an appointment, but the wife refuses and her husband is finally seen and treated.

- Co-ordinated end of life care, although improved in many parts of the country, remains variable
- Physical and mental health services often occur on different sites and are commissioned separately. This means mental health needs are often neglected if both aspects of treatment need to occur concurrently
- Enhanced recovery and reablement schemes are also in their infancy in many localities
- A significant proportion of emergency adult in-patients can be managed safely and appropriately on the same day without admission to hospital overnight. However, the implementation of this approach involving ambulatory emergency care is patchy at best ^[62, 63]
- Community pharmacies are often ignored as they are sometimes perceived by health professionals as operating outside the NHS, despite handling many locally commissioned NHS services such as minor illness schemes and emergency contraception
- Incompatibility of IT systems, as well as inconsistent electronic recording of consultations in different urgent and emergency care services, often results in the lack of availability of clinical information to other healthcare professionals involved in the care of individual patients.

Responsiveness and quality

- Even with co-location, providing appropriate care to patients has not always been achieved, due to services and professionals working in “silos”

- ED (A and E) attendances continue to rise ^[22-25, 54] and GP consultations, many of which involve patients with same-day urgent care needs, also show an increasing trend. Yet access to GPs for urgent same day appointments is variable ^[108]
- There is considerable variation in hospital admission rates for conditions which can be treated using ambulatory emergency care (eg cellulitis) ^[62, 63]
- The variation in the quality and responsiveness of out of hours services and individual clinicians continues to be highlighted by the Primary Care Foundation out of hours benchmark and patient surveys ^[16, 17, 18 19]
- Access to medicines at the time an urgent treatment as required, continues to be challenging for some areas, particularly for palliative care medicines and end of life care. Repeat medication requests need to be managed effectively in the out of hours period to ensure patients are directed back in to regular repeat prescribing and dispensing services. ^[45]
- Until now other than out of hour's services including NHS Direct there has been little or no systematic review of the quality of the interaction or consultations between patients and health professionals in the different services providing urgent and emergency care whether on the telephone or face to face. The universal urgent and emergency care clinical audit toolkit was published in March 2011 ^[64] to support clinical audit and feedback to health professionals leading to reflection and continual improvements in the safety, quality, clinical effectiveness of the care provided with a better patient experience.

CASE STUDY

A few days after returning home from a holiday in the Canaries, Monica started to feel ill. She started coughing and generally felt unwell so she spoke to her local pharmacist who advised some over the counter medication to see if this would help.

However, her condition got worse and she started to wheeze as well as having a bad cough which meant she had to sit up all night. The next morning when Monica was running a high temperature her husband decided to call NHS 111. He explained the situation; they wanted to speak to Monica and asked lots of questions about her general health and any medical problems. They seemed very interested in Monica's holiday and flight time, asking if her legs hurt and if she might have a DVT.

Monica explained it was just her chest symptoms and that she had great difficulty in breathing and talking. The call handler suggested she should see a doctor and asked if they could access her medical records.

Monica was asked if she could get to the urgent care centre at the nearby university hospital for an appointment at 3.10pm. Monica was amazed as this request was at 2.30pm. She agreed and her husband drove her to the hospital and they were seen by the doctor just before 3:10pm. The doctor gave Monica a thorough examination and gave her the antibiotic Amoxicillin to start immediately. He told Monica that if her symptoms didn't improve to see her own doctor.

The following day, Monica was still wheezing so she booked an appointment that day to see her own doctor who gave her a course of steroids which helped to clear her chest.

Monica said of the whole experience that she was very impressed by the service provided by NHS 111, because even though the department was very busy everyone was courteous and friendly and she thought it was a huge bonus that she was seen on time. She would call NHS 111 without hesitation.

Self-care, prevention, anticipatory care and patient empowerment

- Self-care ^[53] and prevention ^[65, 66] strategies for the elderly and those with mental health needs have featured less prominently in the urgent and emergency care strategies of commissioners, yet the potential impact is significant. Similarly, the evidence for the impact of anticipatory ^[67, 68] care in long-term conditions to reduce hospital admissions is substantial, although this has not been exploited



- Relatively mild mental health problems in patients with physical illness can have major effects on the physical condition. For example, a mild eating disorder in a patient with diabetes will have potentially serious long-term consequences ^[117, 120]
- Self-care and prevention strategies for people presenting with mental health problems should always be considered. These include help lines and web-based resources. Local services can be obtained, eg via the Mental Health Helplines Partnership ^[131]
- Children and young adults are the highest attenders of EDs (A and E), with fewest hospital admissions. Many schools simply call an ambulance for a sick child and don't necessarily use services appropriately. Strategies to empower sections of the community, eg parents of very young children and adolescents in schools and youth clubs, to understand and make better use of the NHS have yet to gain a hold ^[69, 70, 71, 72]
- The number of under-18s admitted to hospital due to drinking increased by 32% between 2002 and 2007; an average of 36 children a day admitted for alcohol-related conditions. ^[73, 74, 75] Underage alcohol-related hospital admissions, emergency department attendances and ambulance service call-outs cost almost £19 million nationally in 2007/08. Yet monitoring of alcohol-related attendances and advice with support for young people to modify their harmful drinking behaviour is inconsistent
- Although there appears to be adequate commercial high street pharmacy provision in towns and cities, and dispensing practices in rural areas, greater use of the skills of pharmacists to provide advice about minor ailments and actively promote self-care and
- Outreach of mental health provision into employment and education may reduce demand on urgent care. Alcohol misuse often presents in the ED or as unscheduled admissions. In the general hospital setting, heavy drinkers who are counselled about their drinking have a significantly better outcome than controls when followed-up 12 months later ^[124]
- Major depression increases the risk of developing a morbidity associated with several long-term conditions ^[117, 120] so should be targeted in prevention strategies to reduce urgent and emergency presentations

anticipatory care in people with long-term conditions has not been fully exploited. Although many areas have 100-hour pharmacy openings, the increasing number of requests from patients during the out of hours period often poses greater challenges to patients (even sometimes those with palliative care medicines needs)

- Integrating community pharmacy services as part of the provision of urgent and emergency care supports self-care within the community they serve. In October 2011, the national pharmacy contract will be extended to enable community pharmacists to offer new medicine reviews and target patients recently discharged from hospital for follow up
- Less understood is the widely different service usage pattern by age between different types of service, eg male children under 10 are about 7% of the population yet account for 13% of demand on out of hours services but only 8% of demand on A and E, based on national statistics; and women over 70 years also account for 7% of the population but account for 15% of the demand on out of hours services and only 8.5% of demand on A and E [20, 21]
- The third sector (voluntary agencies) has a key role to play in influencing help-seeking behaviours. For example, those agencies involved in highlighting awareness about meningitis have been successful in prompting earlier diagnosis. Other key groups, eg disability groups, diabetes, stroke association, miscarriage association, action for sick children and age concern and faith groups can have a key influence – but have not always been engaged in service design.



Patient and public involvement

- Patients and the public, including carers, should be involved in shaping the delivery of healthcare services. [76] This poses particular challenges for urgent care and emergency care, where, unlike almost all other areas of healthcare, there is no stable or consistent patient or service user group that can be 'owned' by urgent and emergency care. Consequently, there is no easily constituted group that can be called upon to be involved and only feedback from patients in relation to satisfaction, experience, incidents or complaints has influenced these services. The proposed local "HealthWatch" and national "HealthWatch England" groups will have a critical role in ensuring that the patients' voice is at the heart of decision making about care services. [77]

Knowledge to influence spend

- Every local health economy will have detailed financial information of what their expenditure is on various parts of the urgent and emergency care system, yet until a "programme budgeting" approach is taken for urgent and emergency care, commissioners will not fully understand the actual spend that can be influenced through different mechanisms. Twenty of the programme budget categories all have an urgent and emergency care component. [78]

Monitoring of urgent care services

- There needs to be greater attention on monitoring commissioned services to ensure they meet acceptable standards for patient safety, patient experience and the quality of care
- Current contract management mainly focuses on individual organisation's performance, predominantly acute hospitals, rather than monitoring the whole patient pathway
- Occasionally there is too much focus on the data, i.e, whether a target has been met and not enough use of data to inform improvements to care.

Education and training

- There are inconsistencies in the training of medical and non-medical staff involved in providing urgent and emergency care, such as in the provision of supervised placements for undergraduate and postgraduate training ^[79]
- There is also a lack of knowledge among staff (medical and non-medical) about the role of different professionals and the impact of different services (whether local or national) involved in providing urgent and emergency care

- Commissioners also need to consider issues relating to the development of the workforce, ranging from hospital ED (A and E) departments to out of hospital settings such as pharmacies, GP surgeries, advanced nurse practitioners, paramedics, physicians assistants and Emergency Care Practitioners (ECPs) ^[80-84]
- There is also a myriad of standards and service changes proposed by professional bodies to ensure patient safety and better use of specialists and those in training including:
 - The "Facing the Future" standards and modelling for children's services, ^[85, 86]
 - "EM Consultants – Workforce Recommendations" Consultant numbers in ED (A and E) ^[87]
 - "Emergency Surgery: Standards for unscheduled care" for emergency surgery provision ^[88]
- Finally, the role of "Health Education England" (new in the Health and Social Care Bill 2011) is likely to affect education and workforce training and availability of juniors ^[134].



A complex healthcare system

- We have a complex healthcare system with a range of professionals, eg GPs, nurses, pharmacists, independent non-medical prescribers, dentists, ambulance personnel, pre-hospital clinician's, ED (A and E) staff, specialist stroke, cardiac and trauma centres as well as out of hours GP services, minor injury units, walk-in centres, urgent care centres and 8 to 8 equitable access centres
- The most common points of access to emergency and care services in the minds of the public remain 999, ED (A and E) departments and general practice. Any service re-design needs be consistent across the country to avoid further confusion and will require an appropriate education campaign
- The development of a single point of access for urgent and emergency care with NHS 111 is a major initiative underpinned by NHS Pathways ^[89]. This is a suite of evidence-based clinical assessment content, for triaging telephone calls from the public, based on the symptoms they report when they call
- Together with a directory of services using, for example, the Capacity Management System (CMS) ^[89] which measures capacity and activity pressures in real time, patients with urgent and emergency care needs can be directed to the right service and the right professional at the right time
- The evidence from the NHS 111 pilots so far has identified gaps in locally commissioned services, which mean that people can end up being treated in A and E, eg catheter services not being available 24 hours a day. So, NHS Pathways can also be a useful commissioning tool when used in this way



- A more joined-up approach between physical and mental health services and social care is needed
- The extent and consequences of “health tourism” is poorly understood with inadequate systems to monitor or to recover costs of treatment, overall. This is particularly the case in settings of care outside hospitals for those patients not entitled to free treatment under the NHS and from countries without reciprocal arrangements
- It is estimated that around £35 million of NHS spend is due to health tourism, with tourists accessing free NHS healthcare, some of which includes urgent and emergency care. ^[59, 60, 61] There has also been a growth in maternity-related health tourism which puts maternity units under pressure ^[135]. Although a potentially sensitive subject, commissioners need to recognise the consequences of not addressing this and need to explore every area for improving services and efficiency gains.

6

The Clinical Commissioning Cycle

When commissioning services, the following cycle shows the key stages to be followed to ensure an effective and integrated process. The diagram below shows the four stages of the Clinical Commissioning Cycle as a “dynamic” process.

The four stages of the Clinical Commissioning Cycle can be broken down as follows with details in subsequent sections:

Step 1: Analyse and Plan

(What would a good service look like? Section 7)

This step examines why urgent and emergency care is important from a patient, population, service and financial point of view in order to determine what is required. (Sections 3, 4 and 5).

Step 2: Design Pathways

(What are the key enablers and what to do? Section 8)

This step examines what information or data is available about the quality, effectiveness and cost of current services (sections 3, 4 and 5), how they are used and what kind of services patients and the public need, to inform how best to design pathways of care.

Step 3: Specify and Procure

(How do we re-design, contract and procure? Section 9)

This step looks at what a good integrated urgent and emergency care service might look like, based on the local and national evidence and the processes involved in service redesign.

Step 4: Deliver and Improve

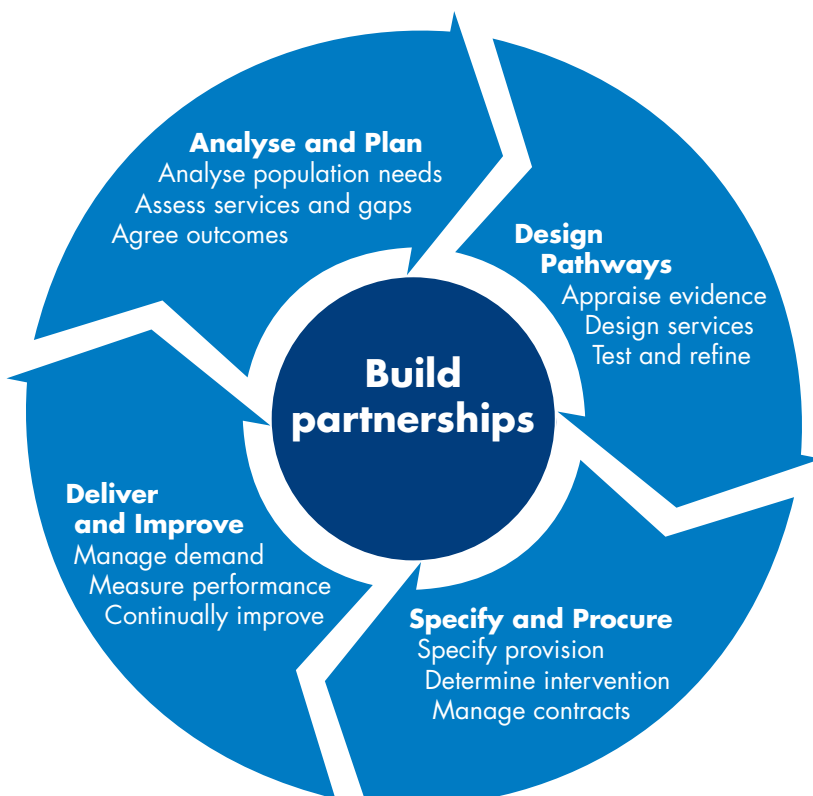
(How do we monitor commissioned services? Section 10)

This step looks at the services provided and how we can continually improve these services to ensure they are safe, of the highest quality, clinically effective, provide a good patient experience and offer value for money, as well as performing to the contract and delivering national and local quality standards.

At each stage of the Clinical Commissioning Cycle, we need to work closely with patients and the public, health and social care commissioners, the voluntary sector and other stakeholders, including providers.

How can we use the Clinical Commissioning Cycle to shape improved services?

The Clinical Commissioning Cycle



7

What would a good urgent and emergency care service look like

Based on the Clinical Commissioning Cycle and using local and national evidence, a good urgent and emergency care service may look like this:

Definition: For face-to-face urgent and emergency care

“Urgent and emergency care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly.” [7]

“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.” [8]

Although this definition relates to healthcare, a holistic approach must also include social care.

The vision of what a good service looks like involves patients and the public having access to convenient, high quality, timely and cost effective urgent and emergency care services and knowing how to access these services effectively when they require them. The aim must be for *‘Patients to be seen by the right health and/or social care professional, in the right setting and at the right time, quality and cost’*. For this to happen a paradigm shift in delivery of

urgent and emergency care is needed, with more care provided in the community, a greater emphasis on prevention and self-care and less focus on hospitals.

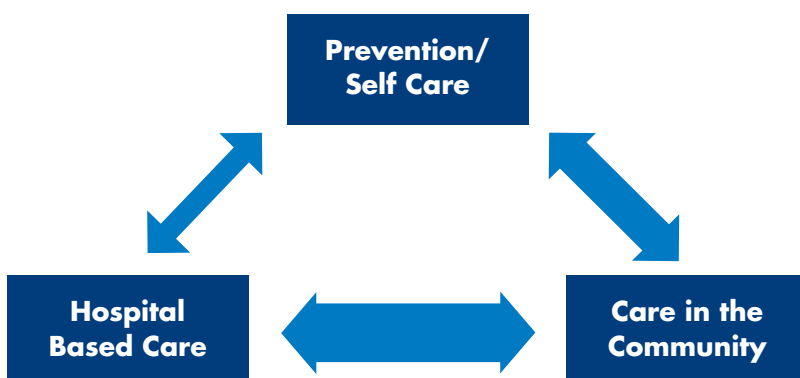
CASE STUDY

When Chester’s mum Jane needed help on a Sunday morning because she was having problems with her bowel, she immediately thought to call NHS 111 for help and advice.

Jane had heard about NHS 111 through her local newspaper. She called 111 and got through immediately. They took all her details and because Jane had previously had surgery they put her straight through to a nurse.

The nurse asked Jane for more details about her symptoms and on the basis of the information Jane gave, the nurse advised her to go to the local urgent care centre. She was given an appointment which was convenient for her and she went along and was seen very quickly.

Jane said the whole experience was fantastic because it was so easy and she was seen and back at home very quickly. She was told by the doctor at the urgent care centre to contact them straight away if she still felt ill or needed further help and was given a contact number. Jane was happy with the service and would definitely use NHS 111 again.



Achieving a good Urgent and Emergency Care System

No confusion of what to do, who to call or where to go

- 999 calls for immediate, life-threatening conditions with the patient transferred by ambulance to the most appropriate setting for care, eg stroke, cardiac or trauma centre or ED (A and E)
- Single point of access – NHS 111 – a memorable number to call when the need is less urgent than 999, providing a safe service with no call backs, and ability to pass directly to 999 for an ambulance dispatch if an emergency is identified
- Access to an up-to-date, live directory of services to direct the patient to the right



professional in the right service, first time – including immediate access to appropriate social care support to prevent unnecessary admissions. This directory of services will also help all staff know where they can refer and help commissioners analyse what is available compared to what is needed

- Adequate emergency dental service provision, integrated with the wider urgent and emergency care strategy, rather than done in isolation with sign posting from the NHS 111 service or NHS Direct in the interim
- Sign posting pharmacy provision as part of the mainstream urgent and emergency care system with greater use of pharmacists' skills and training, eg providing a minor ailments service and supporting patients in urgent need of medicines or advice relating to them
- Better links between local health services and schools, and joint working with school nurses so that school children are referred more appropriately to ED (A and E), with follow-up of attenders causing concern and more preventative and awareness raising activity
- Sign posting new immigrants, such as those from EU countries or whose first language is not English, with urgent care needs who often call 999 or go to ED (A and E) because they may not be aware of the different NHS services or how and where to access them.

CASE STUDY

Mrs Peters was 84 years old and lived alone. She developed chest pain and severe breathlessness in the night and called for an ambulance. She was taken to hospital and diagnosed with pneumonia and atrial fibrillation but with no signs of a heart attack. Mrs Peters was also very dizzy and was at risk from a fall when she was admitted. She was treated for her chest infection and her atrial fibrillation and mobilised by the occupational therapist in hospital. She was adamant that she wanted to go back to her own home. A falls team was part of the integrated discharge team and they visited her home to do an assessment. Her bed was moved downstairs and a commode was provided. Carers were arranged to go in four times a day for three days, as well as the district nurse to make sure Mrs Peters received her medication. She responded well to her treatment and was up on her feet and was much more independent in a few days. Her care package was then changed and someone from a voluntary organisation arranged to look in every other day to ensure she was alright.

Mrs Peters had been worried that she would be in hospital for a long time and that she would not have been able to go back to her own home and was grateful to the team that allowed her to stay at home and get better.

A joined-up and co-ordinated system

- Recognition and support for all carers involved in looking after patients at home. Recognition for the work carers undertake is not likely to come from the carer themselves. We know that carers find it hard to regard themselves as carers, as they value themselves primarily in terms of the relationship they have with the cared for eg mother, husband. The onus must therefore be on those professionals supporting the healthcare needs of the person with the illness or disability, to aid such recognition of the role of the carer. Support for all carers involved in looking after patients at home could be via numerous means such as training (eg emergency first aid, managing medications and medical equipment, dietary awareness), provision of respite, equipment, information and advice (eg referrals to sources of support in the voluntary and community sector) and emotional support (eg referral by GP for counselling)
- Co-ordinated care for elderly patients with urgent and emergency care needs in the community, at home, or in nursing homes, and early intervention to avoid ED (A and E) and hospital admission
- Use of the “Silver Book” standards to plan commissioning of pathways for older people (due to be published in October 2011)
- Co-ordinated care for people with long-term conditions involving care planning to maintain health and wellbeing and avoid exacerbations or complications with anticipatory care, eg Met Office COPD resources [68], falls prevention [90], Rightcare plans in nursing and residential homes [91]
- Co-ordinated end of life care to ensure the right care is available at the right time, and that the patients’ wishes of where they want to die are respected. It is particularly important to also ascertain

the feelings of the carer in this respect. Can they manage a death at home eg in terms of equipment, medication, respite, time off work, emotional support? The patients’ wishes may not be shared by the carer, therefore alternative care provision in the home will need to be arranged, or sufficient support to the carer must be given. Either way, carers must be consulted when end of life care is being planned

- Active discharge planning leading to better outcomes for patients discharged from hospital with co-ordinated **“Reablement”** services, including carer support at home. Carers must be included in planning meetings at the earliest opportunity and consideration given to additional support that may be available from within the community such as the voluntary sector. There is a danger in thinking of carer support as a given when considering reablement services for the patient. Consideration of the carers right to choose care and an assessment of their ability to care, especially if the cared for person’s needs have changed or worsened, is vital. [51,52], see “Silver Book” due for publication in October 2011



CASE STUDY

Mrs Smith is 77 years old and tends to be forgetful. Unfortunately, she had had a fall and fractured her hip. She was taken to an ED (A and E) and seen by the orthopaedic team. She was referred proactively for assessment of her memory problems by an Older Person's Liaison Psychiatry service on admission.

She received pre-operative treatment from the liaison psychiatric team and so avoided post-operative confusion. This facilitated her rehabilitation and allowed her to be discharged home earlier than originally envisaged.

- A 24/7 integrated health and social care rapid response team in every locality responsive to the needs of older people, their carers and professionals involved in their care. An initial contact by the integrated rapid response team on the telephone within one hour of the service being contacted and an appropriate rapid assessment and arrangements in place to address the older person's acute health and social care needs and the immediate support needs of dependants or carers within four hours
 - Involvement of the voluntary sector to provide 'home from hospital' services often for five – seven days of support to help people settle back at home after a fall or short hospital stay, eg preparing the home, shopping and general daily check to make sure everything is alright for those who don't need or aren't eligible for social service support
 - Reablement services are not only relevant after discharge from hospital, but also as part of the 24/7 integrated health and social care response in managing older people with acute medical needs in the community
- when clinically acceptable to do so
- Preventing the need for hospitalisation through more rapid access to homecare, better end of life management and medicines management by dedicated pharmacists in nursing homes
 - Greater use of anticipatory care pathways, eg Met office health forecasting for COPD patients, falls assessments or Rightcare. More widespread use of telehealth technologies to support risk-stratified patients in their own homes, especially to anticipate problems and to support treatment and monitoring
 - If the patients' own home is not appropriate to care for them, then either non-hospital respite or convalescence beds should be available
 - More use of "ambulatory emergency care" schemes, combined with earlier discharge and appropriate care in the community, eg for chest pain, headaches, abdominal pain, renal colic, Pulmonary Embolism (PE) asthma, falls and syncope, gastro-enteritis, asthma, gastro intestinal bleeding. ^[62,63]. This is particularly relevant for older patients who do not require admission but need ongoing treatment (eg in a Clinical Decisions Unit attached to an ED (A and E)
 - Co-ordinated medicines access at the time the treatment is required appropriate to clinical need with access to supporting pharmaceutical advice ^[45]
 - Sharing relevant clinical information with other healthcare professionals in different services involved in the same episode of care of individual patients, eg timely and informative discharge summaries from hospitals to the patients' own GP ^[146]
 - Consistent electronic clinical data recording and more integrated IT systems and reporting in different urgent and emergency care services, eg the electronic forwarding of clinical information from one service to another to avoid patients repeatedly being asked for the same information
 - Co-ordinated, accessible, timely and

high quality mental health care services, including the provision of psychiatric liaison services, appropriate links to community-based mental health services and the presence of a consultant psychiatrist in the primary care setting for urgent or unscheduled primary care led care

- Co-ordinated, accessible, timely and high quality services for children, including for safeguarding and child protection with strong links to other children’s services
- Better outcomes for patients undergoing planned hospital procedures, including reduced lengths of stay due to better planning, reduced risk of infections, complications or delays in recovery through implementation of “Enhanced Recovery” schemes [50] and on site liaison psychiatry [115].

Responsive, high quality and safe service

- Compliance with quality and safety standards, eg CQC, NICE and professional Royal College standards, eg for children [139]
- Improved patient access to urgent same day appointments at GP surgeries
- Progressing the theme of the RCGP Roadmap (2007) [92] for General Practice by developing shared resources and facilities as part of Federations of GP practices with other professionals and community services [93, 94]. Providing access to diagnostics in the community and minor illness and minor injuries services, staffed by local GPs and other appropriately trained practice staff from 8am to 8pm. With walk-in facilities to address any unmet urgent care needs of families, children, young adults and excluded groups (such as unregistered patients, homeless people, travellers and those whose first language is not English) to reduce the burden on the 999 ambulance service and ED (A and E)s
- Adopting a consistent approach to consultations through clinical audit [64],

eg in dealing with the elderly, those with learning difficulties, unwell children with a fever or acute asthma. This could equally include other health professionals, eg Emergency Care Practitioners (ECPs) and paramedics employed through ambulance trusts

- A high quality and responsive out of hours service with minimal variation and with a consistent response, regardless of which clinician is on duty, demonstrated through national benchmarks of similar services



- A coherent 24/7 urgent care service where patients get consistent treatment with patient surveys reporting high quality and responsive care in and out of hours
- Access to Care Plans through effective “links” between services for appropriate professionals providing urgent and emergency care, to improve the continuity of care
- Access to emergency dental treatment by General Dental Practitioners (GDP) both during the day and in the out of hours period
- Access to pre-hospital care which is traditionally defined as that immediately necessary (emergency) care at the scene of a medical or traumatic emergency and during transportation to definitive care.

Such care fills the vacuum when many seriously ill or injured patients would otherwise deteriorate or die at the scene or during transportation to hospital

- Appropriately “segmented” pre-hospital care including an emergency ambulance response, to treatment at the scene or in a patient’s home, staffed by emergency care practitioners, critical care paramedics or specially trained doctors and nurses experienced in dealing with serious accidents
- For patients presenting to ED (A and E), appropriately trained and competent staff, who are able to safely and effectively stream them directly to either the emergency department or an urgent care service. This could be a doctor or a nurse, whichever is felt locally to be most effective in managing the workload appropriately and safely. [95] Generalist clinical competencies would be of benefit, eg in the triage role
- Avoiding unnecessary waiting in the ED (A and E) by using an evidence-based approach and experience in the service of what works and what doesn’t [113]

CASE STUDY

Mrs Smith is 77 years old and tends to be forgetful. Unfortunately, she had had a fall and fractured her hip. She was taken to an ED (A and E) and seen by the orthopaedic team. She was referred proactively for assessment of her memory problems by an Older Person’s Liaison Psychiatry service on admission.

She received pre-operative treatment from the liaison psychiatric team and so avoided post-operative confusion. This facilitated her rehabilitation and allowed her to be discharged home earlier than originally envisaged.

- Emergency departments need to be staffed with the appropriate, recommended number of specialists in emergency medicine [87] attracting the ED tariff for patients seen. A guide to standards for children’s services in ED (A and E) is set out in the “Red Book” [132]
- The urgent care service integrated with the ED is most effectively provided by professionals with a broad range of competencies, eg doctor, nurse practitioner or appropriately trained emergency care practitioners and can attract a locally negotiated, but lower “urgent care tariff”. Joint training and governance of all these clinicians, underpinned by routine clinical audit of consultations and case mix, will allow locally agreed and locally determined workforce configurations based on local audit and outcome data
- Primary care clinicians with generalist competencies would be at risk of losing their generalist skills if they did not also have generalist roles in the community. Training placements for graduates or undergraduates with supervision is integral to the service specification such as GP registrars involved in providing an out of hours service
- Greater use of Clinical Decision Units (CDU) for adults, mirrored by type B short stay paediatric assessment units (SSPAU) [143] adjacent to ED (A and E) to help facilitate early discharge of patients
- Need for support of other services in ED (A and E). Mental health problems are common in frequent attenders and re-attenders, associated with increased risk of leaving ED (A and E) before being seen and associated with delays in leaving the ED (A and E) [115]. Patients with mental health problems frequently have a more negative experience of treatment [115]. Therefore mental health and substance misuse services need to be commissioned to support ED

(A and E) with the clinical indicators. Patients in general hospitals with urgent and emergency mental health problems (eg delirium, suicidal ideas, organic psychosis) would benefit from the same level of access to a consultant psychiatrist as they would from a consultant specialising in physical health problems [116,117,120]. All areas of the pathway need access to responsive and appropriately skilled mental health teams

- Out of hours services co-located and integrated with the urgent care service in ED (A and E) wherever this is logistically possible, eg face-to-face consultations
- Routine review of patient contacts using the Urgent and Emergency Clinical Audit Toolkit [64] wherever the patient presents, eg ambulance, ED (A and E), out of hours service, GP practice, urgent care centre, walk-in centre, GP-led health centre, NHS Direct or NHS 111
- Spread of learning across urgent and emergency care commissioners and providers from patient safety incidents, serious incidents and complaints to continually improve the service provided. Patient safety could be the underpinning element in developing clinical networks involving professionals from different urgent and emergency care settings
- Although reduced hospital admissions [114] may be an agreed outcome, this needs to be balanced with patient safety, clinical effectiveness and the appropriate response rather than admission to a ward itself as an indicator
- To support reablement and reduce the need for hospital admissions, innovative multidisciplinary approaches can be developed, eg giving GPs direct access to domiciliary care and equipment via a 24/7 social care response service.

CASE STUDY

Mrs Dean is 90 years old and lives alone. She is very independent and has lived in her own home for over 60 years – looking after herself since her husband died 30 years ago. Mrs Dean was increasingly being troubled by arthritis with joint pains that slowed her down, especially when going upstairs. Whilst having a bath upstairs one morning, she slipped and hurt her back and right leg. She called her GP surgery and was called back in 20 minutes and asked about her injuries and how she was, generally.

The GP advised her to take simple painkillers and said he would visit her in the next two hours after the end of his surgery. When the GP examined Mrs Dean, he noticed that she had bruised her back and her right leg. He did not suspect any fractures and the patient was still able to walk around, but she was in pain and could not climb the stairs to go to the toilet.

The GP made one phone call and in the next two hours the intensive support team arrived and moved Mrs Dean's bed downstairs and provided a commode. The team organised for carers to visit her four times that day and also to make sure that she had meals. After the first day, Mrs Dean was visited by a care manager who arranged for her to have a carer for the next week until she was better. Mrs Dean had previously refused to go to hospital and was pleased that things were arranged so quickly so that she could stay at home.

Safeguarding the young and vulnerable

- Urgent and emergency care settings are important arenas for identifying abuse, neglect or violence against adults or children
- There is clear guidance around procedures, training and joint working at a national and local level. It is crucial that staff throughout the urgent and emergency care system are appropriately trained to identify the risks and characteristics of abuse and understand the reporting, advice and communication systems in place locally with health partners and social services ^[144, 145]
- Child protection and adult safeguarding within health will be statutory responsibilities of Clinical Commissioning Groups and advice from the designated nurse and/or doctor on systems, training and supervision requirements should be sought in any service design.

Self-care, prevention, anticipatory care and patient empowerment

- Patients and the public need to be more confident and knowledgeable about illness prevention, self-care and self-management with active care planning included in schools, e.g St John Ambulance ^[136], British Heart Foundation ^[137] and Red Cross ^[138] for first aid training and use of defibrillators
- Anticipatory care should be embedded in the care system, eg use of health forecasts by the Met Office for COPD, Rightcare plans in nursing and residential homes, Gold standards framework and Liverpool Care pathways at the end of life. Older people coming into contact with a healthcare provider or services following a fall should be assessed for causes immediately if possible and referred to a multidisciplinary falls service
- Self-care and prevention strategies for people presenting with mental health problems should be considered, including help lines and web-based resources, eg via the Mental Health Helplines Partnership ^[131]
- Better knowledge of the NHS and its use by children and young adults who can then help their families and friends, eg the NHS Institute programme for understanding the NHS in schools. Also this group may be able to make more use of new technologies such as use of text messaging or i-phone apps to find out where to get help
- Identification of frequent callers and/or attenders, with multi-agency proactive case management, eg use of the GP/Urgent Care dash board ^[96].
- Whether it's from care homes or primary care to hospitals, or mental health hospitals to the community, or from hospitals back to primary care, these are times when the risk of things going wrong with medicines tends to increase. It is the



responsibility of all the professionals involved in the care of a patient to ensure the safe transfer of information about medicines ^[148]

Patient and public involvement

- Early involvement of patients and the public as well as more use of service experience as an indicator of how services are performing
- Improved public education and marketing of urgent and emergency care services
- Patient representation on the Boards of Commissioners and providers and involvement in clinical governance and quality review meetings both during announced and unannounced visits to service providers.

Knowledge to influence spend

- Commissioners have a more complete picture of expenditure on urgent and emergency care to be able to influence service re-design
- Better systems to monitor "health tourism" and more effective systems to recover costs of treatment from those who are not entitled to free NHS treatment
- Commissioners will need to be aware of the perverse incentives particularly those created by present commissioning of individual components and the use of "tariff"
- With more sophisticated use of "programme budgeting" for the urgent and emergency care domains commissioners will have a better basis to move towards joined-up "whole system commissioning" that is more responsive to patient needs.

Monitoring of urgent care services

- Monitoring of services needs to include the CQC and registration of providers. All providers of healthcare services must be registered with the CQC and remain compliant with the 24 Essential Standards



of Quality and Safety. Regular monitoring of this compliance should be part of the contract and NHS provided services must also be licensed by Monitor

- Effective systems should be in place for commissioners to routinely monitor services commissioned to provide urgent and emergency care as a "critical friend". With routine reporting and through announced and unannounced visits (by senior clinical commissioners) patient safety, patient experience and the quality of care, as well as how the service is organised, can be reviewed
- Quality monitoring should involve multiple dimensions, including performance against the national clinical indicators, implementation of routine local audit, eg using the Urgent and Emergency Clinical audit toolkit and peer review
- Capacity monitoring and review of resilience during different times of the day or during different times of the week or on bank holidays to ensure that the capacity meets demand and that resilience systems have been tested
- Emergency preparedness in the case of major incidents to ensure that the whole urgent and emergency care system can respond effectively, eg with major incident planning with simulations
- Understanding high volume users and ensuring common causes are understood and actions taken (eg alcohol support services)

- Education and training, to ensure that all staff providing urgent and emergency care are appropriately trained; providers need to be contractually obliged to provide supervised placements for undergraduate and postgraduate training (medical and non-medical), eg high quality out of hours training for GP trainees which includes supervision and experience with consultations on the telephone with patients with urgent or emergency care needs ^[79]
- The core competencies for out of hours GP training includes an understanding of the wider urgent and emergency care system (local and national) and an understanding of the role of different professionals in this patient pathway. Achievement of these competencies should be core to all staff in training (medical or non-medical) to promote a better understanding of the impact of different services and the role of different professionals involved in providing urgent and emergency care
- To ensure that healthcare professionals managing older patients, irrespective of clinical setting, have a generic skill set. This includes:

Knowledge and skills

- **Communication skills:** Often under challenging conditions, to take a detailed history from the patient, ability to explain things in more than one way, give encouragement, and listen attentively
- **Clinical reasoning and assessment skills:** Especially in the setting of complex co-morbidities, poly-pharmacy and altered physiological response to trauma and illness
- **Risk assessment/management skills:** Surrounding discharge planning with a good working knowledge of community services
- **Multidisciplinary team working skills.**

Attitudes

- **Compassion, empathy and respect**
- **Patience and the ability to build a rapport/therapeutic relationship quickly**
- **Creating an environment that helps develop a positive attitude towards older people.**

Local community services

- **An awareness and an understanding of local community services.**



What are the key enablers and what do we need to do?

When developing an urgent and emergency care strategy this must involve patients and the public, physical and mental health and social care commissioners, the voluntary sector, public health and other stakeholders, including providers.

The key principles of a good service include:-

- No confusion of what to do, who to call or where to go
- A joined-up and co-ordinated system
- Safe, responsive and a high quality service
- Self-care, prevention, anticipatory care and patient empowerment
- Patient and public involvement
- Monitoring of urgent and emergency care services
- Knowledge to influence the spend on services
- Integrated mental and physical health care for all.

Key enablers and levers need to be identified, including funding streams to deliver these outcomes with transformational change, e.g:

- National clinical indicators
- CQC and Monitor licensing and compliance with CQC's "Essential standards of Quality and Safety"
- Existing and developing quality standards
- Quality, Innovation, Productivity and Prevention (QIPP) programme
- Reablement funding
- GP Quality and Outcomes Framework (QoF)
- Development of an Urgent Care Local enhanced service
- Consortia development/training funds
- Residual Practice-Based Commissioning (PBC) funding
- Commissioning for Quality and Innovation (CQUIN) payment
- Provider contracts, service quality reviews and Service level agreements (SLA), eg with hospitals, ambulance service and out of hours services
- National Community Pharmacy contract.

The main enabler is Quality, Innovation, Productivity and Prevention (QIPP)

QIPP plans, including for urgent and emergency care directly and other complementary domains have already been developed for each local health economy in England. Business cases for these will have been worked up involving teams from finance, public health, PCT commissioners and clinical commissioners.

The plans will show the net efficiency savings of each scheme, taking into account levels of investment to achieve savings, including the costs of implementing the scheme itself. Given the financial pressures QIPP plans will need to be reviewed and refreshed.

Examples of approved QIPP schemes to help deliver efficiency savings as well as the desired outcomes in the urgent and emergency care strategy above could include:

- Implementation of NHS 111 and the Capacity Management System directory of services
- Improve quality, access and responsiveness of local urgent care services, eg in general practice ensuring that the care response is appropriate to the urgent and emergency care need, such as improving access to clinical and diagnostic assessment.
- Reduce demand on ED (A and E) departments through redirecting patients and monitor this through national and local key performance indicators (KPIs), using an 'Urgent Care Dashboard'

- Reduce the cost of non-elective activity, eg introduction of new locally agreed urgent care tariffs: such as basic: £35; investigation: £43; x-ray and investigation: £63 (2011 prices)
- On-site liaison psychiatry services to reduce admissions and re-attendances at the ED and acute wards
- Community alcohol workers based in EDs to reduce alcohol-related presentations.

For example

End of life: [102, 103]

- Reduce hospital admissions at the end of life
- Full roll-out of the Gold Standards Framework
- End of life care co-ordinator
- End of life quality markers, eg CQUIN

Developing the integrated discharge service at the acute trust

- Create integrated discharge posts – director and manager jointly with the local authority
- Align KPIs, eg length of stay, re-admissions, bed days lost and excess bed days
- Referral to community pharmacy for a new medicines review or follow-up post discharge.

Care homes

- Recruit pharmacists and GPs for routine clinical and medication reviews of patients in nursing homes to identify and address risks in order to avoid crises and hospital admission
- Use of telehealth technologies, eg for long-term condition monitoring and remote ward rounds, as well as development of "virtual wards" for case management for prevention and early intervention to reduce crises and, ED (A and E) attendance and hospital admission.





Mental health

- “My Shared Pathway” (national QIPP) and length of stay. This project aims to enable management of the treatment pathway to ensure appropriate/reduced lengths of stay (5% reduction for one third of patients) and proactive discharge planning to prevent readmission. Innovative approaches such as “buddying” can be scoped, that can potentially have a positive impact on engagements in treatment [100, 101].

Primary care

- Develop a community-based multidisciplinary “hot clinic” for COPD patients’ case management to reduce ED (A and E) attendances, emergency admissions, out patient attendances and length of stay (two days) [97, 98, 99]. Or, in some areas this could be through using community hospitals.

Telehealth

- Use of telehealth for patients with COPD/heart failure/adherence to medication to improve patient experience, patient awareness of their condition, improve patient outcomes, improve control of symptoms and reduce use of emergency care services
- Increase capacity of clinicians to manage larger caseloads – impact on workload of telehealth, successful triage.

Alcohol deflection initiatives

- A triage scheme operates principally at night and serves to distinguish between the “intoxicated and in need of secondary care” and the simply “intoxicated”. The former being conveyed to ED (A and E) and the latter provided with a secure setting in which to sober up [119, 124].

CASE STUDY

Mrs Marlow is 42-years-old and has not ‘been herself’ since she experienced a nervous breakdown ten years ago. She suffers recurrent bouts of abdominal pain and has called an ambulance to take her to hospital each of the last six times this has happened. Each time she spent at least two days in hospital while the doctors tried to find out what was wrong. She has refused to see a psychiatrist (which her GP has suggested). During her last admission Mrs Marlow was referred to the liaison psychiatry services as she was thought to have psychological factors influencing her frequent admissions with uncontrolled abdominal pain. Assessment by a consultant liaison psychiatrist indicated that her admissions related to a way to escape from her husband’s alcohol misuse. This enabled her GP to support her effectively. Despite six admissions for abdominal pain in the preceding eight months, she has had no admissions in the eight months following the assessment.

Targeting specific groups

- Schemes to engage and inform those whose first language is not English about local urgent care services and out of hours services, and improving access to mainstream GP practices to reduce inappropriate use of 999 ambulance services and ED (A and E).

Reablement funding

- This is additional funding available to facilitate seamless care for patients on discharge from hospital and to prevent avoidable hospital readmissions. A proportion of this funding will be used to develop current reablement capacity in councils, community health services and the independent and voluntary sectors, according to local needs. Resources can be transferred to local partners, including the opportunity to establish a pooled budget, wherever this makes sense locally ^[51, 52].

GP Quality and Outcomes Framework (QOF) 2011/12 ^[104]

- GP practices are now incentivised to take steps to avoid and reduce emergency hospital admissions

- (QP9) The practice meets internally to review the data on emergency admissions provided by the PCO
- (QP10) The practice participates in an external peer review with a group of practices to compare its data on emergency admissions, either with practices within the group, or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO
- (QP11) The practice engages with the development of and follows three agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2012
- Clinical Commissioning Groups can actively support and peer review the performance of all their constituent GP practices to satisfy their core GMS (General Medical Services) and PMS (Personal Medical Services) contracts for timely urgent care provision (between 8am and 6.30pm) by fostering “clusters” of practices or “federations” to learn, share data and experiences, and implement changes that support reduction in variation, with continual improvements in access and response to patients with same day urgent care needs.

Development of an urgent care local enhanced service (LES)

- There are examples of PCTs using local enhanced services to support the development of a high quality urgent care offering in general practice. There is a potential for overlap with core GMS/PMS contract responsibilities, therefore the governance processes need to be clear to ensure that conflicts of interest and duties of Clinical Commissioning Groups are worked through.



- This might include incentivising GP practices to develop the provision and consistency in their urgent care offering, for example, three levels of a time-limited urgent care (LES), or:
 - Implementation of Urgent Care Clinical Audit Toolkit, e.g. review of consultations could involve the management of unwell children, the elderly or those patients with learning difficulties, or those patients with specific long-term conditions
 - Implement Primary Care Foundation urgent care initiatives to improve the urgent care response of practices, eg receptionist training, capacity segmentation, prioritisation protocols to improve the urgent care response in GP practices in hours
 - Use 8am–8pm urgent care service in the community. Options include developing some GP practices in Federations of Practices, acting as hubs for community diagnostics and providing urgent care services with extended opening, offering minor illness and minor injuries services.

Note: From April 2013, the NHS Commissioning Board will have responsibility for enhanced service agreements. How enhanced services might be used in the future to support the provision of high quality urgent care can be explored by the relevant national bodies and Clinical Commissioning Groups. Real and perceived conflicts of interest will need to be managed (i.e. Clinical Commissioning Groups commissioning services from their own members). Further guidance is expected later in 2011. Also to note and take into consideration the respective roles of GPs as providers (under contracts held by the NHS Commissioning Board) and their commissioning role in Clinical Commissioning Groups where they are commissioning services from providers.



Funds for Training Clinical Commissioning Groups

- Funding to support the development of Pathfinders and Clinical Commissioning Groups at £2 per registered patient has been made available in 2011/12. Rather than just using these funds for backfill costs, Pathfinders and CCGs have been innovative in using this funding not only for Board developments but also for developing their constituent practices to deliver better outcomes
- “Distributive Leadership” enables leadership development beyond the Board of Commissioning Groups, such as the establishment of clinical, managerial and patient champions to support GP practice team engagement and development using benchmarked data, and providing direct support and encouragement for continual improvement
- Other resources could be used for training GP Practice teams on diabetes, COPD care, reviewing the care of unwell children, the elderly and those with learning difficulties and implementing the Urgent Care Clinical Audit Toolkit, etc.



Residual practice-based commissioning (PBC) funding

- Previous incentive schemes included referral and demand management as well as aspects of medicines management. Freed up funding from previous PBC Boards has been used by Pathfinders and CCGs to top up their development funds for the training of constituent practices for leadership, CPD and for the achievement of local priorities.

Commissioning for Quality and Innovation (CQUIN) payment

- The CQUIN payment enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis
- A CQUIN can be used to implement the Urgent and Emergency Clinical Audit Toolkit for routine review of consultations in ED (A and E) departments
- CQUINS are usually single measures and so risk encouraging perversity. Multi-modal CQUINS that measure outcome and experience as well as structure and process would be preferable.

Provider contracts, service quality reviews and SLAs, eg with hospitals, ambulance and out of hours services

- Working with other Clinical Commissioning Groups to contract with larger providers creates opportunities for service quality and contract performance reviews, as well as service development for desired outcomes in the urgent and emergency care strategy.

Integrated care organisations ^[106]

- These will see hospitals, local councils, community and social care organisations come together to plan each patient's care based on their individual needs. Pilots are currently underway, aiming to manage long-term conditions within the community and prevent unnecessary admissions to hospitals and nursing homes
- This model of integrated care will see GPs work more closely with hospital consultants and social care teams to develop innovative ways of caring for patients, giving them faster access to the right kind of treatment, in the right place, at the right time, with a stronger focus on their long-term needs
- Risk stratification of patients (utilising primary and secondary care data) is essential to support this work
- Approved social worker services with responsibility to the emergency department and acute hospital wards should be an integral feature ^[115].

How do we re-design, contract and procure services?

Once a “strategic whole system and outcome focussed 24/7 integrated urgent and emergency care strategy” has been developed (covering both in hours and out of hours) and key enablers and levers identified, commissioners will need to consider whether the current service is able to deliver. With the urgent and emergency care strategy driving the process, services can be maintained or improved or new services commissioned.

A service specification will need to be developed for any changes. NHS contract variation allows some flexibility, avoiding the need to go out to tender automatically. Most contracts with the main providers, eg hospital trusts and ambulance services, have been rolled over with contract variations in the past. However, the need to make efficiency savings poses significant challenges to providers.

To tackle the financially challenging future, commissioners must be bold and decommission those services that are not meeting patients’ needs effectively, both systematically and responsibly. With a clinical case for change, service re-design can then provide services which are more responsive to patients, avoiding the need for cuts or the perception of cuts. This will

inevitably be difficult when the local population are apprehensive about changes. Local buy-in from opinion forming leaders and stakeholders, especially GPs, hospital trusts, local authority, local government and MPs is essential.

Active Health and Wellbeing Boards provide new opportunities by involving local voluntary organisations and patient groups. The clinical case for change has to be evidence-based and robust and one that can be articulated by clinicians in hospitals or the community to be convincing, eg with the successful reconfiguration of stroke, cardiac, cancer and trauma services in many areas.

Major new service developments, eg NHS 111 requires detailed business cases. However, for NHS 111, the specification has been developed nationally for consistency.

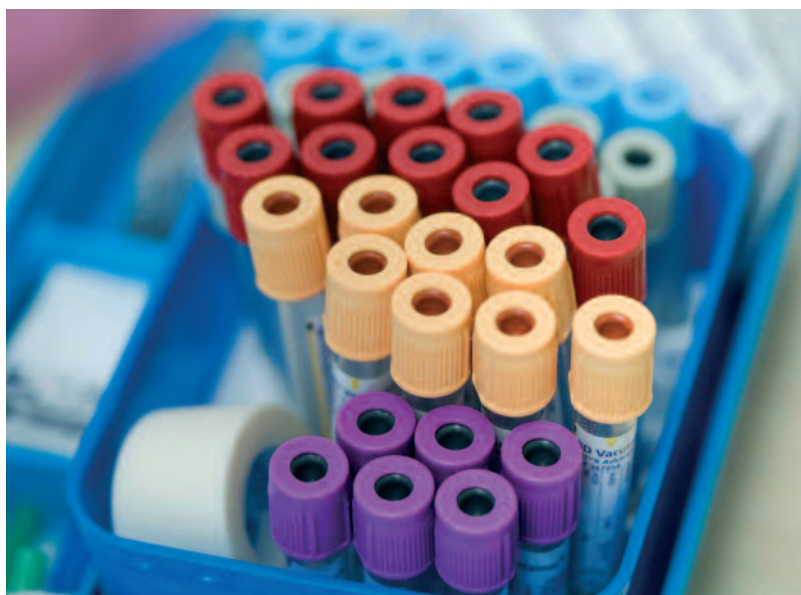
The NHS 111 development as a single point of access for urgent care provides the opportunity to review the urgent and emergency care pathway and decide if the current services need to be delivered differently.



Taking a strategic view, commissioners may decide that the best option is to re-design the whole of the urgent and emergency care provision.

Starting with a pilot “care pathway”, quality indicators, integrated governance and information flows can be developed so that the patients’ journey is seamless. Incorporating learning from the pilot the whole 24/7 urgent and emergency care pathway can then be procured, encouraging collaboration between different providers with contractual levers to put patients at the centre with a focus on safety as well as clinical and cost effectiveness.

There must also be a move towards more local joint commissioning of physical and mental health, learning disability services and social care (with equity of access for mental and physical needs).



Depending on when contracts are due for review, commissioners may wish to procure a significantly different but a joined-up urgent and emergency care service in its specification. The procurement might therefore involve one or more services with different providers promoting integration of service delivery but using competition to drive innovation, e.g:

- To introduce streaming at the point of first contact with patients provided by competent healthcare professionals 24/7, 365 days of the year, to either the emergency department or an urgent care service
- Different centres providing urgent care in the community, including shared facilities and resources as part of Federations of GP practices involving other professionals and community services
- The call handling function of the out of hours service integrated into NHS 111 with the face-to-face element integrated with the urgent care provision in ED (A and E)
- Commissioners can also work closely with ambulance providers to develop alternative ‘hear and treat’ and ‘see and treat’ services
- An urgent care procurement bidder “marketplace” event can be held to test the market before procurement. The next stage in the process involves outlining the service specification, provider standards for scrutiny and timelines for procurement and the competitive invitation to tender. Rather than being awarded a block contract, “any willing or qualified providers” could be paid on a per-patient basis with appropriate checks and balances in the contracts to deter “gaming”.

How do we monitor commissioned services?

Once a new service is commissioned or the contract for an existing service renewed, it is important that good commissioners continually monitor the services they have commissioned

- to ensure they are safe, of the highest quality, clinically effective, provide a good patient experience and offer value for money
- “Any qualified provider” must pass registration and inspection reports and CQC feedback through quality and risk profiles ^[133]



- Lessons from high profile national investigations involving urgent and emergency care and out of hours services suggest that commissioners must not solely rely on reporting to assure themselves of the safety and quality of a commissioned service
- Commissioners and providers must thoroughly understand the information and data which they are presented with to ensure this reflects the urgent and emergency care pathway and the patient journey

- Commissioners in collaboration with providers should also conduct announced and unannounced visits to the service for more robust assurance and act as a “critical friend” to providers
- Commissioners can only gain a better understanding of a service by “walking the pathway” and seeing first hand how the service operates gaining valuable insights from both staff and patients
- Full use of the NHS contract management levers is critical, including robust key performance indicators, thresholds, penalties, incentives (CQUIN) with supporting schedules for information, finance and service development
- Audit should be used routinely as a source of data by commissioners to assess compliance.

Working with patients and the public

- There is no easily constituted group of patients and the public to involve in shaping the delivery of urgent and emergency care. The implementation of a published guide for involving patients and the public in the early and ongoing development of urgent care services will help to address this issue ^[76]
- Strategies for involving children have been described, eg children and young people’s participation in health services ^[140]. Also due for publication are patient reported experience measures (PREMs) in children ^[141]
- Engagement of emerging “HealthWatch” both locally and nationally will add to the patient voice in providing feedback and also in the planning and delivery of services
- GP Quality and Outcomes framework 2011/12 offers another avenue to involve patients through a patient reference group
- Health and Wellbeing Boards offer an additional opportunity to engage with the public on urgent and emergency care services.



- Community pharmacies are now a leading provider of emergency contraception for young people who may not access traditional services, commissioned as locally enhanced services
- The most important part of an urgent care strategy involves the NHS 111 development as a single point of access for urgent care – coupled with a live directory of services with the Capacity Management System (CMS). A memorable number to phone and the ability to direct patients to the most appropriate service, and even make appointments for them, will inevitably lead to addressing health inequalities through better access to appropriate urgent and emergency care services and better use of resources.

Targeting hard to reach groups

- Hard to reach groups, including the homeless, travellers and those whose first language is not English, have traditionally accessed urgent and emergency care services erratically, and have often used the 999 ambulance service or by presenting to an ED (A and E) as a default for all their healthcare needs. Other groups, eg those with learning difficulties or those with mental health needs also need better sign posting to address their urgent care needs
- School children attending ED (A and E) inappropriately are potentially a hard to reach group, so there is a need to strengthen links with schools, school nurses and health visitors who can reach families more easily than others




The role of primary care in the delivery of the urgent care pathway

Primary care has a central role to play with ill-health prevention, self-care, anticipatory care, early intervention, enhanced recovery and reablement

- To make a real difference to the urgent and emergency care system, it is essential that primary care is strengthened with redirected resources as well as new ways of working, eg more widespread use of telemedicine and telecare to free up capacity in the current system
- Primary care is pivotal in the delivery of urgent care, with GP practices providing the bulk of the urgent care response ^[107-111]. Improving both the access and the urgent care response to same day urgent requests in general practice and reducing variation is key to influencing patients' attendance at ED (A and E) and hospital admissions
- Implementation of the "GP Urgent Care Dashboard" will identify patients who are multiple service users and those who are high volume users. Real-time data will show how failure of the urgent care services to get it right first time can result in multiple contacts with different services. It will also provide information about whether NHS 111 is getting it right and if advice is being followed
- Integrated with social care and nursing teams in the community plays a vital role in supporting independent living, especially the frail and elderly with multi-morbidity
- Risk stratification of the long term conditions population and systematised care planning and self management. Together with specialist nurses and other professionals with the appropriate competencies eg ECPs (Emergency Care Practitioners) as part of an integrated team, involving social care can contribute
- Palliative care teams in the community, integrated with social care, are integral to support the end of life pathway and in caring for patients outside of hospital for adults and children ^[142].
- Community pharmacists support emergency repeat medication requests and access to urgent medication as a vital role within an urgent and emergency care pathway
- Community children's nurses working across primary care, secondary care and schools can help children, parents, healthcare professionals and schools to have confidence with self-care for minor illnesses and ensure more appropriate use of health services including attendance at ED (A and E)
- The business model, capacity and capability of general practice needs to adapt. In particular to improve GP access, as well as the urgent care response of practices for same-day urgent appointments requests. Commissioners also need to address the consistency and





continuous quality improvement of general practice with CPD programmes and incentives for better quality and better outcomes

- Federations comprising GP practices and other professionals and community services working together could share facilities and resources, eg with community diagnostics, to respond to the urgent and emergency care demand for same day urgent appointment requests and also to use CPD to address the variation and quality of general practice
- Reducing hospital admissions, emergency readmissions and length of stay for older people in particular is increasingly recognised in social care as being a significant factor in reducing or delaying admission to residential and nursing home care
- The provision of domiciliary care to support increasing numbers of older people to live at home needs to be supported by awareness training on the value of avoiding and preventing emergency admissions where possible.

CASE STUDY

John is 79 years old and has been diagnosed with inoperable stomach cancer. He knows that any treatment he receives will be palliative alone, and this is proving harder for his family to accept than himself. John has put his affairs in order, including making an advanced directive about being resuscitated and where he would like to end his days. He does not want to die in hospital. He wants to die peacefully at home. His GP and palliative care team are supporting John and his family.

John's condition deteriorates markedly and he is in pain. His medication is adjusted to make him more comfortable, however, it means that the John that everyone knew is "not there" due to the effects of the sedative drugs he was administered.

One Friday night, John begins coughing and sweating, with difficulty breathing. His family call the out of hours doctor to visit. The doctor does not know John and suggests that he has a chest infection and that antibiotics would help if only to make him more comfortable. There was no 24/7 palliative care service and the out of hours GP suggests if John does not begin to settle he might need to go into hospital. The family were divided about this suggestion, however, John's wishes prevailed and he was kept at home.

In the early hours of the morning John became very restless and looked distressed. One of his relatives panicked and called for an ambulance. The ambulance arrived quickly and the paramedics assessed the situation and suggested the out of hours GP be called again. This time the out of hours GP was John's own GP (who he had known for over 20 years) and was fully aware of John's wishes. The GP gave John medication to settle him until later in the morning when the palliative care consultant could visit and advise the team on helping John die with dignity in a place of his choice.

General practice is well placed to improve the quality of care

- Improving both the access and the urgent care response to same day urgent requests, eg through rebalancing practice appointment capacity, receptionist training and other measures
 - Implementing the Urgent and Emergency Care Clinical Audit Toolkit to review individual clinical consultations to support reflection and continual improvement
 - Utilising CPD to maintain and develop skills and competencies of GP practice teams for care planning in the care of people with long-term conditions, eg diabetes and COPD to avoid ED (A and E) attendance and hospital admissions
 - Developing Federations of practices to develop shared resources and facilities, including diagnostics in the community with functional links with social care and other stakeholders to make best use of resources to provide accessible services to meet the needs of specific populations closer to home, eg unwell children under five years, young adults, elderly, acutely mentally ill, homeless, travellers and those whose first language is not English
- This approach will put the concepts in the “*RCGP Roadmap: The Future Direction of General Practice*” (RCGP, 2007) into practice to support the transformation of the urgent and emergency care pathway, i.e:
 - Improving health and equity
 - Quality and safety systems
 - Early diagnosis and problem definition
 - Teaching and research
 - Comprehensive and accessible services
 - Aggressive long-term condition management
 - Navigation and integration of care



The vision for Commissioners of a 24/7 urgent care service will be markedly different from what we have been accustomed to. Patients do not have problems that fit neatly into time periods and if we are to be truly patient-centered then only a 24/7 approach is appropriate.

The “whole system” is considerably bigger than most professionals may have imagined and the relationships and interdependencies can be better managed by developing the helicopter view over the wider system of urgent care provision so that it can become more joined-up.

Commissioners are faced with many challenges which can begin to be addressed as urgent care services and professionals work towards common goals leading to greater consistency in accessing individual services; quality and safety embedded in a culture of improvement and focused on the clinical needs of the patient; better patient experience; greater integration between services; and value for money within the confines of the NHS budget.

Aim to commission for avoidance of urgent and emergency episodes by:

- Primary prevention
- Anticipatory chronic disease management
- Pre-arranged contact details in case deterioration occurs, anticipating hot or cold weather spells
- Co-ordination with social care, early or frequent readmissions
- Support for carers and planned respite breaks
- Having a plan for the terminal phase well in advance, understood by all, and sticking to it
- If the emergency case is a notifiable disease, or has possible public health implications of a chemical, biological or radiological nature, don't forget to alert the Local Health Protection Unit (part of Public Health England from April 2013)
- Walk through the patient pathways from various imaginary scenarios such as those listed below, and ask the questions from the next list. (Note: these are listed by Department of Health "programme budget" categories to facilitate assessment of where urgent care fits in the overall programme and balance of investment on this step versus other steps).

Illustrative scenarios. "Does your commissioning cover:

- 1** Infection: Meningitis; febrile traveller from abroad; influenza
- 2** Cancer: New suspected case, complications of treatment
- 3** Blood: Acute bleed in haemophilia patient, sickle cell "sickling" crisis
- 4** Endocrine: Diabetic hypoglycaemia or ketoacidosis
- 5** Mental health: Acute psychotic episode; alcohol binge; self-harm
- 6** Learning disability: Are their special needs met in each scenario?
- 7** Neurology: Epilepsy
- 8** Vision: Acute red eye; trauma or foreign body; sudden loss of vision
- 9** Hearing: Sudden loss of hearing; acute earache (especially children)
- 10** Circulation: Heart attack; brain attack (stroke)
- 11** Respiratory: Acute exacerbation of chronic obstructive lung disease; acute epiglottitis
- 12** Dental: Toothache, abscess or trauma
- 13** Gastrointestinal: "Acute abdomen" such as appendicitis; upper or lower gastrointestinal bleeding
- 14** Skin: Burns, pemphigus



- 15** Musculoskeletal (non-trauma): Acute exacerbation of juvenile or rheumatoid arthritis
- 16** Trauma: Fall, with or without fracture; major trauma as in road accidents
- 17** Genito-urinary: Acute retention of urine; threatened or actual miscarriage; sexually transmitted infection
- 18** Maternity: Emergency contraception; childbirth; post-partum complications
- 19** Neonatal conditions: Neonatal special care and intensive care
- 20** Poisoning and adverse outcomes: Adverse reaction to medication, accidental ingestion of poison
- 21** Social care: Acute collapse of carer support (patient themselves not needing hospital).

(Note: Programme budget categories 21 “healthy individuals” and 23 “Other” have been omitted from this list).

Questions to ask in each scenario:

Is every step in the patient pathway, and not just the emergency response, understood and provided for?

Is our planned proportion of spend on urgent care in each programme appropriate?

Do patients, especially those with known or predictable risks, know what to do and who to contact?

Do carers have the same information and understanding?

Does everyone in the primary care team know the appropriate first point of referral in the various scenarios?

Is the role of the paramedic and ambulance contract used to best advantage?

Is the hospital contract fit for its role?

Are the appropriate elements of the contracts with providers clear, with respect to cost, expected volume, and specification? For example, are the outcomes, including patient experience, clearly stated, collected and reported and acted on?

Is there a feedback loop built in to general practice, so avoidable trends are identified and acted on?

Is there collective audit and governance review at least annually?

(Acknowledgment: Dr Peter Brambleby, Joint Director of Public Health NHS Croydon and Croydon Council).

Appendix B

Improving access and the management of urgent care in general practice

There have been many attempts to improve access in general practice including the Primary Care Collaborative that was widely implemented across England. The GP practice is the first place that most people go when they have a health problem.

Nationally, about 100 million same day appointments per annum are made across around 8,200 practices throughout England.

A small change in general practice can have a significant impact on flows to other parts of the urgent care system. Effective and timely responses in general practice benefit patients and reduce acute referrals to Hospital. Ensuring general practice develops a rapid and effective response in every practice should be a fundamental part of every urgent care strategy.

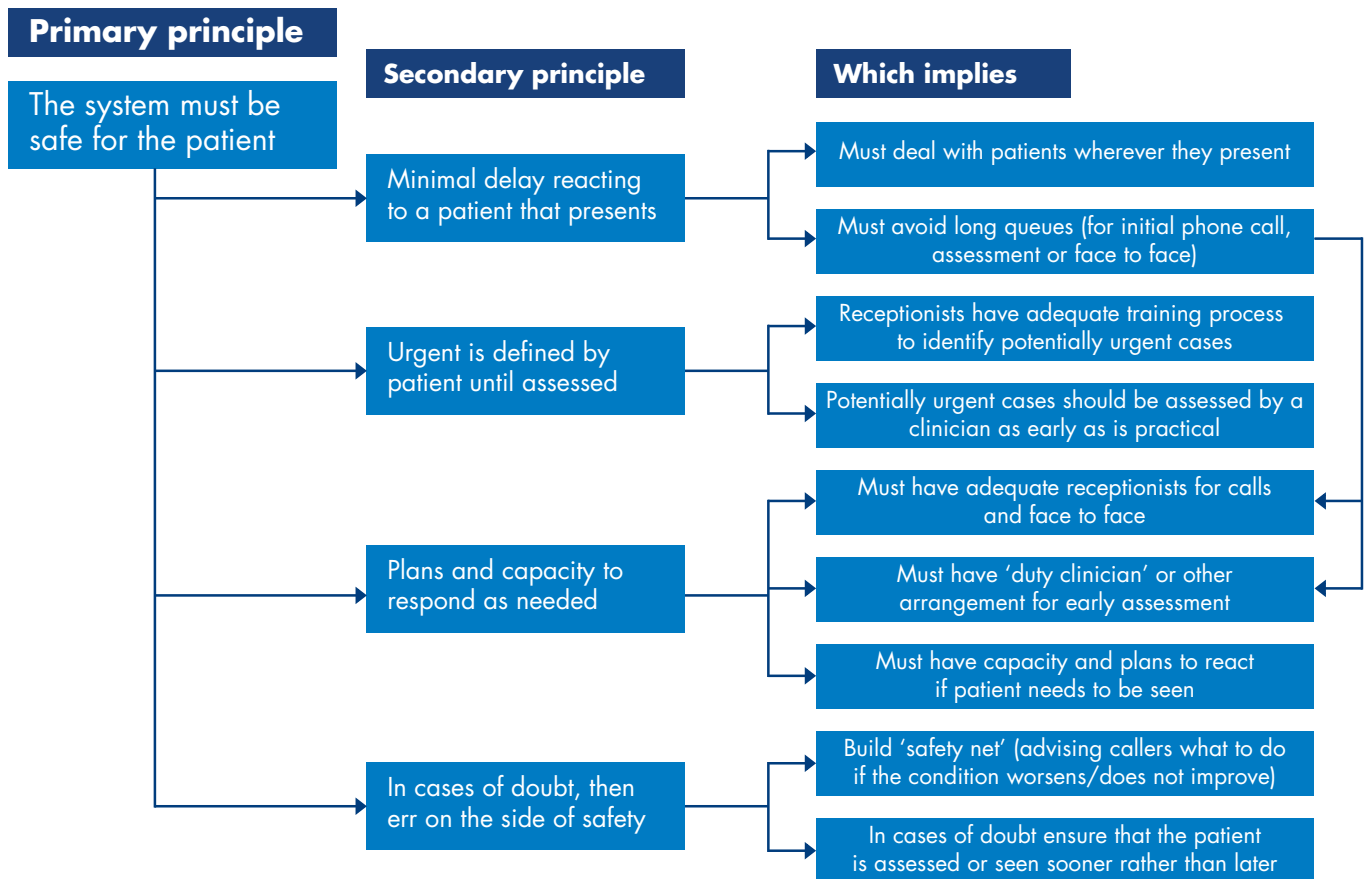
More recently, there has been an increasing focus on the management of urgent care in general practice, after a long period during which the management of long-term conditions was seen as a much greater priority.

In May 2009 a report 'Urgent Care in General Practice' commissioned by the Department of Health and with the widespread backing of the profession was sent to all practices, PCTs and SHAs in England (for the full report, visit: www.primarycarefoundation.co.uk/what-we-do/urgent-care-in-general-practice).

The report from the Primary Care Foundation encouraged practices to take a fresh look at the barriers to effective access by focusing on patients requiring same day care with potentially urgent needs and highlighted a series of principles, described below. Most people requiring urgent care make first contact with the NHS through general practice and it remains the best opportunity for rapid intervention, reducing the need for hospital care.



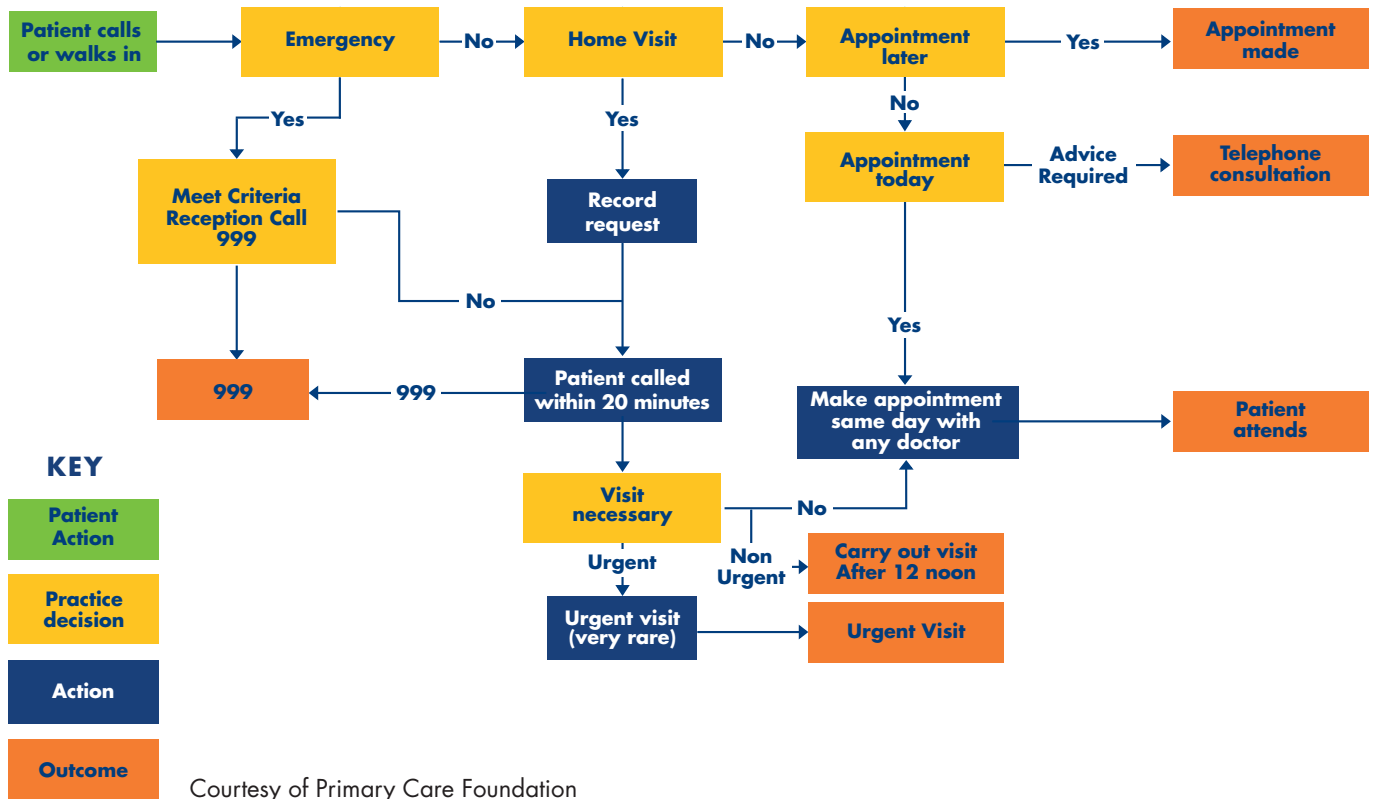
Developing the principles for urgent cases presenting in general practice



Courtesy of Primary Care Foundation

More recently, the Primary Care Foundation has developed a web-based tool that analyses practice data, compares key indicators, offers practical suggestions for improving care in the practice and a learning tool for reception teams. Many practices have found that they can modify their process and how staff and appointments are utilised so that they offer improved service with a lower number of appointments. They work smarter rather than harder. The most important outcome for many is to improve continuity and a patient's ability to access the doctor of their first choice, first time, reducing re-attendances.

Research evidence has shown improved continuity reduces the number of acute admissions. The process is improved by a follow-up session in the practice and the opportunity to access ongoing advice and support. The aim is to automate reporting to the point that it is simple for the practice manager to submit data for regular reporting to monitor progress in improving access and care.



Two aspects that many practices have found particularly helpful are:

- Allowing the patient to make the judgment over whether the case might be best dealt with through a telephone call. It seems that patients are generally good at judging whether the episode is likely to be successful by phone so that the percentage of cases where both a telephone call and a face-to-face consultation is required is relatively small, avoiding the 'double consultation' that many practices find is the burdensome result of other telephone consultation approaches

- Focusing on early assessment of home visits. Studies have shown that those requesting home visits are much more likely to be admitted and the advantage of early intervention is not just that it provides the opportunity for treatment before the condition deteriorates further, but it also reduces the chance that the delays in primary care and transport mean that the ill patient arrives at the hospital just as the majority of staff are going home.

(Acknowledgement: Rick Stern, Primary Care Foundation).



Appendix C

Integrating Urgent Care – NHS Pathways – Capacity Management System (CMS)

NHS Pathways and the CMS Directory of Services is a suite of tools specifically designed and built for:

- Consistent, evidence-based clinical assessment across all telephone access points regardless of when or where the patient calls, at the first point of contact. This can include 999, GP out of hours, local single point of access, NHS Direct and NHS 111
- Early identification of emergencies and dispatch of ambulances from all telephone access points. The tool provides the call handler with pre-arrival advice for the patient, relevant interim first aid instructions when needed and a scene safety check for the paramedic crew
- Effective identification of the care each patient requires and if an ambulance is not required the tool accurately matches the clinical needs of the patient with a local service that is available, with the appropriate clinical skills within the required timeframe required to treat the patient
- Completion of assessment and referral on the first call for most patients, reducing the need for call backs. The system also fully supports clinicians using the clinical assessment tool and the directory of services, although it is shaped to ensure they only become involved in calls that require clinical input to determine appropriate care for patients
- A whole system approach to managing urgent and emergency care.

NHS Pathways is an NHS-owned tool, built and maintained by NHS clinicians. It is led by a team of doctors and nurses with strong experience in telephone triage and urgent and emergency care delivery. NHS Pathways is governed by an intercollegiate National Clinical Governance Group, chaired by the RCGP. This means that clinical priorities and the referral timeframes set within the system for any given condition are based on the latest evidence and are controlled by the national clinical community.

The combination of the NHS Pathways clinical assessment tool and directory of services brings significant new functionality when used on all calls from the public seeking urgent or emergency care. This includes:

- A consistent clinical assessment governed by the relevant Royal Colleges and professional bodies
- An accurate matching of individual patients with a service that has all the clinical skills required for definitive care
- A structured format for gathering information on the clinical skills offered by each service across the health economy.

Note that NHS Pathways only determines a level of care and a timeframe (for example primary care in two hours), along with the clinical skills needed. It does not determine a location of care, or the type of clinician required. The location of care for any given patient is determined locally via the directory of services and dialogue with the patient.

Every search made on the directory of services is recorded and it is possible to build up an automatically extracted picture of the clinical skills needed, by time of day and post code. This also shows which services missed out on a referral due to opening hours, specific unavailable clinical skills, or boundaries of services.

This means commissioners are able to continually review, determine demand and supply and shape service provision in their health economy by:

- Removing any duplication of service provisions
- Enhancing existing service provisions – through small changes to opening hours, or skills provided, to reflect more accurately the needs of the population and maximise the cost efficiency of delivering high quality appropriate clinical care
- Commissioning new services that are currently in demand but not available to specific health economies
- Determining trends in usage of services, eg winter colds and coughs, spring-time hayfever, childrens' accidents during summertime school holidays. This will allow commissioners to prepare for seasons.

NHS Pathways has been academically evaluated* and was concluded to be 'safe and appropriate'.

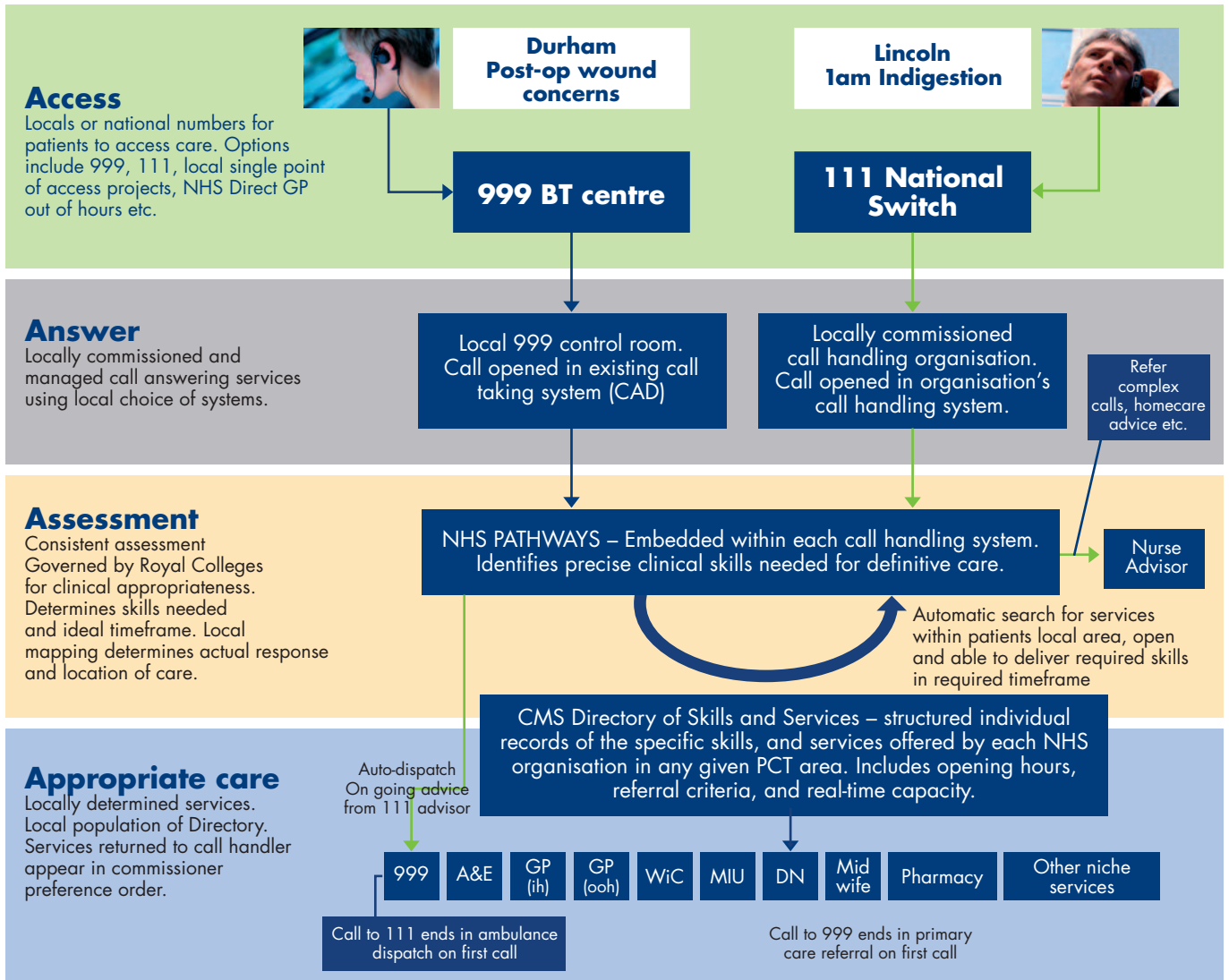
NHS Pathways has also helped to generate an average 7% net reduction in emergency department attendance in County Durham and Darlington** . This is due to limited call backs, and patients being referred to appropriate care on first contact. The cost per call** is much lower with no reduction in the quality or effectiveness of care for the patient.

*An evaluation of the accuracy and safety of NHS Pathways, 2008

<http://www.parliament.uk/deposits/depositedpapers/2009/DEP2009-0605.doc>

** Evaluation of NHS 111 pilot sites, first interim report, 2011

http://www.shef.ac.uk/polopoly_fs/1.44100!/file/NHS111finalinterimreport.pdf



(Acknowledgment: Jackie Shears and Dr Peter Fox, NHS Pathways)

Appendix D Ambulance Service Commissioning

Nationally, ambulance services cost around £1.9 billion each year but have an impact on around £20 billion of NHS spend on emergency and urgent care, through associated ED attendances and admissions – so, it is essential that the commissioning models for ambulance services are right. The potential of ambulance services is still not widely understood, as it is still viewed by many as fundamentally a transport service, whereas the majority of interventions are for urgent (not life-threatening) calls.

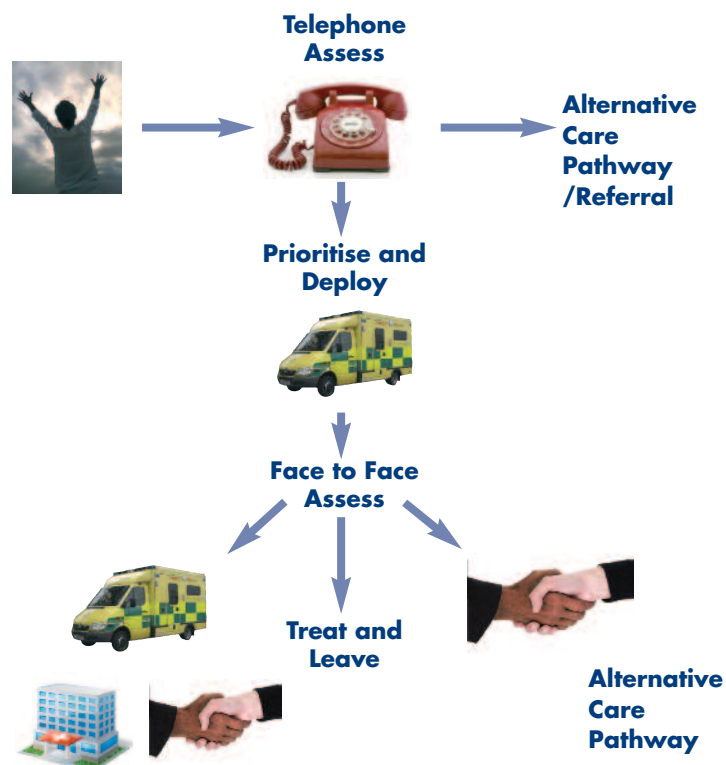
Ambulance services – a lever for change


In the context of a financially challenged NHS, the role of the ambulance service as a lever for change is significant:

- **Reduced conveyance** to hospital leading to reduced A and E attendance and potential admission
- **Reduced duplication** through use of NHS Pathways and Directory of Service
- **Internal efficiencies** within the service from the change to outcome indicators
- Focus on **outcomes** not processes.

The National Audit Office's June 2011 review of ambulance services, supports this with key recommendations for a more integrated urgent and emergency care system, and delivering significant overall savings.

"...There is scope across the urgent and emergency care system to make more of different ways of responding to patients, such as clinical advice to callers over the phone and taking patients to minor injuries units rather than A&E departments. The NAO estimates that if all 11 Ambulance Trusts adopted the best practice currently being used in at least one trust, this could save the NHS £165 million a year..."





It is critical that for urgent and emergency care quality, innovation, prevention and productivity plans, they should recognise the central role of the ambulance service. A short summary of examples identified below:

Quality

- Older people and those with chronic conditions are major users of emergency and urgent care. Ensuring that care plans are used, will improve clinical outcomes and patient experience
- Developing specialist pathways (stroke, trauma, cardiac) to improve outcome of care.

Innovation

- Establishing new pathways for patient care
- Extended skill development for paramedics to “see and treat”, including prescribing.

Productivity

- Ambulance services responding differently, with less multiple sends (in some regions there are on average 1.8 vehicles attending each incident)
- Less A and E attendances and admissions by less conveyances (through “see and treat” and “see and refer”).

Prevention

- Reducing incoming call demand, including identifying root causes
- Handling and responding to the calls differently – more “hear and treat” and use of the new 111 – non-emergency number, with the underpinning directory of services.

Ambulance service commissioning

Ambulance commissioning will continue to be managed on a collaborative basis. Currently, a lead PCT or cluster of PCTs commission emergency ambulance services on behalf of all PCTs in the region covered

by each ambulance trust. In the new commissioning structures, this responsibility will be hosted by a CCG or other pan-regional body. Associate commissioners (in the future Clinical Commissioning Groups) will continue to be involved either directly or via a locality structure in the larger areas.

To help inform the discussion as a result of recent policy developments, the Ambulance Service Network (ASN) and the National Ambulance Commissioning Group (NACG) produced a joint discussion paper which sets out some shared key messages about the future models for ambulance services, including the different roles of an ambulance service (local urgent care, 999, 111, emergency preparedness, patient transport) for the consideration of policy makers and GP commissioners.

Expert support

Dedicated ambulance commissioning expertise supports all clinical commissioners to challenge and influence the urgent care system in respect of the developing role of ambulance services. The National Ambulance Commissioning Group (NACG) is a forum for the lead commissioners, under the umbrella of the PCT Network in the NHS Confederation, and they have developed a shared strategic direction ‘Achieving Integrated Unscheduled Care’. This provides a more detailed overview of the current and future context within which commissioners of ambulance services do and may work, and aims to promote understanding of the benefits, enablers, challenges and outcomes of the implementation of integrated unscheduled care.

Clinical commissioning cycle

The full clinical commissioning cycle requires the lead commissioner to work closely with local commissioners on needs analysis and ensuring that the strategic direction supports urgent and emergency care improvement. Service development focuses on pathway

design to support QIPP improvement, such as appropriate alternatives to emergency departments for ambulance crews.

Commissioning for quality

Each ambulance contract will have a Clinical Quality Review Group, which should have clinical representation from Clinical Commissioning Groups, led by a clinical lead from the host PCT or CCG. The key function is to review the quality of the ambulance service, support the service development agenda, and shape the CQUIN. The areas for further development will include new care pathways, and involvement in integrated care, in particular between primary and secondary care.

Walk the walk

All interested clinical commissioners should consider visiting their local ambulance service control room, and going out on a "ride along" with an ambulance crew. This experience will help inform and guide effective commissioning, through improved understanding of the significant opportunities and challenges of the ambulance service and its interaction with the wider urgent and emergency care system.

Key performance indicators

Ambulance performance is nationally assessed, and a new outcomes framework started in April 2011.

Timeliness of care will still be an important factor – as it is not acceptable for unnecessary delays in care to increase, but crucially time will not be the only factor. Importantly, the ambulance clinical quality indicators will improve the quality and safety of care by focussing on those groups of patients who need the most urgent care rather than according to the category of the call alone.



Rural versus urban performance

It is important to understand that current ambulance performance standards are set at a regional basis, rather than by each PCT or clinical commissioner. The role community responders play is important in helping deliver a fast response in rural areas.

Responsible commissioner

The responsible commissioner (and funder) for all ambulance incidents is the defined geographical location of the PCT or Clinical Commissioning Group's, not the patient's registered GP practice.

(Acknowledgement: Neil Kennett-Brown, Director of London Ambulance Service Commissioning, Strategy Lead for National Ambulance Commissioners Group).

- 1 Transforming Ambulance Services**
http://www.nao.org.uk/publications/1012/nhs_ambulance_services.aspx
- 2 Tackling rising demand', DH 2009**
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106925
- 3 DH 111 guidance**
http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/DH_115054
- 4 Ambulance Commissioning – compelling vision**
Ambulance Service Network/NACG
- 5 Achieving Integrated Unscheduled Care**
Ambulance Service Network/NACG

Appendix E

Commissioning an integrated emergency department (A and E)

Background

Emergency departments (EDs) or accident and emergency (A and Es) have seen steady rise in attendances. Causes for this are multifactorial, including patient expectations, 24/7 predictability of ED response and non-uniform, unpredictable response from all other components of the urgent and emergency care system, with significant variation in services offered since 2003/04 when the statistics also started including such figures as from those from walk in centres and minor injury units.

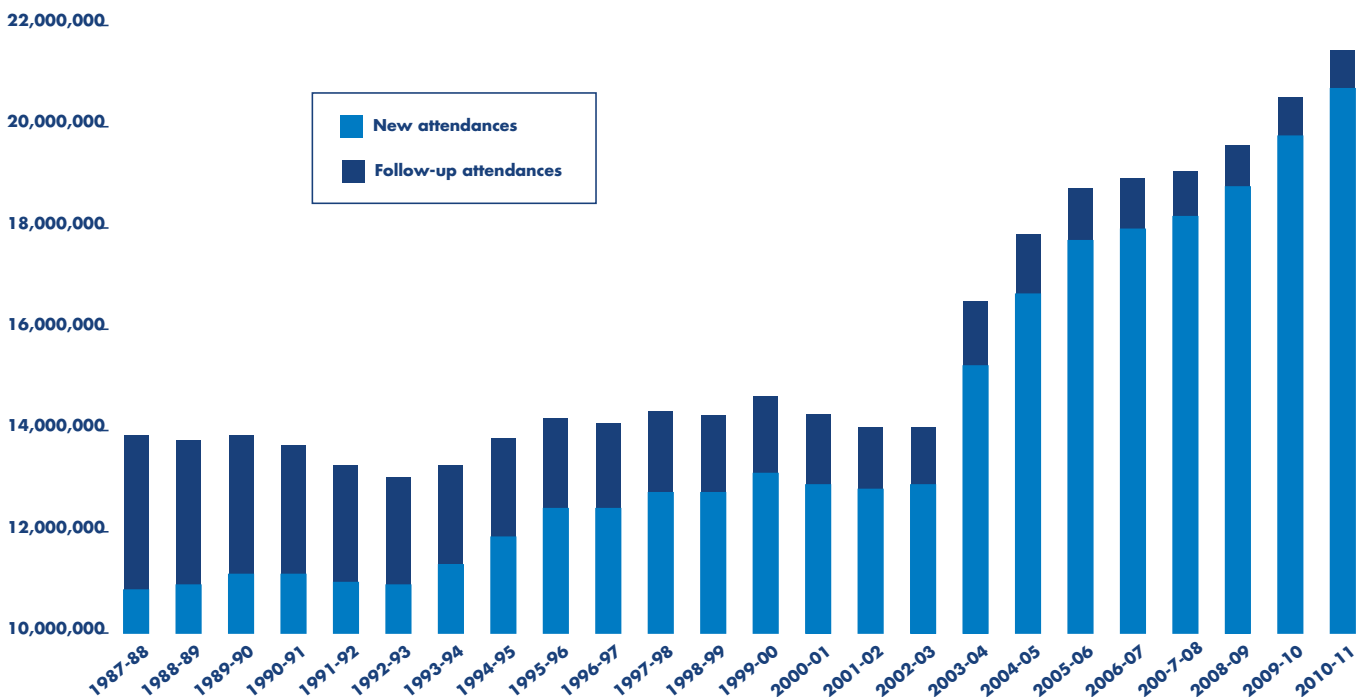
EDs deal best with emergencies – competencies, skills, attitudes and resources are already part of the system to care for serious and potentially serious illness as well as all kinds of injuries. They are good at discharging people and are the front door to the hospitals.

GPs deal best with urgent care, excluding some minor injuries and with their traditional expertise in chronic disease management form the “gatekeepers” to the hospitals.

GPs and ED doctors are “quality assured” via professional regulations and well defined national competencies. The framework is not as robust for many other professional groups increasingly employed in different settings within urgent and emergency care to deliver diagnostic management to patients.

Demographics with increasing numbers of older people are beginning to present a different challenge across the urgent and emergency care system requiring competencies, skills and attitudes not present in much of the existing workforce.

Emergency Department Attendances – England 1987-2011



Training and development, although paramount to ensure sustainability and help prepare for the future, cannot solve the current problem – integrated models of care are required to tackle this. This will help build on the strengths of the professional groups and shield their weaknesses.

ED patients are a self-selected group of attenders who have a higher prevalence of serious diseases than the group going to their GP, hence the commissioned model needs to acknowledge this and procure with reference to patient safety.

Why not maintain separate ED and Urgent Care Centre (UCC)?

- The main drivers behind many of the initiatives to introduce primary care services into and adjacent to emergency departments were based on the notion of achieving cost savings, educating patients, to meet the needs of patients that came to EDs and the four hour target. (Primary Care and ED, Primary Care Foundation, 2010)
- Surveys have shown that the responsibility for the process by which patients are directed towards the right stream rests with the acute hospital in the majority of cases. The process becomes less contentious if it operates across non-rigid boundaries and there is mutual trust between the clinical staff. This prevents wastage of valuable operational time in directing patients in between areas. (Primary Care and ED, Primary Care Foundation, 2010)
- Isolated UCCs located alongside EDs cause patient confusion because of signage. Plethora of choice between different variably reciprocated services delivering urgent and emergency care adds to the confusion. Dissatisfaction related to care in many UCCs is often apportioned to the ED by the complainants – a sign of how people perceive the urgent care facility as being a part of the ED
- Patient education has not been shown to




have any effect on attendance to acute care except in patients with chronic conditions. (Reducing waiting times in ED, Cooke et al, 2004)

- Isolated and non-integrated ED and UCC risk silo working with organisational boundaries interfering with clinical co-operation. Service provision under these circumstances is driven by what can be provided rather than what is needed within a patient-centred system at the front door to an acute care hospital
- Tariff inhibits an integrated approach because of fundamental disagreements between ability to define primary care patients in the ED. This is done retrospectively and is different to a prospective risk approach typical of clinical management.

Why integrated?

- Co-operation is central to delivering high quality care in the NHS and providers and commissioners need to co-operate to foster patient choice and offer patients an experience of a seamless health service, whilst maintaining service continuity and sustainability (Co-operation and Competition Panel)
- Several benefits are associated with integrated ED (A and E) and UCC,



including the ability to serve complex itinerant inner-city population; better management of demand from patients who “vote with their feet” and utilise the secondary care facilities as their walk-in centre; and a more flexible utilisation of workforce across the services to match risk and demand

- Whole systems integration will help address safety, quality and accountability
- Integrated ED-UCC enable the service to respond to patient expectations at the front door to an acute hospital to help ensure a safer delivery of care
- Attendance patterns specific to certain post codes or practices will assist gap analysis of resources and performance-related issues amongst primary care providers hence, “turning away inappropriate attenders” need not be a demand management tool – the system needs to acknowledge there are no inappropriate attenders but inappropriate responders in a disjointed underperforming system
- ED-UCCs need to be able to deliver the most efficient and effective care for children, frail and older people, mental health patients, substance abusers and the homeless. These groups by virtue of their physical, emotional and social isolation do not access the “right” services so the services need to be right for them at the point of access – which frequently is an emergency department and out of hours.

What does the best front door look like?

That depends on the outcomes:

- Clinical: Evidence-based care, safe care, patient-centred care with surveys
- Cost effective: Evidence-based care is likely to be cost effective, but depends on local capability including resources – requires prioritisation based on local need
- System efficiencies: Need to focus on deliverables that contribute towards home

care, decrease hospital admissions and readmissions and contribute towards community risk assessment. It needs to reassure patients as well as address the clinical uncertainties in decision making among clinicians

- Timeliness: Is crucial, hence diagnostics, in-flow and out-flow with efficiencies in processing is key
- Managing demand: Across the system using dashboards and NHS Pathways will facilitate real time management across the system.

Role of the Clinical Decisions Unit:

- This needs to be a decision making unit operating on same lines as the rest of the ED, integrated with the ED-UCC, with assessment, management and diagnostic processes aimed towards facilitating discharge following an extended work-up by multi-disciplinary teams with specialist, senior led pathways
- Service planning and delivery needs to strategically align emergency physicians, geriatricians, paediatricians, liaison psychiatrists, general practitioners and social care with specialist nurses (such as diabetes, mental health, pain) and therapists in the hospital and in the community, together with timely information to deliver these outcomes from the moment a patient presents to the emergency department who may be dischargeable
- This ideal combination, utilising a whole systems approach, not only provides the optimal blend of expertise to provide the right clinical risk assessment and management for older people and children who attend the emergency department, but also to develop better systems at the front door to reduce the need for inpatient management by delivering ambulatory emergency pathways for a variety of conditions for which local expertise is available
- This needs to be accessible to both UCC

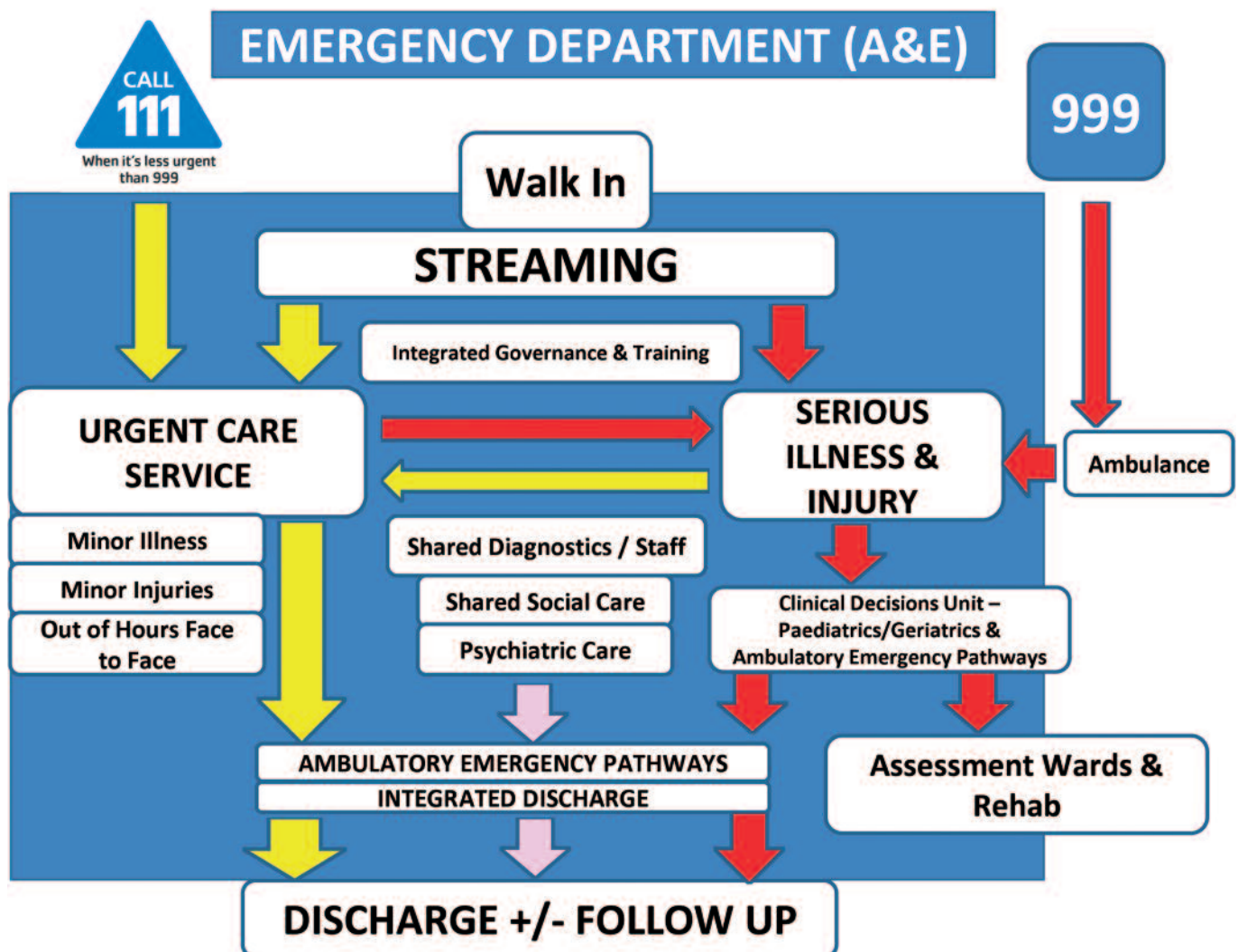
and ED at the front door to include the entire presenting population and address clinical uncertainties.

Principles:

- Senior decision making 24/7 with staffing matched to flow
- Integrated processes for acute medical and acute social care across the interface
- 24/7 access to geriatricians, paediatricians, psychiatrists with daily presence between 10:00 and 22:00 hours
- Operative ambulatory emergency pathways for common conditions such as chest pain, headaches, abdominal pain, renal colic, PE, falls and syncope, gastro-enteritis, asthma, gastrointestinal bleeding, etc
- Serve as a "referral unit" to carry out rapid assessments of patients being admitted to non-hospital facilities to assist developing care plans for implementation.

(Acknowledgements: Dr Jay Banerjee, Consultant, Emergency Department, University Hospital Leicester and John Heyworth, President, College of Emergency Medicine)

A suggested model



Case Studies: Emergency Departments

ROYAL VICTORIA HOSPITAL, BELFAST

DC Cardioversion for acute Atrial Fibrillation

Mr Smith is an 87-year-old man who presented with a three hour history of palpitations associated with some chest discomfort. There is a history of stable ischaemic heart disease only, with no known history of atrial fibrillation. ECG revealed atrial fibrillation with a ventricular rate of 145bpm. The patient was DC cardioverted in the emergency department under conscious sedation by two emergency medicine consultants. He was admitted to the ED short stay ward for post-sedation care. CHADS-VASc score calculated at three, therefore the patient was discharged on warfarin following full counselling by the ED pharmacist, a beta blocker and outpatient cardiology follow-up. No acute input from cardiology was required and acute admission avoided.

Resuscitation bundle for severe sepsis

Mrs Van is a 72-year-old woman who presented to the emergency department with severe chest sepsis. She was hypoxic with a reduced level of consciousness and a serum lactate of 9.1. She received oxygen, antibiotics and fluid boluses. When she failed to respond to the fluid boluses, an arterial line and femoral CVC line were inserted by the emergency department registrar and consultant, and an infusion of noradrenaline was commenced. She stabilised and was transferred directly to the intensive care unit from the ED for further monitoring and management. No acute input from the medicine or anaesthetic teams was required.

Major trauma

Mr Hhowe is a 50-year-old man who received multiple stab wounds to the chest and abdomen. He was hypotensive on arrival at emergency department. Bedside ultrasound of the patient's chest, heart and abdomen was performed by the emergency medicine consultant and revealed a left-sided pneumothorax. Needle decompression and intercostal drain were inserted by an emergency medicine consultant with resolution of haemodynamic status to normal. The patient was transferred to the CT scan after stabilisation and subsequently taken to the interventional radiology suite for embolisation of the lacerated renal vessel.

Conscious sedation

The emergency department currently carries out approximately 400 fracture and joint reductions per year under conscious sedation, performed by the emergency medicine staff.

Mr Harrow is a 79-year-old man who presented with a dislocation of his prosthetic left hip. This was reduced by the emergency medicine registrar under sedation with propofol and fentanyl, administered by the emergency medicine consultant. The patient was observed in the emergency department short stay ward following sedation and subsequently discharged back to the nursing home.

Biers block

Mrs Banks is a 66-year-old woman who sustained a displaced fracture of her distal radius after a fall at home. Reduction of the fracture was carried out by the emergency department consultant under Biers block using prilocaine. Good result from reduction and discharged with outpatient follow-up in fracture clinic.

Rapid sequence intubation

Mr Carter is a 72-year-old man who fell over, sustaining a head injury. He presented with a GCS of 7/15 with vomiting. He was intubated with rapid sequence induction by the emergency department registrar under supervision of the emergency medicine consultant. He was then transferred for a CT scan by the emergency medicine registrar and onward to ICU for monitoring and management of traumatic brain injury.

Ambulatory care

Care pathways are in place for the ambulatory management of deep venous thrombosis (DVT), cellulitis, low risk cardiac chest pain and thunderclap headache. The investigations and initial management of these conditions is performed by the emergency department staff.

Miss Anderson is a 24-year-old woman who presented with a two day history of thunderclap headache. A CT scan of her brain revealed no abnormality, so a lumbar puncture was carried out by the emergency medicine consultant in the short stay unit. The result of CSF analysis was normal and therefore the patient was discharged.

ROYAL LANCASTER INFIRMARY

Suturing of facial wounds

A young child presented with a facial wound that could be safely sutured in ED (A and E) under local anaesthetic and ketamine sedation, thus preventing admission. In some hospitals, children with these sorts of injuries are admitted under maxio-facial units for a general anaesthetic. These cases are now routine at Lancaster.

Acute Atrial Fibrillation

Patients with new onset atrial fibrillation can either be electrically or chemically converted to sinus rhythm then discharged for OPD follow-up without the need for an admission.

Wrist fractures

Patients with wrist fractures can be manipulated under sedation or regional block in the ED (A and E) again avoiding admission. Some ED (A and E) departments are still admitting these cases under orthopaedics.

SALFORD ROYAL HOSPITAL, MANCHESTER

Suspected DVT

An 85-year-old woman was referred by the local walk-in centre with suspected DVT. Her mobility was being restricted by pain in her left calf. Full clinical assessment noted no evidence of pulmonary embolism PE (no chest pain or shortness of breath) and early warning score of 0 but a Wells score of +4 for DVT. She was commenced on tinzaparin, (having checked her recent bloods, which showed a GFR=60). Her FBC and U and E were repeated, and she was advised on analgesia and discharged from the ED (A and E) – an urgent OPD appointment organised, with a Doppler the following day with a subsequent review by a Physician on EAU. This is the standard ambulatory care pathway for suspected DVT patients which prevents needless admission and ensures prompt and safe diagnosis.

Early intervention with safe sedation in trauma

A 37-year-old fire fighter who had fallen out of a tree was brought to ED (A and E) by ambulance. The emergency department consultant and the trauma team conducted the standard primary survey which revealed no life threatening injuries. However the patient was in severe pain due to an open displaced distal tibial fracture where a large bone fragment was protruding through the 5cm wound over his medial distal shin. After cannulation and bloods, 20mg of iv morphine, establishing monitoring, the ED consultant and the orthopaedic registrar promptly reduced the fracture prior to any x-ray, under sedation in the resus room, hence ensuring maximal chance of avoiding amputation. This allowed the patient considerable early relief from pain, and to have a planned orthoplastic procedure in theatre later (having fasted) rather than a more rushed general anaesthetic procedure purely to achieve reduction. A good case as a DOP for a ST4 EM trainee on safe sedation.

Suturing in a child

A seven-year-old boy was brought to ED (A and E) having sustained a deep laceration over his left patella during a fall onto gravel. He was in considerable discomfort and distress (as were his parents) on arrival. Reassurance and analgesia were provided during the initial assessment by the ED consultant in combination with paediatric nurses and play leader – all present in a dedicated paediatric assessment and diagnostic unit (PANDA). The boy was calm during x-ray to rule out an underlying fracture. The nurses then applied LAT gel which allowed the child and his family to watch the wound infiltration, debridement and suturing that the ED consultant then conducted without discomfort or distress. The child was discharged for district nurse follow-up with antibiotics. The ED consultant also provided step-by-step explanations for GP VTS trainees and medical students who were present in the unit at that time.

(Acknowledgement: College of Emergency Medicine).



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About the author



Dr Agnelo Fernandes MBE FRCGP

Dr Agnelo Fernandes has been a GP at Parchmore Medical Centre in Croydon for 22 years and is a GP Trainer, Educational Supervisor out of hours, GP appraiser, a member of the LMC and a Governor at Royal Russell School in Croydon. He was awarded the MBE for services to medicine and healthcare in 2004.

He was previously the Clinical Champion for Urgent Care for the Royal College of General Practitioners (2007-2010), and is currently its GP Lead for Urgent and Emergency Care and a National Clinical Commissioning Champion for the RCGP Centre for Commissioning. He is also a national special medical adviser to NHS Direct, Chair of the National Intercollegiate Clinical Governance Group for NHS Pathways and was Chair of the national reference group that developed the urgent and emergency care clinical audit toolkit (2011). He was involved in the set-up of Croydoc – formerly a GP out of hours provider and one of its medical directors (1995-2010), and is currently the Chair of the ‘Croydon Healthcare Consortium’ Pathfinder Clinical Commissioning Group.

He has also been the Chair of the Croydon Federation of General Practices that was the winner of the HSJ Award in 2008 with its Community diagnostics project (putting ultrasound and echo functionality into GP surgeries and access to MRI), and finalist in the HSJ Awards 2009 with “Improving the urgent care response in hours” project. He was the senior clinical adviser to the Care Quality Commission (CQC) investigation into out of hours services (2009-2010), and is also currently a member of the national DH Programme Board for NHS 111, a member of the national NHS Pathways CMS Programme Board and the Intercollegiate Committee for Children in Emergency Departments, Royal College of Paediatrics and Child Health.

Over the past twenty years he has been involved in leading numerous projects including the set up of NHS Direct in South West London, the NHS Walk In Centre in Croydon, and an out of hours training scheme for GP trainees across three PCTs. He chaired a popular Urgent Care Learning Set for clinicians and managers to spread learning and innovation across London for over five years without funding. He was the only GP member of the London Modernisation Board and has been involved in NHS modernisation through various ICT developments and the national Collaborative programmes especially in Primary Care, Medicines Management, Emergency Care and Practice Based Commissioning. He has been a Clinical Governance Lead and Caldicott Guardian for the various organisations he has been associated with and his GP practice has received numerous awards, including an NHS Beacon Award for the use of ICT, and in 2010 the ‘Quality Practice Award’ of the Royal College of General Practitioners.



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