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Urgent Care Centres: What works best?

A discussion paper from the Primary Care Foundation
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Review of Urgent Care Centres

Contents

	Page
Executive summary	3
1 What does good urgent care look like? Criteria for the review	5
2 Findings: how did UCCs measure up?	8
3 Findings: where was there variation?	14
4 Findings: services do not collect the information they need to measure their effectiveness	16
5 Findings: The clinical process and integration with other services	18
6 Lessons: Key points for clinical commissioners	20
Appendices	
A Key findings summary	23

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Executive summary

Clinical commissioning groups are in many places looking at how to provide the government's vision of integrated urgent and emergency care while at the same time NHS 111 services are being launched. They are doing it against a backdrop of the need to contain cost and considerable attention is given to driving down attendance at emergency departments (EDs), while meeting the rising expectations of the public.

Urgent care centres of various types have evolved as a way of meeting these needs. But we found little published evidence that they reduce attendances at A&E and some suggestion that they might increase the total burden on the NHS. Certainly many are meeting primary care needs (though some count these cases as urgent) and they are now firmly established. Many have the loyal support of local users who rally to defend their local centre when commissioners attempt to replace it.

This discussion paper looks at the different models for providing urgent care services and evaluates their impact. Through site visits to 15 urgent care centres (UCCs) and a literature review carried out by Warwick Medical School as well as the support of a reference group we identified some criteria that we believe define a good service, one that delivers high quality, clinically appropriate and cost-effective care.

We believe a good service is one in which:

- *Care is provided promptly*
- *The patient's urgent needs are met (including reassurance where this is appropriate)*
- *The scope of the service is clear*
- *There is clear governance and management responsibility for improving quality and cost-effectiveness*

- *The environment is appropriate for provision of good quality care and supports integration with other services*
- *The process used supports these objectives*
- *There are mechanisms for capturing and acting on patient experience and other feedback.*

The paper looks at the extent to which the UCCs we visited measure up to these criteria. We found wide variation in the nature of the service that had been called an urgent care centre. There was also a lack of rigour in data collection so it was difficult to get a true picture of their effectiveness or cost. Finally, the paper offers some key thinking points for clinical commissioners to consider as they develop their plans for integrated, 24/7 urgent and emergency care.

In summary clinical commissioners in managing, developing and commissioning services need to pay attention to:

- *Clearly defining the expectations of any urgent care services and measuring their impact across a whole health economy*
- *Specifying the data required to demonstrate the impact and analysing that intelligently*
- *Integrating urgent care services with the wider primary and secondary care system*
- *Using "see and treat" processes rather what might be called "triage and wait"*
- *Developing a consistent approach to governance that looks at the totality of care provided to patients*
- *Collecting feedback consistently and coherently and acting on what it tells you*
- *Describing urgent care services accurately both for patients and the NHS 111 Directory of Services.*

This discussion paper complements our report *Breaking the mould without breaking*

the system: new ideas and resources for clinical commissioners on the journey towards integrated 24/7 urgent care published in November 2011 with the NHS Alliance. Readers might also like to refer to the paper produced for the Department on *Primary Care in Emergency Departments*. Both of these can be downloaded from www.primarycarefoundation.co.uk.

Much of our learning comes from unpublished work carried out for the Department of Health in 2010 - but the views are those of the Primary Care Foundation.

We hope that these criteria and the learning from the visits to UCCs will help inform

commissioners as they develop local urgent care strategies and begin to commission an integrated, urgent care system that meets the needs of patients.

We are aware that the study looks at a limited number of services and that urgent care centres may have developed further since some of the research for this paper. The Primary Care Foundation looks to highlight examples and promote the spread of good practice. We would welcome the opportunity to provide details of any aspects of good urgent care services if they are drawn to our attention so that we can make them available with this paper through our web site.

Chapter 1 What does good urgent care look like?

In 2009/10 we carried out a review of Urgent Care Centres (UCCs) to identify different models across England and evaluate their success in terms of:

- Value for money
- Quality and timeliness of care
- Patient experience
- Impact on the rest of the urgent and emergency care pathway, within and outside the hospital.

We looked at 15 different centres in 10 PCT areas, reflecting a range of rural and urban, relatively affluent and deprived communities. They provided a wide range of different centres for site visits. We have also included the learning from visits to a number of other centres.

Site visits included:

- Discussion with commissioners about their urgent care strategy and how UCCs fit into this
- Identifying the clinical process
- Collecting information about comparative performance
- Identifying key themes and learning
- Interviewing patients, where possible.

Colleagues were given an opportunity to check and validate our findings. There was also a half-day session with a national reference group that included representatives from the PCT sites within the study to review the information gathered and begin to develop our findings.

We assessed the UCCs against the following criteria:

- *Care is provided promptly*
- *The patient's urgent needs are met (including reassurance where this is appropriate)*
- *The scope of the service is clear*

- *There is clear governance and management responsibility for improving quality and cost-effectiveness*
- *The environment is appropriate for provision of good quality care*
- *The process used supports these objectives*
- *There are mechanisms for capturing and acting on patient experience*

Care should be prompt

Prompt care is good care. There is plenty of evidence that among those with more acute conditions, patients whose needs are addressed sooner rather than later are likely to enjoy better clinical outcomes. We do not under-estimate the clinical value in some cases of observation over a period of time and waiting to see if a condition develops or deteriorates. This is sometimes appropriate. A conscious decision by a clinician that this should be done is very different to letting patients wait, with the inevitable increase in probability that some will choose to leave without being seen and that the condition of others will deteriorate.

Many services use triage or another system to decide which patients need to be seen first and who can wait longer. Initial streaming is appropriate and safe if the patient moves quickly to the full clinical consultation. We investigated how quickly patients received a full consultation that was fully documented, including:

- Taking a history
- Carrying out any necessary examination
- Diagnosing the case or identifying what diagnostic tests are needed
- Providing pain relief if needed.

We also wanted to see what proportion of cases was discharged at the end of that first

consultation with the necessary treatment, or advice and reassurance.

Patients should be able to understand what is available

We expect UCCs to care for any patient who believes that they have an urgent care need. We felt that services must both:

- Meet the immediate needs of the patient
- Complete the vast majority of episodes of care.

A small proportion of patients will require transfer to an A&E department or follow up appointments with their GP. But we expected it to be clear to health professionals and the public what sort of treatment could be provided at the UCC.

We looked at NHS Choices and Google to see how easy it was to:

- Identify whether there were facilities for dealing with fractures (listing them amongst the injuries that could be treated, or stating that X-ray facilities were available)
- Identify whether a doctor could be consulted about a complex condition that might be beyond the scope of most nurse-led walk-in centres.

We also wanted to see consistency. Does the service vary depending, for example, on the time of day or who is on duty?

Governance and management responsibility should be clear

UCCs should have clear lines of responsibility and good information to support governance of the service as a whole. It should also be possible to look across services at the total episode of care where a number of different organisations or units are involved. Some UCCs are clearly defined and separate from other services, while others form (for all practical purposes) part of the emergency department or are closely linked with other services on site. We looked

for clear, comprehensive governance arrangements that sought to deliver consistent, safe, effective and cost-effective care.

We wanted to see intelligent data collection and analysis, so that services can understand the detail of clinical decisions made. Cost and quality are driven by the individual clinical decisions made about treatment, prescribing and referral for further care and we expected the organisation to be collating and reviewing these data as part of the governance process.

Average demand is predictable as is the random fluctuation around this hour by hour and capacity can be matched to meet this. However, there will be occasions when there are unpredicted peaks or interruptions – for instance, if there is a major incident or a number of particularly resource intensive cases arrive together.

We wanted to understand who made decisions about what action to take on the proverbial ‘wet Wednesday’? Who took responsibility for redeploying resources and assessing the clinical risk of delaying treatment for some patients if a peak in activity demanded this?

The environment should be right

We were also looking for centres that operated in an environment that supports good quality care. This relates to principles in *Transforming Emergency Care* and the sixth domain in *Standards for Better Health*. We wanted to find:

- Clean, hygienic surroundings.
- Convenience for patients: transport links, parking and accessibility.
- Adequate privacy so that patients could be treated with dignity and respect
- Adequate consultation lengths for assessment, examination and any investigation and for explanation so that the patient can understand the condition, treatment, what actions

they should take and what was to happen next.

- Integration with other services within the local health economy. Information should be transferred between services, and nothing should inhibit the transfer of a patient to another area or person able to provide better care. We asked about organisational boundaries, financial incentives, IT systems and cultural/political issues.

The process should support the features of a good service

Spotting potentially urgent cases early, so that appropriate action can be taken before any deterioration, is particularly important in urgent care services. We paid particular attention to the operational process from the arrival of the patient through assessment, diagnosis and treatment. The

process should support an early full consultation, although this consultation will not always end the episode of care because the patient may need further tests or investigations.

Feedback should be measured and acted on

Measuring patient feedback consistently and coherently and acting on the information this provides is expected of all NHS services. UCCs need both to monitor the views of large numbers of patients and to carry out detailed interviews with individuals to capture patient stories. A consistent, long-term approach provides a better understanding than a one-off audit. Similarly we were interested in processes for gathering feedback from staff and other clinicians such as the patient's GP.

Chapter 2 Findings: how did UCCs measure up?

Having visited a variety of UCCs, we believe that although there are significant differences in terms of aim, objectives, staffing and services, they can be categorised into three main types:

- **Full case mix UCCs co-located with an Emergency Department.** On a hospital site with access to diagnostics and a full range of clinical staff patients often do not recognise any distinction in the services and think of them as A&E.
- **Full case mix stand-alone UCCs.** Remote from a hospital but with a full range of diagnostics and clinical staff.
- **Restricted case mix UCCs.** Often similar to a walk-in centre but sometimes even more restricted. They may include minor injuries but we found many had limited capability for dealing with fractures.

While provision varies hugely, there were striking similarities:

- Volumes did not vary widely. Many services are dealing with 90 to 120 cases per day.
- The pattern of demand is predictable, reflecting that seen in A&E.
- The case mix is very similar to the simpler cases seen in A&E.

Demand is consistent and predictable

Despite the considerable differences between centres, there were some common features in terms of demand.

- The UCCs that we examined dealt with a **similar case volume**. Most saw between 90 and 120 cases per day. Many centres received an

average of around seven to 10 cases an hour between 8am to 6pm.

- The **pattern of demand was similar** to that in emergency departments.
- The **pattern of demand was predictable**, with variation at an hourly level being within the expected range, and rarely exceeding one-and-a-half times the average.
- The **cases completed** within UCCs were very similar to the simpler cases dealt with in A&E. As in A&E, some of these cases were similar to those seen in primary care. But UCCs often failed to distinguish planned follow-up cases. They were sometimes counted as if they are urgent cases and were included in the statistics for A&E attendance. This planned care (for example changing a dressing) is sometimes counted as urgent care, inflating the apparent demand.

Productivity

The typical number of cases seen per clinical hour across the 15 UCCs we visited appears to be between 1.5 and 3.0 (we looked between 8 and 8, not during the quieter overnight period). Most clinicians with whom we discussed these findings, knowing the case mix that is seen in the centres, felt that this level was low. It compares with a range of between 1.5 and just more than 5 cases per clinician hour for out-of-hours services seeing patients face to face in a primary care centre.

Literature review

An analysis of 42 published papers concluded that there is a lack of published evidence to support the hypothesis that UCCs and walk-in centres will reduce attendances at A&E, and some suggestion that they may increase total burden on the

NHS. The literature review is available from the Primary Care Foundation on request.

Did the UCCs display the key features of a good urgent care service?

Prompt care

We found that although only very small numbers of cases completed within the UCCs breached the four-hour waiting time standard, many services had very little focus on providing care more promptly. The majority of centres completed fewer than half of cases within one hour. But a minority operated with a very different ethos and completed over 90% of cases within an hour.

Very few services had information available about the overall patient journey, identifying the time at which each intervention took place. A substantial proportion did not report on waiting times in any more detail than against the four-hour target.

By now we would expect UCCs to be reporting the median, 95th percentile and longest time to treatment and to discharge/admission in line with the A&E Quality Indicators published in 2010 and in use since April 2011.

Knowing how far away some services were from capturing such detail, we fear that such data is, as yet, rarely collected in Urgent Care Centres. Examination of the experimental statistics published by the NHS Information Centre for May 2012 indicates that there are gaps and data quality issues apparent in the data more than a year after the quality indicators were introduced.

Meeting urgent needs

We believe a UCC should be capable of dealing with patients that attend (except for the small proportion who need the immediate attention that can only be provided in an emergency department). The clinical process should avoid any unnecessary delay as this presents very real

risks to the patient if any urgent clinical needs are not identified.

However, on the ground, we found that the mix of cases that some services could treat varied depending on time of day. Examples of this were when X-ray or other facilities were available for a restricted period or dependent on who was on duty with some clinicians able to prescribe more widely than others.

All the centres that we visited treated the majority of patients that attended. But in cases where there is variation in capability over time or where the scope of the service is unclear there is a greater likelihood that patients will be referred to another service or that patients that could be treated go elsewhere.

It is entirely proper that many patients who attend an urgent care service are referred to their GP - many studies have shown the benefits of the continuity of care that is provided by general practice. But we are wary about the glib assumptions that are sometimes made about schemes to divert patients from A&E.

Patients with an urgent care need coming to a UCC or any other service should be assessed thoroughly by a clinician, their immediate care needs should be met including any treatment, pain relief and advice. In addition UCCs need to avoid both the risk of deterioration during any delay needs to be considered and the danger that patients with a chaotic lifestyle who are unlikely to attend their general practice are effectively denied care.

Our suspicion is that any attempt to establish a diversionary scheme will require very similar levels of resource and skill as that required to assess and treat such patients in a well-organised emergency department. In our report *Primary care in emergency departments* we drew attention to the higher acuity of many patients that choose to attend A&E compared with those

coming to a GP practice. We caution commissioners and providers about the risks of making optimistic assumptions about the time taken by any clinician to assess patients so that significant numbers can be safely diverted to be seen some time later in primary care.

This is not to suggest that some UCCs set up at the front of A&E may not have delivered benefits. Making sure that there is a focus on providing care promptly and keeping up with demand as patients arrive is a good thing. Establishing a UCC at the front of A&E may have provided this focus and driven other benefits such as improved productivity. Nor are we against the use of primary care clinicians in such settings, we are simply cautioning against over-simplistic assumptions and, as described below, arguing against confusing patients by introducing the term 'UCC' when they already understand and recognise 'A&E'.

Clear scope of service

There is considerable confusion about what services are available to patients with an urgent need. Not only does the term UCC cover very different services, some of which can deal with a much narrower case-mix than others, but also we have already described how at some the capability may vary at different times. This inconsistency increases the risk that a patient attends for an urgent condition that cannot be adequately treated

How easy is it for patients to find information about the services provided by UCCs and their opening hours?

We tested this, not just in our discussions with commissioners and health professionals, but also by looking at NHS Choices. Those responsible for the site have tried to limit the categories of emergency services (which can be listed by proximity to a post code) to A&E, Minor Injury Units and Walk in Centres. NHS 111, Major Trauma services and the ambulance service are also described and NHS Direct is mentioned but

Urgent Care Centres are not listed as a separate category.

Whilst the generic descriptions for the capability of these units are clearly structured they do not match what we found on the ground. For example the generic description of walk in centres says that they treat 'fractures and lacerations' and minor injury units 'broken bones' but this was not always the reality. Drilling down to the description of the local service, some had clear descriptions of the sorts of conditions that might be treated (and a few helpfully identified some that could not be treated). But in many instances there was no description of this sort and in others no information was available.

Patients understand A&E and they know what to expect from their GP practice. With the wide variety of terminology used for similar centres and the lack of clarity over what each service can treat (even to health professionals that we asked) it seems inevitable that patients will often opt for A&E when they have an urgent care need

This confusion is not helpful to patients, to healthcare professionals, to commissioners or providers. Consistency and clarity matter if patients are to identify the appropriate service.

These difficulties have to be resolved in developing the local Directory of Services that underpins NHS 111. Doing this provides an opportunity to refresh the description of services, opening hours and conditions that can be treated.

It would be naive to think that patients will always ring NHS 111 - they will continue to make their own judgment about which service to attend, so we urge those responsible for compiling the information to ensure it is used to update local and national sources of information for patients. It will take time, but if there are to be urgent care services that fill a gap between A&E and

general practice then patients should be helped to understand what they offer.

Ideally there would be a definition of the minimum requirement for a service of this type with a recognisable name that was easily understood by the public. Our own preference would be to call any such service 'A&E Local' because we felt that patients would both understand what was offered and recognise that it would not include the full range of treatment available at A&E. Clearly if the service is co-located with A&E there is no point in changing the term that is already well understood, especially as the full range of A&E capabilities can be delivered to any patient that attends.

Clear governance and management responsibility

We looked for clarity in the governance and managerial processes aimed at ensuring a good quality service is delivered, cost effectively. We found very few services were routinely measuring the time to the first full consultation (though hopefully this is changing with the new A&E clinical indicators). We also found that clinical coding was often incomplete. Too many cases were categorised under a general classification and often it was impossible to identify whether patients had gone on to secondary care or were referred to their GP for follow-up.

Without this detailed information, it is difficult to see how anyone could evaluate whether the objectives for the service were met or get a clear picture of how the service integrates with others in the local area.

Where two organisations were involved, we were concerned that the totality of the patient journey along a pathway was often not reviewed.

We also asked who was responsible for:

- Reallocating resource if demand was very different to that expected
- Making sure that clinicians worked productively

- Accountability if things went wrong.

We found that in some UCCs this is clear but in others, particularly where two providers were involved, this was not the case. Some services were complaining that they worked hard whilst the other linked provider sat idle which is perhaps a clear indication that the process isn't working.

We frequently found services co-located with GP out-of-hours services, but did not always find an operational link between the two separate services. This is strange as often the only difference between the groups of patients treated was how they had chosen to access care.

Where services are (or could be) co-located there will be opportunities for integrated working that will make balancing the workload easier and increase the range of conditions that can be treated.

Commissioners and providers need to work together to realise these benefits - in particular to define who has the responsibility for reallocating resources or redirecting patients at peak times whilst recognising the impact on the performance measures of the individual services.

The environment

In addition to the need for clean, hygienic surroundings and a reasonable degree of privacy, we looked for adequate length of consultations, and effective integration with other services so that nothing inhibits the transfer of a patient to another area or person able to provide better care.

We found that many of the UCCs are in new (or recently refurbished) buildings that provided superb facilities. Although in other cases the service was provided in an older building, the comparatively recent establishment of the UCC often meant that the environment and facilities felt clean and fresh.

Waiting areas often seemed to provide a cleaner, more peaceful and comfortable

space than those in many emergency departments. In most centres, patients were seen in separate consulting rooms, although in some services co-located with A&E screened cubicles were used. There was occasionally less privacy for the initial triage process when this took place in an open area, either on arrival or in the waiting area. But most services sought to find a small room adjacent to the waiting area for this purpose.

Where two providers were involved in delivering care, we found examples where there were barriers between them, around protocols for transfer of patients or different IT systems for instance. Fortunately, despite various obstacles, clinicians were insistent on doing the right thing for patients when it is critical – but the process ought to operate smoothly even in less critical cases. We stressed the importance of addressing these issues in our report *Primary care in emergency departments* and in the report for commissioners of urgent care services, *Breaking the mould without breaking the system*. Both of these can be downloaded from www.primarycarefoundation.co.uk.

The clinical process

A UCC is likely to receive cases of greater acuity compared with those in primary care. Spotting potentially urgent cases early is important so we paid particular attention to the operational process at the front of the service.

We found that nearly all services used clinicians to assess patients. Sometimes this was a cursory check but in others the process took longer and involved a brief history and examination, though in most cases patients were returned to the waiting area to await a fuller consultation. Services aimed to identify patients where imaging or diagnostic tests might be required so these could be initiated early. But surprisingly not all services used triage to initiate early pain relief.

In considering the clinical process within UCCs, we felt it was important to draw a distinction between 'triage' and 'see and treat'.

'Triage' is the immediate sorting of patients according to the seriousness of their condition - but it is only this. The episode of care is not completed as part of the triage process. Since all patients (except those requiring immediate care) are returned to a queue (often a long one) before receiving a full consultation and treatment the process might be described as "triage then wait"

See and treat involves seeing patients on arrival, assessing their needs and, where it can be readily done, providing treatment and advice so completing the episode of care. The approach was recommended from 2002 as one that would address many of the problems of waiting times and aid delivery of the four hour standard. The see and treat process does recognise that, where diagnostic tests or imaging are required or where a period of observation is necessary, the patient will have to return for a second consultation later – but delay is not built into the system as it is with triage for all but the most pressing cases.

A small number of services aimed, where practical, to see and treat patients in one consultation rather than having triage followed by the main consultation. We believe that this approach has benefits for patient safety and improves the patient experience by avoiding the need for repeated queuing. With appropriate training and management practices this should be a sustainable approach with triage being relegated to part of the contingency plan, only for use in the event of a major incident when prioritising treatment is essential.

Measuring patient experience

Our site visits identified a number of methods for understanding the patient experience. These included:

- Immediate feedback, giving a score for patient satisfaction, delivered via a touch screen computer
- Standardised surveys sent to patients homes
- The use of *ad hoc* questionnaires and topic guides, most often completed face to face
- Discovery interviews of patients by nurses.

Whatever approaches are used, it is crucial that services reflect on the findings and respond to concerns. It should be possible to identify changes made as a result. It was not always apparent that there was a forum for reviewing findings and taking action.

We were disappointed that in too many services, there was little consistency in the arrangements for carrying out surveys. In some cases, there had been a long gap since the last survey had been conducted; in others, the questions had been changed so that it was impossible to compare results to find out whether recent changes had improved the experience of patients.

We strongly support the emphasis in the A&E Quality indicators on a narrative description of what has been done to assess the experience of patients, what the results were and what improvements have been made. There seems no reason that this requirement should not apply to all urgent care services. Commissioners will need to ensure that this process is followed with professional rigour if it is to contribute effectively and they might like to consider careful design of the process and questions across all urgent care services to allow comparison of patient views of the different services.

Services should also ensure that feedback from other sources is also reviewed. As a minimum, other feedback should be followed up (for example by expanding the complaints process to cover comments on web-sites and all types of feedback from other health professionals) but we also saw some good examples where feedback from such sources was actively sought - for example by surveying the opinions of GP practices.

Chapter 3 Findings: where was there variation?

We found significant variation in the services provided, their scope, the speed of response and cost.

Some centres were set up to provide rapid care to patients, with ambitious targets for the time to initial assessment and to completion of the large majority of cases. Others responded much more slowly and were concerned only about the four-hour waiting time standard. The objectives, as understood by staff and translated into the reality of the service, varied considerably.

Some UCCs operated 24 hours a day, some 12 to 14 hours, others 8am to 6pm. A number had very limited diagnostics and appeared to be able to deal with a far narrower range of urgent cases than walk-in centres or minor injury units. For example, they may not have had access to X-ray facilities so could not identify and treat fractures.

Most centres allowed patients to walk in, but others only received patients after a streaming process at the front of A&E. There was also a small number that focused on avoiding hospital admissions, operating almost as a GP-led medical assessment unit.

In one case, the newly opened integrated care centre (also described as a UCC) is merely the building. It housed:

- A relocated walk-in centre (renamed the UCC)
- The out of hours GP service
- A dentist
- Four different GP practices
- The headquarters of the rapid response service.

Case mix

The mix of conditions that could be treated varied enormously. Some centres treated many routine cases that would be appropriate for a GP practice. Elsewhere, after meeting any immediate care needs, patients were referred back to their

practice. Some UCCs were staffed and equipped to see a limited case-mix, for instance employing nurses only. Others ensured doctors were available to see patients, including those with multiple conditions. Some saw a much larger proportion of acute cases, particularly if they were at the front of A&E or were sufficiently distant from the acute hospital to serve as a mini A&E.

A few health professionals told us they now send away routine cases that they used to see when operating as a walk in centre because the condition is not urgent. Others provided whatever care the patient required and that was within the capability of the unit and staff.

Variation in services

The availability of particular types of service often varied by time of day. Sometimes, this was planned (so X-ray facilities might be available for only part of the opening hours, or GPs might be available for part of the time only); sometimes, it was simply a function of which staff happened to be on duty and their skills and experience. This falls short of the principles that services should be accessible, understandable and patient-centred. Whilst we found some referral of cases between services, this also often depended on the time of day. As we highlighted earlier, this variability increases the risk that a patient may attend for a condition that cannot be treated by the service, increasing delay and clinical risk.

Costs – a confused picture

We found a wide variation in stated cost per case, from £28 to £85, with most falling in the range from £28 to £40. This compares with a minimum tariff for an A&E attendance of £59 plus the Market Force Factor (MFF).

However, it proved impossible to obtain comprehensive data that is reliable enough to act as a true cost comparison with A&E.

No service seemed able to provide a full picture that included factors such as: building and facilities; employment; consumables such as medicines and dressings; non-clinical staff; training and development; IT; accounting support; administrative and HR support; clinical and operational governance; legal fees and insurance.

In at least one case there were indications that the A&E department remained as the backstop for an urgent care centre that was sometimes under-staffed. As a result, it would, from time to time, pass significantly more patients across to A&E than at other times making it very difficult for the A&E department to make savings.

Speed of response

Many UCCs offered a service that seemed slow. We validated this by analysing waiting times.

Qualitatively, we observed places where there was no sense of urgency as the notice in the waiting room was turned over to say 'the waiting time is now between two and three hours' or the queues grew so long there were not enough chairs for everyone.

We observed a pattern in some UCCs where significant queues built up and were then cleared in sudden flurry of activity. This is inefficient and stressful for both patients and clinicians. It is often associated with the use of triage: patients wait once to be prioritised and then wait again for a full consultation. Whilst triage does not necessarily imply that patients have to wait for long it seemed that the assumption was made that they could.

In others, the clear aim of all staff was to see patients early, to understand their health needs and to provide treatment and advice or make decisions about the next steps promptly.

Whilst some of this difference is because of the complexity of some cases and the need for diagnostic tests or imaging, the key factors were ethos, approach and attitude. Centres that focus on seeing patients as quickly as possible, and making sure that those with minor injury or ailment did not clog up the waiting room, completed a very high proportion of cases quickly. This focus led to their choosing to adopt a see and treat approach.

We are not under-estimating the effort that was put in to achieve this – the services had matched staff numbers to demand, they made sure that the staff carrying out the initial consultations had the necessary skills to complete the majority of cases (instead of using the least experienced person to triage the patient into a queue) and they made sure that staff focused on keeping the queue to a minimum. These factors avoid the build up of significant queues and are often associated with see and treat. This:

- Minimises the productivity-sapping need for triage followed by a full consultation.
- Reduces the peak load on individual clinicians, allowing adequate time for proper care.
- Improves patient satisfaction by reducing delays in the process. (See Chapter 5 for a longer discussion of the relative merits of triage and see and treat.)

Chapter 4 Findings: services do not collect the information they need to measure their effectiveness

Lack of information

We compared each of the services that we examined in detail, using the key features of a good system:

- Prompt care
- Meeting the urgent needs of the patient
- Clear scope of service
- Clear governance and management responsibility for clinical quality and cost effectiveness
- An appropriate environment
- A process that supports these objectives.

In addition to looking at the processes and environment we looked for data on:

- The pattern of demand – daily and hourly.
- Timeliness of response – the proportion of patients discharged within different time horizons and the variation in time to the first full consultation
- Productivity – the number of cases per clinical hour
- Cost per case and information about the clinical condition and referral to other services

We did not expect that the information necessary to judge these aspects would be in a standard format. We recognised that measurement points would vary – but we did expect UCCs to collect and examine sufficient data to understand their service and its performance.

We found that, regrettably, much of this information was not reported. In many cases, the systems did not readily allow the data to be extracted. In one or two centres, we found the reports that were produced were misunderstood and did not reflect a real measure of the patient's episode of care.

In general, services do count the number of patients seen and often understand the pattern of average demand well. They often collect information about ethnicity and where the patient says they might otherwise have gone. These things do matter, but we came away with the impression that little attention was paid to using data to examine the overall process and patient journey, the quality of care provided and meeting patient expectations.

We found a surprising lack of attention paid to:

Time to discharge

We were surprised that there was so little attention paid to the time to discharge except against the former four-hour standard. Measuring the percentage completed in one and two hours and following the trends over time provides a very easy way to track how the service responds to the majority of patients who require a very small (albeit important) amount of clinical input.

Average waits

Little importance was placed on measuring average waiting time, despite the target in previous NHS plans of an average waiting time of less than 75 minutes. We were particularly interested in the time to treatment that is now included as one of the A&E clinical indicators but was seldom reported.

Multiple consultations

At least one service measured the waiting time ahead of each consultation, but had failed to recognise that for a small number of cases there were two or more consultations. This made it impossible to calculate both waiting time and overall time to discharge.

Productivity

Very few services routinely measure productivity. Those that did were mainly independent organisations that appeared to have been given more demanding targets. They highlighted their focus on this aspect and described their careful adjustment of the rota to match demand. See Chapter 6 for more details.

Clinician consultation rates

Services seldom appear to compare the consultation rates of individuals to identify good practice. Some clinicians may be so quick it raises questions about the thoroughness of their consultation. Others are so slow that the service is unable to keep up with demand. This sort of comparison needs to be interpreted with care and understanding of the service - but it is a vital part of clinical governance and ensuring that the service delivers value for money.

High quality clinical coding

Services are often set up to provide additional capacity to support either primary or secondary care. Here, we would expect close attention to be paid to the type of case that presented. But in many instances, clinical coding was incomplete, and too many cases were categorised under a general classification such as 'other'. Without this information, it is difficult to see

how an evaluation can be carried out of whether the objectives were met .

Referral to secondary care

Few services measure and report exactly which patients have gone on to secondary care. Whilst some UCCs collect and analyse this data, the coding is often poorly defined or inconsistently used. It can be difficult to see whether the patient was referred to their practice/secondary care or simply given advice that they should go there if the symptoms got worse or they did not recover within a given time. 'Safety netting' is important, but should not be coded as a referral.

Value for money

Many PCTs claimed UCCs deliver better value for money compared to the tariff for A&E attendances. But even when cost information was available, it was incomplete. It was very difficult to judge whether it could be legitimately compared to the all-inclusive tariff price and whether the service resulted in a saving to tax payers. Without comparing the total costs with the savings that have been made elsewhere it is difficult to be sure if a new service has really saved money - but certainly we were wary of claims based on a simplistic comparison of partial costs with the tariff in A&E.

Chapter 5 Findings: the clinical process and integration with other services

Triage versus see and treat

Most centres that we visited used clinicians to triage patients. Sometimes this was a cursory check to direct the patient to the appropriate stream. In other services, patients had to wait in a queue to be triaged. In some of this latter group, triage involved a fuller history and examination.

In one UCC dealing with a relatively simple caseload analogous to that in many walk-in centres we saw a 15-minute triage process followed by a significant wait and then a 25 to 30 minute consultation. We believe that the process was unproductive and the waiting provided a poor patient experience.

All services aim to identify patients where the process might take longer, such as where imaging or diagnostic tests are required, and to order any tests early enough to complete the episode of care in four hours. Sometimes the triage clinician could order the relevant tests. In other cases they were prioritised and another clinician then examined the patient before specifying and ordering the appropriate tests or images.

When challenged, services agreed that the triage process added little value but defended it on the basis that when the service got behind it was better than the alternative, because cases that require urgent attention were given priority.

We remain sceptical that a quick 'eyeball' of a patient was enough to ensure any delay is safe. The longer triage process was more thorough but we were still wary of any assumption that an extended wait was therefore safe. We were also very conscious of the duplication of effort associated with triage – with every patient being seen by at least two clinicians, each of them starting from the beginning again.

An important benefit of the see and treat approach is that duplication is reduced, freeing capacity instead of tying one clinician up in triage. This makes it much easier to keep up with demand. One of the key features of see and treat we saw was the use of experienced staff to carry out the process. This put them in the position of making key decisions about the use of other staff thereby making effective and productive use of other staff groups by monitoring their workload and directing patients accordingly.

Whilst it is true that see and treat becomes very difficult to achieve if the centre is understaffed, the duplication of clinical resource inherent in the triage process also puts great pressure on an understaffed unit. Understaffing should not be regarded as the norm for which services have to develop unsatisfactory work-arounds.

Integration and consistency of service

The centres that we examined had often been commissioned separately, yet it was striking how often they were sited next to an out of hours service or a GP-led health centre. However there were rarely any formal operational links – indeed, often contractual arrangements were a barrier to joint working. We were pleased that many staff had made practical and informal links to make sure that patient needs were met. But in some places these links were only effective when certain staff were on duty.

We could not see any good reason why two services, working side-by-side and seeing a similar group of patients, should operate entirely independently. Better joint working could lead to more efficient use of staff, with more ability to respond to the inevitable hour-by-hour fluctuations in demand. There is also potentially much higher productivity when there is sufficient

work for each group of clinicians (nurses, nurse practitioners, GPs etc.) to focus on their areas of strength.

Commissioners should ensure that services on the same site seeing similar patients work together, whether they are badged as urgent care, out of hours, walk in centres or minor injuries. At one centre we visited the provider has integrated the staff and infrastructure (despite having to operate under separate contracts) for an 8-to-8 centre and a UCC.

There seems to be a particular issue with nurse-only services where there is often a wide mix of capability that means the case mix that can be seen depends who is on duty. At the times when an experienced nurse practitioner is not available, a narrower range of patients can be treated.

We advise commissioners to check that the capability of the service does not vary significantly over time and that the capabilities are such that the objectives set for the centre can be met.

To address this issue one walk in centre moved from a nurse-only model to a mixed group of GPs and nurses. A focus on productivity has reduced waiting times and ensured consistent service throughout the opening hours. This has reversed a decline in the number of patients using the service. In another more rural area considerable effort has been made to ensure all MIUs operate a consistent service and have a common skill

base for all Emergency Nurse Practitioners staffing the service.

NHS 111 phone number

The new 111 telephone initiative is still being implemented, so it is too early to say what level of demand it may generate and what proportion of cases are likely to be directed. Indeed, the same case may potentially be referred to a number of possible services – a UCC, an ED, the patients' GP or an out of hours service.

There are, however some things that are clear. The volume will be large - and is likely to be larger than that indicated by the pilots once the service covers all of England, is advertised and widely recognised by patients and when the NHS Direct service is decommissioned.

The work involved in setting up a comprehensive and effective directory of services to direct patients to the right place, where they can be given the right care, is considerable. Even when it is up and running in each area, it is inevitable that operational experience will, in many cases, lead to further changes to the way that urgent care is provided.

The pressing need for services to work together will, if anything, be even greater when NHS 111 is rolled out nationally from April 2013.

Chapter 6 Lessons: key points for clinical commissioners

There are a number of useful lessons for clinical commissioners from this review. In particular, commissioners need to think about:

- Clearly defining the expectations of all services and measuring their impact across a whole health economy
- Specifying the data required to demonstrate the impact and analysing the data intelligently
- Integrating urgent care services with the wider primary and secondary care system
- Promoting the use of “see and treat” processes rather “triage and wait”
- Developing a consistent approach to governance that drives quality and cost effectiveness
- Collecting patient feedback consistently and coherently and acting on what it tells you
- Describing urgent care services accurately for the NHS 111 Directory of Services and using this data as the basis of clear information for patients.

Clearly defining services

Commissioners should pay attention to:

- Carefully defining the expectations of new services
- Designing services that are capable of meeting those expectations
- Analysing any service carefully, measuring its impact across the whole health economy
- Working with providers to publish and share analysis of impact and results.

Specifying the data they require and analysing it intelligently

This review shows that many UCCs do not routinely collect the data needed to show how effective they are. They were not able to provide robust information about productivity or cost, for example. Attention needs to be paid not only to what data to collect but also to its quality, in particular the quality of clinical coding. For example,

UCCs should report the relevant measures from the A&E clinical quality indicators such as:

- Unplanned re-attendance
- Total time in the UCC and, if co-located, within the UCC and A&E together
- The percentage who leave without being seen
- Service experience
- Time to treatment.

Commissioners and providers should be careful to identify all costs including medicines and on-costs such as cleaning, management and governance, buildings and facilities etc. In justifying centres on the basis of cost savings commissioners should not assume a below-tariff cost per case means a saving will be made, but make sure that the level of savings will be made in A&E.

Providers should demonstrate how they plan resource levels to meet average demand and the predictable variation around the average

Integrating urgent care services

This has a number of domains.

Commissioners and providers should ensure that UCCs and other co-located services such as GP out-of-hours services make effective use of skills, facilities and management resources in a joined-up model. In some cases, the separation of out-of-hours services from walk in centres or UCCs is already being eroded. We welcome this process but our benchmark of out of hours services highlights the importance of doing this in a way that does not lessen the standard of responsiveness to either group of patients.

Whether or not the service is co-located with A&E it is vital that the process for patients referred from the UCC to A&E is timely and that all relevant information is passed across effectively. This is a group of patients that by definition will be suffering

from some acute condition, require specialised treatment or be in considerable pain. Commissioners should make sure that the processes are well designed and well understood by all staff on both sides. They should also ensure that the process brings together the necessary information to allow the totality of the patient journey to be followed and analysed for governance purposes as described below.

Commissioners must ensure that there is clarity about who has responsibility in what circumstances for reallocating resources and patients (including between providers) when this is necessary. How does this work when, for example, the UCC is under-staffed one evening and there is a knock on effect on the performance of both the co-located out of hours service and the local A&E department?

Finally commissioners should consider the impact of NHS 111 on the likely demand and distribution of cases between services. It is vital that urgent care services of all types work effectively, both individually and jointly, if the promise of 111 is to be delivered.

Avoiding a 'triage and wait' process

Triage plays a very important role as part of an emergency or disaster plan after a major incident but this approach is unnecessary, inefficient and inappropriate for dealing with everyday standard demand in UCCs. Clinical commissioners should work with UCCs to adopt a 'see and treat' approach rather than 'triage and wait'. This has benefits for patient safety, improves the patient experience and allows for improved utilisation of different skill groups.

A 'see and treat' approach is workable. With careful design of the rota to meet predictable demand and, for centres dealing with a very wide case mix, training of reception staff to point patients to the appropriate skill group, the service will be able to keep up. A small number of services

achieved this but we saw no reason why this should not be much more common given:

- The predictability of demand
- The headroom that clinical leads identified in productivity, measured in cases per hour
- Planned staffing levels are consistently achieved.

Developing a consistent approach to governance

Commissioners, managers and clinicians should establish a consistent approach to governance. If more than one organisation is responsible for delivery, one should be given lead responsibility for improving the service to patients across the totality of the pathway. All providers should understand the overall pathway and be able to see how their part in the care of an individual fits into the whole process.

Commissioners should ensure that:

- Information is collected for all patients that come to the UCC and any other related services, all pathways (including referral to or from services elsewhere) and all clinicians.
- The information covers a range of measures, looking particularly at clinical coding and decision-making. For example, reviewing particular sentinel conditions to see whether the treatment is in line with best clinical practice.
- They ask for data about the mix of cases seen, productivity and levels of referral to other services. They should expect to see how the provider analyses this in detail to improve the clinical quality and cost effectiveness of their own service and how this leads to suggestions to improve and better integrate care to the benefit of patients
- Information is analysed, interpreted and compared with other services and across individual clinical staff

within the service. By developing a process that provides feedback to clinical staff about their practice (in an appropriate constructive and supportive way) the mass of individual clinical decisions that drive health improvement, resource and cost can be validated and the service improved.

Capturing feedback and patient experience

The different perspectives offered by quantitative and qualitative research are complementary. UCCs need to monitor the views both of large numbers of people and of individuals. They should take a consistent, long-term approach. Greater consistency in the way questions are asked across all services would assist comparisons across different centres but is unlikely to take place across England unless collected through large-scale surveys such as the GP Patient Survey that already covers out of hours services.

In the meantime commissioners can make sure that feedback, not just from patients but also from staff within the urgent care system and other clinicians such as those in primary care is sought, captured and acted upon. The requirements in the A&E clinical indicators for a provider to demonstrate and report as a narrative on what they have learned and what action has been taken to improve the service is one that requires rigour and follow-through if the benefits to patients and the local health economy are to be fully realised.

Describing urgent care services accurately

The Directory of Services – the DoS – underpins NHS 111. It lists the local services and the skills they have on hand as well as their opening hours and contact details. Call handlers receive an incoming call from a member of the public and ask questions guided by an IT-based clinical assessment system. This identifies the clinical skills that are required to treat the caller, enabling the NHS 111 call handlers to search the DoS for the local services with the necessary clinical skills available. Patients are then directed to the best-places local service to meet their needs.

Commissioners should ensure that this data is utilised both to update information for patients and reflected in NHS Choices and similar local sources of information. Whilst there are many alternative ways in which it could be presented we recommend that, at least for NHS Choices, a consistent structure is used that makes plain what conditions can be treated and whether there are limitations on prescribing, for example because the service is staffed only by nurses.

As mentioned above, commissioners should also make sure that the advertised services are available consistently over time and not subject to variation depending on who is on duty. Finally we urge commissioners to review the multiplicity of names for urgent care services in their locality and look to simplify these in the interests of clarity for users.

Appendix A Key findings – a summary

Summary of key findings

1. There appears to be little focus on providing prompt care in many centres, so long as four-hour waiting times are not breached. Many services paid scant attention to early completion of cases or time to the first full consultation. Even since the introduction of the A&E Quality indicators too few services provide full and complete information on such measures as:

- Time to treatment
- Unplanned re-attendance
- Total time in the UCC (or UCC and A&E if co-located)
- The percentage leaving without being seen
- Service experience and feedback from patients, staff and other health professionals

2. Most centres completed fewer than half of cases within an hour, although a small number completed over 90% of cases within this timescale.

3. Many centres had little information readily available about the overall patient journey, the level of referrals and clinical coding was sometimes so incomplete to be of limited value in understanding case mix.

4. Productivity was typically between one and a half and three cases completed for every clinical hour (though higher in some restricted case-mix centres dealing with less complex cases). The centres' lead clinicians felt that this level was low – which leads us to believe that such centres do have the headroom to be able to keep up with the peaks of demand.

5. There were striking similarities across the centres in terms of demand. Most services are dealing with 90 to 120 cases per day. The pattern of demand is predictable, and the case mix is very similar to the simpler cases seen in Emergency Departments.

6. Information for the public about opening hours and the range of available services is incomplete and unreliable. In too many centres, services vary depending on which members of staff are on duty.

7. Assessing the most urgent cases quickly on arrival in urgent care is crucial, yet methods vary. Definitions of 'triage' and 'see and treat' should be better understood. Routine superficial 'eyeball' triage of patients in urgent care seems unsafe and wastes time. With appropriate planning and training, 'see and treat' should be standard practice.

8. Information on costs and cost-effectiveness is insufficient to judge whether centres offer good value for money.

9. Responsibility for overall governance was clear in some centres but opaque and fragmented in others, with ownership only of elements of the overall service. There is often a lack of clarity over who has responsibility for reallocating resources and patients and in what circumstances this would be appropriate.

10. There are unrealised opportunities for integration and joint working, especially where centres are co-located with other services such as GP out of hours.