Not just a matter of time
A review of urgent and emergency care services in England
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Healthcare Commission Not just a matter of time 1
The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission’s role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

• Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.

• Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.

• Be independent, fair and open in our decision making, and consultative about our processes.
Summary

The term ‘urgent and emergency care’ is used to describe the care provided by a number of important services, and ranges from life-saving treatment for people who suffer strokes, heart attacks or other serious medical conditions, to providing treatment and support to people with an urgent need for care or reassurance.

Every year urgent and emergency care services help many millions of people. During 2007/08 in England:

- There were 19.1 million attendances at accident and emergency (A&E) departments and urgent care centres (our term for walk-in centres and other facilities that treat minor injuries and illness without the need to make an appointment).
- 7.2 million 999 calls were made to ambulance services.
- 8.6 million calls were made to out-of-hours GP services.
- 4.9 million calls were answered by NHS Direct’s 0845 number.
- Around 300 million consultations took place with GPs and practice nurses, many of which were of an urgent nature.

These services have received significant attention from Government for a number of years, which has included setting a range of targets, introducing new services such as NHS Direct and NHS walk-in centres. As a result of these and other changes, major improvements have been achieved within the main urgent and emergency care services, particularly in performance against national targets and standards for access to services.

More recently, each NHS region in England has set out its vision for the future of local urgent and emergency care services as part of the work following up Lord Darzi’s report *High Quality Care For All*. These aim to address a range of challenges, which include dealing with increasing demand, treating more people closer to home, improving services for patients with life-threatening conditions and improving public awareness and understanding of the full range of urgent and emergency care services available.

Our review

This review looked at out-of-hours GP services, A&E services and urgent care centres, emergency ambulance services and, to a lesser extent, urgent GP services delivered during usual surgery opening hours and NHS Direct. We gathered data from all these services to produce a combined assessment of urgent and emergency care across each local area, based on the boundaries of each of the 152 primary care trusts (PCTs) in England.

This was one of the most ambitious reviews carried out by the Healthcare Commission. The challenge was to assess services from the point of view of the patient and, rather than assessing each individual service separately, we created a method of assessment which could be applied across different services. This was then used to produce an overall rating for each local area.

Through our engagement work with patients, service providers and PCTs, we identified three key themes that we used to assess the performance of organisations:
• How services are accessed and delivered.
• Working together to provide effective care.
• How services are managed.

Our findings

The review looked across all urgent and emergency care services to produce a combined assessment of the care provided across each local area:

• 33% of local areas were rated as “best performing”.
• 27% were rated as “better performing”.
• 22% were rated as “fair performing”.
• 18% were rated as “least well performing”.

Most areas performed well in the overall scored assessment produced by the review. The areas rated as best performing generally provided prompt access to services, met the needs of most of their patients and worked together to provide care and plan services in an integrated way. Performance was particularly strong in the north-east of England, where all areas received a rating in the top two categories.

Even though services in the 18% of areas rated as least well performing may be achieving the main high profile national targets, their performance was typically weaker in areas that have had less national attention. These include the performance of out-of-hours GP services, how well services are meeting the needs of people with disabilities or long-term health conditions, or in the time that patients wait at A&E or urgent care centres to see a doctor or nurse who is able to treat them.

The areas rated fair performing also have significant room for improvement, particularly in how well services work together when planning and delivering services. For example, they may be missing opportunities to share data electronically between different services or to engage patients and the public in plans for improving local services. Performance was particularly variable across London, where many areas scored in the bottom two categories.

How services are accessed and delivered

Most areas performed well against national standards for access to services:

• 97.9% of patients in A&E departments and urgent care centres were dealt with within four hours.
• 77.1% of category A ambulance responses arrived within eight minutes.

However, performance was more variable in aspects of services which have received less national attention. Although there have been significant improvements in the proportion of out-of-hours GP services that meet national quality requirements, some still cannot show that these are met. For example, only 70% of services meet national requirements for answering telephone calls, and 65% meet requirements for starting telephone-based assessments within 20 minutes of the patient's initial contact for urgent calls, or 60 minutes otherwise. (This includes some services which could not report performance against these requirements.)

Our surveys have found that most patients are positive about their experiences in A&E, but many people still experience problems contacting or seeing their local GP. For
example, 55% of people “always” or “sometimes” had a problem getting through to their GP practice or health centre on the telephone and 25% reported that they had at some time been put off going to their GP practice or health centre because the opening times were inconvenient for them.

Performance against the national target for responding to Category A 999 calls (those that are immediately life-threatening) is generally good. However, performance against the target for other urgent calls (Category B) varied between areas from under 80% to almost 100%. In a third of areas, 10% of 999 calls were not answered for more than 30 seconds, although there is some evidence that this situation has improved significantly in recent months following changes in how national targets for the time within which a response must reach the patient are measured (which have meant that services have had to improve their call answering).

We also found significant variations in the proportion of patients that were seen by a doctor or nurse within an hour of their arrival in A&E departments and urgent care centres (from under 40% to 100%), and in people’s access to medication from out-of-hours GP services (most services did not comply fully with guidance for providing medication when no other source is available).

Although many patients report positive experiences of services, our engagement work with patients and the public has found that many people are either unaware of the full range of urgent and emergency care services or are unsure about how and when to use them. Most people understand the role of their local GP and A&E department, but many are either less aware of, or less confident in using the range of new services designed as an alternative. Some people also report that it can also be difficult to navigate between services. We found a number of examples where patients were referred to services that were not available, and only 44% of out-of-hours GP services had arrangements in place with most local GPs to automatically divert calls made to the GP practice to the out-of-hours service when the surgery was closed.

Urgent and emergency care services also need to look at whether they are meeting the needs of patients with complex or particular individual needs, such as vulnerable adults and people with disabilities. While some new initiatives have been introduced to improve services for people with long-term conditions, we found some evidence that the needs of these groups are not always met and that patients are not always treated with dignity and respect.

**Working together to provide effective care**

Nearly all patients in A&E departments and urgent care centres are dealt with (discharged, admitted or transferred) within four hours and the majority of patients requiring urgent face-to-face assessments by out-of-hours GP services are seen within two hours of being assessed on the telephone (the majority will be dealt with shortly after this).

However, other ways to measure the quality and outcomes of care are more limited. The data available shows variations in the approaches taken by different services to monitoring the quality of care, and variation in the extent to which they follow guidance on issues such as the delivery of pain medication. For example, although there has been a small
improvement in the proportion of children with a fractured limb who receive pain medication within 60 minutes of arriving at A&E, performance between different A&E departments still varies from under 20% to 100%. The data also highlights the need to plan care for patients with life-threatening conditions (such as stroke or major trauma) on a regional basis, so that these patients are taken as quickly and efficiently as possible to specialist units.

There is also a need to improve the way that services work together in delivering coordinated care. Too often, patients have to repeat their details or staff have to ask for information which should be to hand, as services do not always share data effectively. While links are generally in place between GPs and out-of-hours GP services, links between other urgent and emergency care services and primary and social care are limited. For example:

- While out-of-hours GP services in 75% of areas have access to information on care plans about patients with more complex needs, the number of care plans held per patient varies, with some services holding five times as many plans per patient than others.
- Only 20% of A&E departments are able to receive electronic data from ambulance services.
- Only 30% of urgent care centres reported that all local GPs were able to receive electronically summary information about patients seen in their unit.

‘Pathways of care’ are an important means to ensure that the care of patients is coordinated across different services. However, while specific pathways are generally in place for patients with chest pain and for patients receiving end-of-life care, they are less developed for other conditions, such as mental health disorders and chronic obstructive pulmonary disease (a common long-term lung disease). As a result, some patients may be left feeling that they are being passed between services with little resolution of their problem, or they may be admitted to hospital unnecessarily as opportunities to treat and support them in the community are missed.

How services are managed

The review looked at a number of issues related to how PCTs were coping with their role as commissioners of local services. These included how well they were networking with other PCTs and with service providers, whether a clear plan was in place for local services, how well they were monitoring the performance of service providers, and whether they were listening to the views of patients and the public.

Overall, 30% of PCTs performed well across these aspects of the review and therefore were coping well in their role as commissioners of local services. Conversely, 40% scored poorly on two or more of these aspects of commissioning.

These difficulties may be due to a lack of clear models of good practice for some aspects of services as well as data on the cost, capacity and outcomes of services. Where data is available, it highlights significant opportunities to make better use of resources. For example:

- In some areas, 50% more patients than expected are admitted to hospital for conditions that could either be prevented or dealt with elsewhere.
• The proportion of ambulance journeys to A&E departments with a turnaround time of more than 15 minutes varies from under 10% at some departments to over 90% at others (although it is recognised that data in this area could be improved).

While PCTs and service providers may meet regularly, there is less evidence of joint action, effective monitoring or of a clear plan for how services will evolve. Many urgent and emergency care networks cover only a single PCT area, which limits their ability to plan how specialist services will be delivered and to compare performance across different providers.

Many PCTs and service providers need to make better use of data on their performance and improve their engagement with patients and the public in developing their plans.

All PCTs monitor performance against national standards and the level of use of the main urgent and emergency care services. Many also regularly monitor (at least quarterly) aspects of the quality of out-of-hours GP services, such as patients’ complaints (74%) and patient safety incidents (66%). However, only 25% monitor complaints about ambulance services at least quarterly and only 30% monitor levels of patient safety incidents in A&E departments. All PCTs have taken some action to try to increase people’s understanding of urgent and emergency care services, but because they do not evaluate its impact, they often miss opportunities to identify when this work makes a real difference.

Conclusions

There have been significant improvements over recent years in the number of people dealt with within four hours in A&E departments and urgent care centres, the proportion of category A ambulance responses arriving within eight minutes, and the number of out-of-hours GP services meeting national quality requirements. These achievements have taken place despite the pressure from the significant growth in demand for many of these services.

But performance in the other aspects of the review is more variable. In particular, although most people understand the role of their local GP and A&E department, many are either less aware of, or less confident in using, the range of new services in between. In such an environment, our work with patients suggested that people’s preference is often to stick with the services they are familiar with.

In part, these problems may reflect a lack of awareness and understanding of the range of new services that have been introduced in recent years. However, our analysis has also found that many of the problems patients experience relate to the pathways they follow into urgent and emergency care. Where patients are dealt with by the initial service they contact, their care usually proceeds reasonably smoothly. But where patients are transferred or referred between services, they can experience problems, such as:

• Being told to call another service which then takes them to an answering machine.
• Having to repeat their details to each service they speak to.

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- Experiencing delays while being handed over when an ambulance arrives at A&E or when they are admitted to hospital.

As a result, it is not surprising that some patients told us that they were left feeling confused, that their care was poorly organised or that services were ‘passing the buck’.

There has been some progress in setting up local networks for planning and managing urgent and emergency care, and all regions have now set out their visions for the future of these services. However, while these managerial arrangements are now generally in place, services have some way to go before they are working in an integrated way to meet the needs of patients.

These problems can impact hardest on people who often need these services the most, such as older people and people living with long-term health problems or disabilities. Negative experiences of care for these patients can not only lead to frustration and anxiety, but can leave them upset – particularly where they do not feel that they have been treated with dignity and respect – and anxious about using services in the future.

**Next steps**

All regions now have the opportunity, through the regional NHS Next Stage Reviews and the data produced by this review, to improve this situation significantly.

**Recommendation 1: PCTs should ensure that they have a clear plan for the delivery of integrated urgent and emergency care services across their area.**

Urgent and emergency care services face some key challenges, including increasing people’s awareness of services, making best use of resources, and better meeting the needs of patients with more complex needs. Delivering services in an integrated way should not be seen as yet another challenge – in fact, the key lesson from our work is that integration is the answer to these challenges. Integrated services are easier for patients to understand and navigate, they are also more likely to make the most of their resources (for example, avoiding unnecessary journeys to hospital) and they are better placed to meet the needs of people with complex needs.

The NHS Next Stage Reviews have provided an opportunity to clarify both the purpose of different services and how they fit together to provide care in an integrated way. Clarity over the purpose of services should also enable PCTs to better monitor how each service is contributing to this vision and therefore evaluate whether services are providing value for money. Once the purpose of each service is clear, it will be easier to explain them to patients and the public and build people’s understanding of where, when and how to use them.

A common theme of the regional NHS Next Stage Review is simplifying how services are accessed. For example, most considered the introduction of a single telephone access number for urgent care services (an urgent care alternative to ’999’). Such a service could potentially help to ensure that patients get to the right service as quickly as possible. But it would also fundamentally change how services are delivered and will need to be developed with the full engagement of local health and social care services.
Recommendation 2: PCTs should ensure that patients and the public are fully engaged in plans for the future of services, particularly those from vulnerable groups and those with complex needs.

It is particularly important that this work engages people from vulnerable groups and patients with more complex needs, whose experiences in the future will provide a key test of whether current reforms have worked.

Recommendation 3: Service providers should ensure that they are fully engaged with PCTs in addressing the results of the scored assessment and in driving improvements to services.

Even though the configuration of local services may differ between local areas, all services should meet relevant requirements and standards. PCTs and service providers should now work together to ensure that performance against these standards and requirements is monitored and reported, and to address the issues highlighted in their local scored assessment. Service providers also need to ensure that they are engaged in wider plans to deliver integrated urgent and emergency care services. Indeed, much of the innovation currently taking place has been driven by providers, where a range of partnerships have grown up between services looking to work in more integrated ways. Providers also have a vital role in ensuring that the right performance measures and incentives are in place to encourage integrated working.

Recommendation 4: PCTs should ensure that they are making effective use of information to monitor and improve urgent and emergency care services. This should include ‘whole system’ measures of outcomes and patients’ experiences, from initial contact to resolution of their problem.

Recommendation 5: Service providers should support PCTs in the design, collection and reporting of this information.

To support the delivery of integrated services, commissioners and service providers need data that provides a balanced picture of the performance of services. National targets and standards within each urgent and emergency care service have played an important role in driving improvements for patients. However, the challenge now is to develop measures that look along pathways and across services, such as measures that show how efficiently patients are handed over between services, the proportion of patients treated by the most appropriate service and ‘whole system’ times from initial contact to resolution.

Recommendation 6: The Government should review what national action they can take to support integration across urgent and emergency care services and simplify how these services are accessed. This should include:

- Helping to ensure the organisational stability that PCTs and providers need to plan ahead.
- Supporting the planned pilots of a single telephone number for urgent care.
- Ensuring consistency in terminology, targets and standards across services.
- Reviewing how targets should evolve to support integration of services – including supporting the development of whole system measures of outcomes and patients’ experiences.

There is much that Government can do to help commissioners and service providers. Greater organisational stability should help to ensure that all commissioners adapt to their new
Summary

roles and that the ambitious plans set out in the NHS Next Stage Review can be delivered. The Government will also have an important role in supporting plans to pilot a single telephone number for urgent care services.

The Government should also ensure that policies look across services in an integrated way. For example, greater consistency in terminology (such as in the names given to urgent care centres and the terms used to prioritise patients’ needs) should both support integrated working and make services easier to understand. It is also about ensuring that, as far as possible, standards and targets are applied consistently across different services. The Government should review whether targets to measure the performance of individual services should, in the longer term, be replaced with ‘whole system’ performance targets (similar to the 18-week target for inpatient treatment).

**Recommendation 7:** Government and national organisations (such as the Ambulance Service Network, the Royal College of Nursing, the College of Emergency Medicine and the Royal College of General Practitioners) should support the development of better information on the performance of urgent and emergency care services.

National professional organisations, as well as the Government, also have an important role in supporting the development of better information on the costs, processes, quality and outcomes of care.

Taking regulation forward

The Healthcare Commission will be working with trusts in the least well performing areas over the coming months to ensure that areas of poor performance are addressed. We will also be supporting a series of regional workshops aimed at those who commission services, to explain how they can make the most from the data collected during the review.

We will also aim to pass on the key lessons from this review to the Care Quality Commission, which takes over as the new integrated regulator of health and social care from April 2009. The new regulator should be in a strong position to take these lessons forward, through both its assessments of the performance of commissioners and by ensuring that its assessments of providers look at how well different services work together. It will also be in a powerful position to look beyond urgent and emergency health services to how urgent needs for social care are met. This will be particularly important in looking at how well local health and social care systems are responding to the needs of people with long term conditions and other more complex needs.
The term ‘urgent and emergency care’ is used to describe the care provided by a number of important services, and ranges from life-saving treatment for people who suffer strokes, heart attacks or other serious medical conditions, to providing treatment and support to people with an urgent need for care or reassurance.

Each year, urgent and emergency care is provided to many millions of people. During 2007/08, there were 19.1 million attendances at accident and emergency (A&E) departments and urgent care centres*, ambulance services received 7.2 million emergency calls, 8.6 million calls were made to out-of-hours GP services, and 4.9 million calls were answered by NHS Direct’s 0845 number. In addition to this, around 300 million contacts are made each year between patients and GPs and nurses in local general practices, many of which require urgent care (see box 1 over the page).

This report looks at the main general urgent and emergency care services. It focuses on the work of out-of-hours GP services, A&E services and urgent care centres, and emergency ambulance services. It also looks, to a lesser extent, at urgent GP services that are delivered during usual surgery opening hours (where only limited data is available) and at the work of NHS Direct. In addition, it looks at the work of primary care trusts (PCTs) and local networks in managing and coordinating these services.

In the review, we considered urgent and emergency healthcare services from the point that the need for care is identified, up to the point that this need is resolved, for example, through treatment, reassurance, or admission to hospital. The review did not look in detail at specialist services such as those for urgent sexual health or at the delivery of urgent social care. However, where possible, it did look at the links between these services and the services listed above. It did not look in detail at care provided after a patient was admitted to hospital, which was the subject of a previous review by the Healthcare Commission.¹

Urgent and emergency care has been the focus of Government reforms for a number of years. Services have been subject to a range of Government targets (aimed particularly at making services easier to access), as well as other reforms that aim to deliver services closer to people’s homes and improve care for people with long-term conditions.

As a result, major changes have been made across these services – new services such as NHS Direct and NHS walk-in centres have been introduced, and the roles of nurses, paramedics and other staff have changed with the introduction of roles such as emergency nurse practitioners and emergency care practitioners. Many services have also experienced significant reorganisation, including major changes to the responsibilities of PCTs to the boundaries of most ambulance trusts and changes to the organisation of out-of-hours GP services (see box 2 on page 13).

¹ In this report, we use the term ‘urgent care centres’ to describe walk-in centres, minor injury units and other facilities that treat minor injuries and illness without the need to make an appointment.
## Box 1: Overview of urgent and emergency care services

### A&E departments and urgent care centres

- Major A&E departments operate 24 hours a day and provide the full range of urgent and emergency care. They are a consultant-led service with full resuscitation facilities and designated accommodation for the reception of patients.

- Urgent care centres are usually open outside usual office hours and provide care for minor injuries and illnesses. Walk-in centres are typically located in town centres, while minor injury units are typically located next to A&Es.

- During 2007/08, these services received 19.1 million attendances (compared with 14 million A&E attendances in 2002/03). Most of this extra use is due to the increased number of urgent care centres.

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

### Emergency ambulance services

- These respond to emergency (999) calls from the public and health professionals through the deployment of ambulances and other response vehicles. They also respond to some non-urgent calls with telephone advice and can provide other services such as urgent care services in the community.

- During 2007/08, they received 7.2 million 999 calls, they responded to 1.8 million Category A (life-threatening) incidents, and they made 4.3 million journeys to hospital.

- Between 2001/02 and 2006/07, the number of emergency calls increased from 4.7 million to 6.3 million.

- The total cost of these services is around £1.1 billion a year (or £23 per person).

### Out-of-hours GP services

- During 2007/08, out-of-hours GP services received 8.6 million calls and completed 6.8 million medical assessments (there is no good national data on the long-term trend in the use of these services, but these levels are broadly similar to those in 2006/07).

- They carried out 2.9 million assessments by telephone, 0.9 million assessments on home visits and 3 million assessments where the patient attended a primary care centre.

- Around 1.5% of the calls they deal with are classified 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).

### NHS Direct and other urgent primary care

- During 2007/08, 4.9 million calls were answered by NHS Direct’s main 0845 service, down 3.3% from 2006/07.

- Each year around 290 million consultations take place with GPs and practice nurses, many of which are of an urgent nature.

- Between 1995 and 2006, the number of consultations grew at the rate of 3% each year. Over this same period, there was also an increase in the proportion of telephone consultations (up from 3% to 10% of contacts) and a decrease in the proportion of home visits (from 10% to 4% of contacts, although this is largely linked to the reorganisation of out-of-hours GP services).

- Around 750 million prescription items are dispensed each year by local pharmacy services, many of which also relate to urgent care.
Box 2: Why and how urgent and emergency care services have changed

<table>
<thead>
<tr>
<th>Drivers of change</th>
<th>Changes to services</th>
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<tr>
<td>Long waits for services and treatment.</td>
<td>Changes to how patients are managed in hospital (for example, greater use of minor</td>
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<td></td>
<td>injury areas/units and emergency nurse practitioners, and improvements in how</td>
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<td></td>
<td>admissions are managed).</td>
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<tr>
<td>Increasing use of services.</td>
<td>Reorganisation of out-of-hours GP services.</td>
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<tr>
<td>Pressures on facilities and staff (including changes to working arrangements).</td>
<td>Changes to the responsibilities of GPs.</td>
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<td>Concerns over sustainability of GP services delivered in usual surgery hours and</td>
<td>Introduction of walk-in centres (including commuter walk-in centres).</td>
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<td>out-of-hours.</td>
<td></td>
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<tr>
<td>Increasing number of patients going to A&amp;E departments and subsequently being</td>
<td>Specialist roles for nurses and paramedics (for example, to enable more patients to</td>
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<tr>
<td>admitted to hospital.</td>
<td>be treated at home).</td>
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<tr>
<td>Rising expectations for convenient services.</td>
<td>Increased resources and number of staff.</td>
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<tr>
<td>Fragmented working across services.</td>
<td>Introduction of NHS Direct (and extensions to other telephone advice services).</td>
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<td>Variations in standards of care.</td>
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<tr>
<td>Patients going to ‘the wrong service’.</td>
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</table>

As a result of these and other changes, major improvements have been achieved within the main urgent and emergency care services, particularly against national targets and standards for access to services (discussed later in this report).

More recently, each NHS strategic health authority in England has published its own locally-developed vision for the future of urgent and emergency care in response to the work of Lord Darzi’s *NHS Next Stage Review: Our NHS Our Future*. These show that, while there have been improvements in the range and responsiveness of many urgent and emergency care services, there are still significant areas of concern. These include:

- A rising demand for services.
- Patients attending A&E who could have been treated nearer to home.
- A lack of public awareness of some services and confusion over how to access the right service for their needs.
- Variable access to high quality specialist services.
- Problems getting services to work together well.
- Problems accessing some services, such as GP appointments or specialist diagnostic tests.
The urgent and emergency care service review

Service reviews look in detail at particular healthcare services or the care given to specific groups of patients. We carry out reviews where an aspect of health or healthcare is of importance across the country and where there are opportunities to make substantial local improvements. Service reviews promote improvement in performance (and therefore benefits for patients) by assessing local services, publishing data and highlighting key national issues.

For this particular review, the challenge was to assess services from the point of view of the patient. Rather than assess each individual service separately, we created a method of assessment which could be applied across different services, and then used to produce an overall rating for each local area. These local areas were defined by the boundaries of the 152 primary care trusts (PCTs) in England. PCTs are the main NHS organisations responsible for planning and overseeing the delivery of local NHS services. While much of the data looks at the performance of a particular urgent and emergency care service, where possible we looked across services to see how well they were integrated (how well they work together to better meet patients’ needs).

These area-based assessments were built up in a number of stages:

1. Data on individual services was collected (directly from the organisations involved, or, where possible, from existing national data sources).
2. This data was then matched to the relevant local area.
3. A set of 36 ‘scored indicators’ was formulated which measured aspects of services on a common scale (see Appendix A).
4. These scored indicators were then combined to form scores for each of the three ‘themes’ in the review:
   - How services are accessed and delivered.
   - Working together to provide effective care.
   - How services are managed.
5. Scores for the three themes were combined to give an overall score for each area, which was labelled: “least well performing”, “fair performing”, “better performing” or “best performing”.

To ensure consistency across the 36 indicators in the framework, each was scored between 1 and 5. Where possible, a score of 3 represents the level of performance set in national standards, targets or quality requirements. Where this is not possible, a score of 3 is generally set to represent average performance. Scores of 3 and above then represent performance that exceeds these acceptable levels of performance and scores below 3 represent performance below these levels.

We developed the framework for the review between January and August 2007, and worked with a number of local services to develop and test the framework and the data collection forms. The draft framework was then discussed with the review’s advisory
group, which included representatives from a range of national organisations, and the draft data collection forms were issued for consultation. The data was collected between October 2007 and April 2008, with the majority covering activity for the six-month period from April to September 2007.

To ensure that the framework focused on what matters most to patients and the public, we held a workshop with representatives from a number of national patient groups, and we reviewed existing research into people’s views of urgent and emergency care. As much of this work focuses on the view of the public in general, we also carried out some further research that sought the views of patients with complex or particular individual needs to see how well their needs were met.

Where possible, these findings were used to develop the indicators in the review. For example, we were advised to ask not just whether A&E departments and urgent care centres had hearing loops, but to ask how often they were tested, as some patients reported that these systems were often not working properly. However, not all the concerns raised by these groups related to issues which could be measured, and instead these particular concerns are included in the relevant sections of this report.

This report

This report summarises the findings of the review, drawing mainly on the data used in the local assessments. It also uses the findings of our engagement work with patients and the public, as well as some data from other sources. It highlights important lessons for PCTs, service providers and Government and other national organisations.

The findings will be of interest to service managers, staff in PCTs and national policy makers, as well as others with an interest in urgent and emergency care. It follows the same broad structure as the scored assessments, and should therefore also help people to better understand the results for their local area.

This report is being published alongside the results of the scored assessments and a set of more detailed benchmarking information, which aims to help service managers and PCTs make best use of the assessments. We will also carry out some further work in areas scored as least well performing, which will involve regional Healthcare Commission staff visiting local managers to discuss what action they will take to improve.
What we found overall

Most areas performed well in the overall scored assessment produced by the review. Thirty-three per cent of all areas were rated in the “best performing” category, 27% were rated “better performing”, 22% were rated “fair performing” and 18% were rated “least well performing” (figure 1). These overall scores represent the combination of performance across all the services covered by the review and across each of the issues in the performance framework.

The main reason that many areas received positive assessments is that performance across the measures in the ‘access’ theme was generally strong (the average score for this theme was 3.10, compared to 3.02 and 3.04 in the other two themes). In turn, this performance reflects the strong focus given to response times and other measures of accessibility in national targets and standards.

Although services in the least well performing areas may be achieving the main high-profile national targets, their performance is typically weaker in aspects of services which have had less national attention. These include the performance of out-of-hours GP services, how well services meet the needs of people with disabilities or long-term health conditions, or how long patients wait in A&E or urgent care centres to see a doctor or nurse who is able to treat them.

Areas rated fair performing also have significant room for improvement, particularly in how well services work together when planning and delivering services. For example, they may be missing opportunities to share data electronically between different services or to engage patients and the public in plans for improving local services.

In general, the better and best performing areas perform well across many of the issues addressed by the review, including: providing prompt access to services, meeting the needs of most of their patients and working together to provide care and plan services in an integrated way. However, even in these areas, there was room for improvement in some of the aspects of services looked at in the review.

Performance in different areas

Looking across the regions of England (as defined by the boundaries of the 10 strategic health authorities), most received similar average overall scores. Figure 2 shows the range of performance in each region, as well as the average of the scored assessments. All regions have some PCT areas which score in the best performing category, and most also have some areas which are scored as least well performing. The one region with a significantly higher overall average score is the North East, which is also the only region with no PCT areas scored as least well or fair performing.
During the development of the review, we talked to managers from a range of services about the challenges of delivering services in different regional areas. For example, in rural areas journey times are likely to be longer, lack of public transport may make facilities harder to access for patients and helicopter services may be needed to get some severely injured patients to specialist facilities. In urban areas, while journey distances may be shorter, traffic congestion can cause similar problems. Some areas had also introduced specific services to deal with other local issues (such as in town and city centres with alcohol problems at weekends).

In order to investigate these issues further, we looked at how the scores of different areas varied depending on the type of area, using the categories defined by the Office for National Statistics. This found that, despite these concerns, those classified as ‘coastal and countryside’ areas performed well. We also found that performance was weaker in outer London, compared to the performance in ‘London centre’ areas, which was generally good. We found no clear link in this review between overall performance and deprivation (as measured by the index of multiple deprivation).

The underlying reasons for these variations are complicated. The good scores in the North East reflect, in part, strong performance against national targets and standards. The poor performance in some parts of London is explained in part by the fact that some of these areas were not able to provide adequate data on the performance of out-of-hours GP services.

**What patients told us**

The scored assessment element of a service review must focus on aspects of performance that we can measure. As there is a danger that such work misses out on reporting other
What we found overall

aspects of patients’ experiences, service reviews always include some further work that looks at the experiences of patients in more detail.

With urgent and emergency care, there has already been a significant amount of work carried out to find out what patients and the public want. The results of this work are broadly consistent. For example, in its 2006 report *Negotiating the out-of-hours maze*⁷, Which? concluded that patients want “effective resolution of their problems through the provision of appropriate care or treatment, with:

- Reassurance and prompt attention
- Effective and timely care
- Integrated services – not to be passed from one service to another
- Their GP to be kept informed”.

And, while this work found that people are generally satisfied with many aspects of these services, it also found that many were either unaware of the full range of services available to them or were confused about how to gain access to them.⁷, ⁸

To supplement this work, we looked in more detail at the priorities and experiences of patients with complex or particular individual needs, including relevant carers and family members. This was both to ensure that we heard the views of patients from seldom-heard groups and because patients from many of these groups are more likely to come into contact with these services and to experience more complex pathways of care.⁹, ¹⁰, ¹¹

In the first phase of this work, we spoke to a number of national voluntary and patient-led organisations to find out about the priorities and experiences of their members. Following this, we worked with a national network of community groups to collect the general views of their members (including the families and carers of patients). We also worked with them to carry out structured interviews with members who had recent experience of urgent and emergency care in order to obtain specific stories (see box 3). We spoke to a total of 90 patients, carers or family members and collected stories on over 150 contacts with services (most people had used urgent and emergency care services more than once in the last year).

Overall, the people we spoke to from these groups had similar priorities to the rest of the population. But most also had particular priorities that related to how their specific needs were met. These included the availability of interpreters, staff knowing how to deal sensitively with their needs (such as those related to disabilities) and services sharing information effectively.

We also looked at the particular aspects of care that were the focus of people’s comments, and whether their comments were positive or negative. Two-thirds of these comments were positive, and the majority of people were happy with the services they received. In particular, most people were positive about how they had been treated by staff and how quickly they had been seen. But there were also some aspects of care where services had fallen short of people’s expectations. These included a number of examples:

- People’s individual needs had not been met or staff had not known how to deal with people sensitively. This was a particularly
common theme in the experiences of people with disabilities.

- People reported long waits to see a doctor or nurse, or for an ambulance to arrive. This was linked, in some cases, to delays caused by waiting for interpreters for patients whose first language is not English.

- People were referred to other services inappropriately. For example, they were told to call an alternative telephone number that went to an answering machine or referred to a service which referred them back to the first service.

- People had to repeat their details to

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<tr>
<th>Community/voluntary group</th>
<th>Target group</th>
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<td>Binoh of Manchester</td>
<td>Older people from an orthodox Jewish community</td>
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<tr>
<td>Brunswick Community Development Association, East Sussex</td>
<td>Older people from an Arabic speaking community</td>
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<td>Chinese Mental Health Association, London</td>
<td>Older people from a Chinese community</td>
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<td>DHIVERSE, Cambridgeshire</td>
<td>People of all ages living with HIV and AIDS</td>
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<td>Directions Plus, Cambridge</td>
<td>People of all ages with complex physical disabilities</td>
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<td>Ethnic Minorities Development Association, Blackburn</td>
<td>People of all ages from a South Asian community</td>
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<td>Waltham Forest Mencap, London</td>
<td>People of all ages with learning difficulties</td>
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<td>West Bromwich African Caribbean Resource Centre</td>
<td>Young people and older people from an African Caribbean community</td>
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<td>Wiltshire and Swindon Users Network</td>
<td>People of all ages with a range of disabilities</td>
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<td>Homeless people*</td>
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<td>Young parents from deprived communities*</td>
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* This work was carried out by the Vision 21 consultancy. Their work with homeless people was carried out with the help of the Big Issue (Manchester).
What we found overall

different members of staff and to different services. This was a particular concern for people with long-term conditions or disabilities, who were likely to be on many different medications or had complex medical histories.

Most people also had a good understanding of when and how to access their local GP, ambulance services and A&E department. However, they were less aware of out-of-hours GP services and some were unsure about what other local services, such as urgent care centres, were available or were unsure about when to use them.

The results are broadly consistent with other recent projects that have looked at the experiences of older people and people with learning disabilities\textsuperscript{10, 12} and are discussed further in the following chapters.

Conclusions

Although many areas were scored well in the review, two-fifths of the areas were rated as least well or fair performing. Even in the better and best performing areas, there is room for improvement in some of the issues that the review looked at. In particular, while most services scored well against high profile national targets for gaining access to services, performance in other aspects of care is more variable.

Patients are generally positive about their experiences of urgent and emergency care services. However, work with patients and the public has found that many people are either unaware of the full range of urgent and emergency care services or are unsure about how and when to use them. Our work with patients with more complex needs also raised questions about how well services meet these needs.
Urgent and emergency care encompasses a wide range of different healthcare needs, but all have a common requirement for a timely response. In some cases, such as heart attack, stroke or major injury, a quick response may make the difference between the patient making a full recovery or either dying or living the rest of their life with a disability. In other cases, a fast response will ensure that a patient’s condition does not deteriorate or lead to further complications.

As a patient may not know how clinically urgent their needs are, a fast initial response (by telephone or face-to-face) is important to identify any potentially life-threatening situations. Even where a fast response is not necessary from a clinical point of view, a timely and appropriate response is important to build the patient’s confidence in services and minimise the concern that waiting can cause.

Our work with patients found that most understood the need for services to prioritise and that other people may have more urgent needs than their own. But it was also clear that waiting for care can lead to frustration and anxiety, particularly where patients are not told why they are waiting or feel that they have been forgotten. While it is important for patients to gain access to services in a timely way, many also told us that it was equally important to have easy access to services and that services meet their individual needs well.

This chapter reviews these issues, and asks:

- Can people gain access to services easily?
- Are assessments started in a timely fashion?
- Can people access the services in ways that meet their needs?

### Can people gain access to services easily?

“I think the efficiency [of the walk-in-centre] was what impressed me, the fact that you could just walk in off the street, it was really easy.”

“The walk-in centre, I mean I didn’t know about it until my brother’s girlfriend had to take her kids there, that’s how I found out about it.”

“You have to really push the [GP’s] receptionist to get seen today and then they’ll squeeze you in, but even then you may get seen quicker in the A&E.”

“Maybe there should be a night time GP service which would relieve the pressure on the A&E.”

### Out-of-hours GP services

For most patients, the initial contact with out-of-hours GP services is by telephone. In 90% of areas, less than one in 1,000 of these calls hear an engaged tone. Levels of abandoned calls, when a caller terminates the call before they speak to a call handler, are higher in some areas. For example, 15% of areas reported that more than one in 20 calls are abandoned (although this may be because some could not exclude calls abandoned during the introductory message, which may be appropriate where the caller is referred to another service). Nine per cent of areas could not provide adequate data to show that they
meet these levels of performance, as set out in national quality requirements.*

National quality requirements also state that 95% of calls to out-of-hours GP services should be answered within 60 seconds of the end of an introductory message (or within 30 seconds for services that do not use an introductory message, which only applies in three areas). These standards also say that any introductory message should not exceed 30 seconds. Overall:

- 25% of local areas “fully met” these standards, and one in five areas answered 98% or more calls within the relevant times (a significant improvement from a review in 2005, which found that fewer than 5% of areas were fully compliant).

- 45% of areas “partially met” these requirements, with between 90% and 95% of calls answered within the relevant times (or where 95% of calls were answered in these times, but the introductory message was over 30 seconds).

- 30% of areas did not meet these standards (including some areas that were unable to provide adequate data).

GP services can make it easier for patients to access out-of-hours services if they divert telephone calls made to the usual practice number to the out-of-hours service during the out-of-hours period. However, only 44% of out-of-hours GP services reported that such arrangements were in place with at least half of the relevant GP services in their area.

**GP services during working hours**

The urgent care service that deals with the greatest number of patients, but for which the least amount of data is available, is the urgent care delivered by general practices during normal office hours. The ability to see a GP quickly and conveniently was a common concern in our work with patients. While out-of-hours GP services are subject to a range of national quality requirements, national targets for GP services in normal office hours relate more to the general accessibility of services than response to urgent needs – that is for patients to be able to book an appointment with a practice nurse within one working day and with a GP within two working days.

In our survey of patients’ experiences of local health services, carried out in 2007, we looked at two issues that were more relevant to urgent care. We found that 55% of people “always” or “sometimes” had a problem getting through to their GP practice or health centre on the telephone (varying from 36% to 68% between different areas), which is an improvement from 57% in 2005. We also found that 25% of respondents said that they had at some time been put off going to their GP practice or health centre because the opening times were inconvenient for them, up from 21% in 2005. This was a particular problem for younger people (aged 18 to 35), 38% of whom reported that they had been put off seeing their GP for this reason.13

Similarly, there is variation in the proportion of GP practices that offer some extended

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* The Department of Health has set a number of national quality requirements for out-of-hours GP services. Some of these performance levels are set for when services are both “fully met” and “partially met”. The scoring framework sets out how the indicators for the review were constructed and the rules under which data from out-of-hours GP services were considered to be adequate.
opening hours (for example, in the evening or at weekends). In 23% of areas, at least half of the GP practices offered extended opening hours, while in 26% of areas none offered these. It is also unclear whether these extended hours were available for urgent (rather than booked) appointments.

These findings are consistent with the experiences described by the patients we spoke to as part of this review. While many valued their relationship with their GP, many also reported that they had problems getting appointments and that this was a key reason for using other urgent care services.

**A&E departments and urgent care centres**

For A&E departments and urgent care centres, our work with patients highlighted convenience and accessibility of location (including availability of public transport and parking) as important issues, particularly for patients who lived in rural areas. While nearly all such units are located in town or city centres or on public transport routes, only a third reported that adequate parking was available at all times. Charges for parking also vary significantly. While most (54%) urgent care centres do not charge at all, charges at A&E departments and other urgent care centres typically range from under £1.50 to £6 for a two-hour stay.

**Ambulance service 999 telephone response times**

There are no national standards set for the time it takes ambulance services to answer 999 calls, although good practice suggests that calls should be answered within five seconds at least 95% of the time. Therefore, to look at this issue, we collected data on the median and 90th percentile time taken by ambulance services to answer 999 calls. The median gives a measure of typical performance, while the 90th percentile gives a measure of how long people wait at busy times.

The median answering times were five seconds or less in most areas, and were even recorded as zero (to the nearest second) in some (figure 3a). However, in five PCT areas this median answering time was 19 seconds.
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and in many areas people could wait significantly longer than even this. For example, in a third of areas 10% of 999 calls were not answered for more than 30 seconds (figure 3b).

From April 2008, the time taken to answer telephone calls has been included as part of the overall response time in order to measure response time targets for the ambulance service. Before April 2008, the ‘clock start’ for ambulance response times (the key measure of how long it takes ambulance staff to reach an incident) was when the member of staff taking the 999 call had identified a ‘chief complaint’, an address and a telephone number on their computer. It now starts from the moment when the 999 call is connected to the emergency control room, and, as a result all ambulance services have been working to ensure that any avoidable delay at the call-answering stage is removed. Data collected during July 2008 covering 106 PCT areas found improvement in both these measures. For example, 90th percentile telephone response times fell in 92% of these areas, with an average improvement of 26 seconds on the data originally submitted.

Are assessments started in a timely fashion?

“I rang the ambulance when my mother had a stroke and told them the symptoms. In less than three minutes they were there.”

“Twice when I went to the walk-in centre the wait was over an hour, so I went away and came back later, which was unsatisfactory and discouraging.”

“I expect that there will be a bit of a wait, but if it’s not too long I don’t mind. I expect people to treat me in a friendly way, and explain what’s going on.”

Many patients make their initial contact with urgent and emergency care services by telephone. While this contact should allow staff to decide the priority of a caller’s needs, in particular to identify immediately life-threatening conditions, it does not usually involve a full assessment of their needs. This assessment typically happens at the next stage, for example:

- When the patient is called back by the GP or nurse from an out-of-hours GP service.
- When the patient is transferred to, or called back by, the nurse working for NHS Direct.
- When a doctor, nurse or paramedic starts the patient’s assessment in an A&E or urgent care centre.
- When an ambulance arrives at the patient’s location.
**Out-of-hours GP services**

National requirements for out-of-hours GP services state that a patient’s assessment should start within 20 minutes of their initial contact where a patient’s needs were initially prioritised as urgent, and within 60 minutes otherwise. These standards are considered to be fully met if they are met for at least 95% of patients and to be partially met if they are met for between 90% and 95% of patients.

Overall, for telephone-based assessments, we found that 65% of areas fully or partially met both of these requirements, including 24% where these requirements were significantly exceeded (figure 4). These figures show a significant improvement since 2005, when less than 10% of assessments were started within national quality requirements (although this may, in part, be because better data is available). This still leaves over a third of areas that could not show that these national quality requirements are met. We also found that the proportion of calls prioritised as ‘urgent’ varied from under 4% to over 32% between services, raising a concern over the consistency with which these requirements are measured.

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* This excludes patients initially prioritised as having ‘immediately life-threatening’ conditions, who should be transferred to ambulance services. Also some services do not prioritise their calls as urgent/non-urgent, in which case all assessments should be started in 20 minutes.
**NHS Direct**

NHS Direct delivers an important element of urgent and emergency care, including telephone-based assessments, advice about self-care, and acting as a gateway to other services. It has two targets for starting telephone-based assessments, similar to those for out-of-hours GP services: for more urgent (‘priority 1’) calls, to start the assessment within 20 minutes and for other urgent (‘priority 2’) calls to start the assessment within 60 minutes. During the data collection period, performance against these targets was 98% for priority 1 calls and 99% for priority 2 calls – both well above the 95% target agreed with the Department of Health. As calls to this service are dealt with according to a single national queue, and performance across the country is uniform, areas were given the same score in our framework.

**A&E departments and urgent care centres**

When a patient arrives in an A&E department or urgent care centre, they are usually booked in by a receptionist. Patients with immediate medical needs should be identified at this stage, but most usually have to wait to be seen by a clinician before their needs are fully assessed and their care is started. We measured this aspect of performance by looking at the proportion of patients who wait more than an hour from their booked arrival to when they are seen by a nurse or doctor who is able to treat or discharge them. In an A&E department, this will often be a doctor, emergency nurse practitioner or emergency care practitioner. In an urgent care centre, it will generally be a nurse.

In a typical A&E department, care starts within an hour for only 57% of patients. While there has been a small improvement in this measure over recent years, performance still varies significantly between departments and all still have further room for improvement (figure 5). This variation is wider than expected (given that nearly all departments meet the standard to deal with patients within four hours, discussed in the next chapter) and may reflect differences in how services are organised, such as whether patients are initially seen by a ‘triage nurse’ and whether nurses are able to treat or discharge patients. We found that most A&E departments use a mix of these two methods (depending, for example on time of day), while most urgent care centres aim to see and treat patients at the same time.

Equivalent data for the performance of urgent care centres was only available for 62% of centres, possibly reflecting the fact that many of these centres are relatively new or have limited IT systems. However, where this data exists, it does suggest that these centres perform significantly better. In a typical urgent care centre, care starts within an hour for 93% of patients.

Long waits for care can lead to frustration and anxiety for patients and their carers, as highlighted by our work with patients. It may also lead to some people leaving the service before their treatment is completed (although some may also leave for other reasons, such as deciding that their need for care was not as urgent as they originally thought). On average 3% of those attending A&E departments and 1% of those attending urgent care centres did not wait to complete their treatment, with rates generally higher where people wait longer for their care to start.
Ambulance services

The targets for responding to emergency calls made to ambulance services depend on the category to which the call is assigned:

• Category A – immediately life-threatening: the initial response should arrive within eight minutes of the initial call in 75% of incidents; an ambulance capable of transporting the patient (where needed) should arrive within 19 minutes in 95% of incidents.

• Category B – serious but not life-threatening: an ambulance capable of transporting the patient should arrive within 19 minutes in 95% of cases.

• Category C – other calls, including those which do not require an ambulance response: no national target – managed locally.*

These targets apply and are measured at the ambulance trust level as part of the annual health check. However, as this review looked at performance across the smaller local areas defined by PCT boundaries, we have also collected equivalent data for PCT areas (there are 12 trusts providing ambulance services in England, compared to 152 PCTs).

During our data collection period, performance at the ambulance trust level was

* The starting point for measuring performance against these targets changed in April 2008. Our data was collected using the previous definition.
generally good for category A calls, with all but one ambulance trust responding to 75% of category A calls within eight minutes. At the PCT area level, performance was more variable (figure 6). For example, in 29% of PCT areas, the proportion of incidents where the first response arrived on scene within eight minutes was under 75%.

Interestingly, we found that this aspect of performance was slightly better, on average, in areas classified as ‘coastal and countryside’ (with a median performance of 79%, compared to 78% across the whole of England). This suggests that the actions taken by ambulance services and PCTs, such as community first responder schemes and community paramedics based in rural areas, are having a positive impact.

In most PCT areas (89%), an ambulance arrives on scene within 19 minutes for at least 95% of all Category A calls. However, performance against this measure for Category B incidents within 19 minutes is significantly weaker, with only 36% of PCT areas having an ambulance on scene within 19 minutes for at least 95% of all category B calls.

These figures are consistent with national data on the performance of ambulance services, which show some improvement in response times over the last six years, but also that response times to category B calls still fall some way below the target (91.5%, compared to 95%). The 2005 ambulance review recommended replacing the Category B target with indicators based on clinical outcomes. The Department of Health has begun to look
at this, but in the meantime, the Category B target remains an important target for trusts. The target recognises that, although Category B patients may not be in immediate danger of dying, they may still be in need of urgent medical attention, including many who will be in severe pain.

Can people access the services in ways that best meet their needs?

“Staff were friendly and communicative when I got a chance to see them, but there were long periods when I was left to my own devices and wasn’t sure what was going on.”

“No interest was given or arrangements made to ensure that I had transport or money for transport.” [older patient discharged from A&E late at night]

“The staff treated me very well but I could see that they were working under tremendous pressure.”

“The walk-in centre couldn’t prescribe what I needed, so that’s why I was referred back to the GP.”

“I attended an out-of-hours GP centre suffering from a migraine headache. After waiting 45 minutes in a brightly lit room I was given a prescription. I then had to drive around town to find an all-night chemist to pick up the medication. All the stress and delay meant that the attack lasted three times as long as usual.”

A key message from our work with patients and the public was that how services are accessed is just as important as how fast services are accessed.

Surveys of patients provide one measure of how well services meet people’s needs. For example, in our recent survey of the experiences of hospital inpatients, we asked those who were admitted via A&E about whether they were given sufficient information about their condition or treatment and whether they were given enough privacy when being examined or treated, from 77% in 2006 to 75% in 2007. Conversely, respondents in 2007 were more likely to say they were given the “right amount” of information about their condition or treatment, 74% compared with 72% in 2006. 19*

We also looked at what arrangements out-of-hours GP services had in place to help patients to get any necessary medication. National guidance sets out that a full course of medication should be supplied where: treatment needs to start immediately; the medication required is standard; and where other methods of supply are not available. 20 We looked at what arrangements were in place to meet such needs following face-to-face assessments in an out-of-hours care centre or in a patient’s home, and following telephone assessments for housebound patients. We also looked at how services

* The findings of our current survey of A&E patients will be published later this year.
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ensure that the range of drugs available meets local needs and reflects good prescribing practice.

Only 29% of areas scored well in all these respects. The remainder need to improve local policies and practices to ensure that they comply properly with this guidance. For example, 39% of areas were not able to supply all the items in the out-of-hours formulary set by the Department of Health and 36% provided either a full course of medication for housebound patients, or arranged a face-to-face assessment.

It is more difficult to measure how well urgent and emergency care services meet the needs of specific groups of patients, as national survey data is not available. Therefore, for this particular element of the review, we looked at what systems are in place to meet these needs.

Children

“The A&E waiting area was uncomfortable and crowded with a noisy television blaring away in the corner. There was a distinct lack of privacy. A lady sitting opposite me was in considerable discomfort and distress having to support her obviously ill and listless son.”

“The walk-in centre they’ve got a few books (for children) but that’s about it. And at my GP’s they have got a box of toys in the corner and they’re all broken and way too old.”

We looked at what facilities were in place in A&E departments and urgent care centres for children, for example, whether children were treated in a separate area from adults and whether these areas had toys and soft furnishings. While such facilities appear to be in place in most A&E departments, they appeared less well developed in urgent care centres. For example, 92% of A&E departments had facilities to occupy children while their parents or carers were being treated, compared to 85% of urgent care centres, and 88% of children’s areas in A&E departments had toys, soft furnishings and suitable décor, compared to 38% of such areas in urgent care centres.

All healthcare services that may come into contact with vulnerable children should have clear policies on what action to take if concerns arise and there should be clear lines of responsibility for implementing these policies. We found that systems to protect vulnerable children were in place in most services, but that systems for vulnerable adults were often less well developed (figure 7).

We also found that 15% of A&E departments or urgent care centres and 54% of out-of-

![](image-url)
hours GP services had not trained all their staff in procedures for protecting children. Frontline staff, in particular, have a vital role in identifying and reporting potential abuse. We will look at this issue further in the follow-up to our review of acute services for children, which will take place later this year and will look in more detail at specialist services such as paediatric life support.

**Different ethnic groups**

“The staff always spoke clearly and slowly when I asked questions so that I can understand, especially medical terms.” (Chinese patient)

“An interpreter would have been able to help and put us at ease. We had to wait over four hours for one to arrive.” (Arabic patient)

Urgent and emergency care services should also be able to meet the needs of patients from different ethnic groups. As services in different locations deal with very different populations, it is not possible to define a comprehensive measure of this sensitivity. However, we did look at basic issues relating to providing information in different languages and whether services monitored the ethnicity of patients.

Performance in this area was mixed. Only 63% of PCTs made information leaflets available in different languages, but most services (with the exception of some A&E departments and urgent care centres) collected limited data on the ethnicity of patients. The introduction of the NHS personal demographic service is designed to help services access data on ethnicity from a central source. This should help to improve this situation, and therefore enable providers to better monitor how people from different communities use their services.

**People with disabilities**

“I felt like I was herded, not guided. I missed my slot as no-one came to get me and I could not see numbers on the ‘next appointment’ board.” (Patient with visual impairment)

“The assumption is that, if you have cerebral palsy you can’t think for yourself.”

“Hospital people don’t think in terms of your wheelchair being your legs. They move your wheelchair but don’t bring it back, so that you end up stranded, for example in the toilet.”

“I told them that they would have a big problem taking blood from me, but they didn’t listen to me as usual as they seemed to think they know best. They put in the butterfly needle and caused me great pain and bruising, so I feel that the staff need to listen to disabled people, as they know their bodies.”

“I did feel I was being treated differently, but I think this was justified because of my weight loss and HIV status. It reassured me that staff were taking my needs seriously.”

The provision of facilities for disabled patients by A&E departments and urgent care centres was more variable. Although all stated that facilities were accessible by wheelchair users and 82% reported that signs in the unit were suitable for people with visual impairments, we found that:
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- Only 54% had undertaken an audit of facilities for disabled people, that had actually involved disabled people.
- In 49% of units, less than half of the staff had received training on disability awareness.
- Only 54% of units had a hearing loop in place (and of these, a third did not test their system regularly).
- Only 41% of units produced information for patients in ‘easy read’ formats suitable for people with learning disabilities.
- 23% of A&E departments and urgent care centres did not have tools to help them assess the needs of people who find it difficult to communicate (for example, people with learning disabilities).

These findings are consistent with the views of the patients we spoke to as part of this review. While most were positive about how they had been treated by staff, some reported that staff did not always explain what was going on or seemed too busy to give them proper attention. Some also reported that waiting areas were crowded and unpleasant or that staff were rude or offhand. While some people reported that services were good at meeting their individual needs, patients also told us of a number of cases where services had fallen short. Although the number of people we spoke to was relatively small, it is a concern that people with disabilities reported many poor experiences.

Conclusions

Overall, most areas performed well on the aspects of the review related to how services are accessed. Phone calls were generally answered promptly and most patients were able to see or speak to clinical staff within the timeframes set out in national standards. Performance has improved against targets, standards and quality requirements for answering phones and starting assessments, which are now met by most services.

However, while there have been significant improvements in the proportion of out-of-hours GP services meeting national quality requirements, a minority still cannot provide adequate data to show that they meet them. Similarly, many do not fully comply with guidance on access to medication from out-of-hours GP services. PCTs, who are responsible for contracting the majority of these services, should review local arrangements to ensure that this information is accurately reported and that these requirements are met.

There are also significant variations in how quickly and easily patients can gain access to services, including how quickly patients are seen in A&E departments, ambulance response times to Category B calls, and how easily people can see their GP. Many services also need to look at whether they are meeting the specific needs of patients including vulnerable adults, children and people with disabilities.

There are inconsistencies in the levels set for standards and requirements, in the aspects of services they cover and even the language in which they are expressed. For example, GP services in normal working hours, out-of-
hours GP services and urgent care centres all provide a range of similar services, yet the standards and requirements that apply to each service are very different.

These inconsistencies make comparisons between services difficult and may lead to confusion for patients. They will become increasingly unsustainable as the lines between services blur. For example, many out-of-hours GP services now allow patients to walk into their centres without phoning in advance or are located in A&E departments, while others are providing services in normal working hours as well as out-of-hours. Primary care centres are offering general ‘walk-in’ services, while GP services are set to extend their services into evenings and weekends. And both out-of-hours GP services and ambulance services in some areas are acting as a hub for local urgent care services – putting patients in touch with a wide range of local health and social care services.
Working together to provide effective care

Urgent and emergency care services treat a wide range of medical conditions and other problems. They also have an important role in assessing patients’ needs and providing reassurance in cases where no medical care is required and in stabilising patients’ conditions before passing them to other services.

Patients want effective resolution of their problems through appropriate care, treatment and reassurance, delivered by competent and professional staff. But patients do not view the clinical aspects of their care separately from other elements. They want services to be organised and delivered in a way that meets their needs. To do this effectively, services need to work together to share data about patients and to ensure that their pathways of care are smooth and well organised.

This chapter reviews these issues, asking in turn:

- Do people receive effective urgent and emergency care?
- Do services share information about patients effectively?
- Are ‘patient pathways’ integrated across services?

Do people receive effective urgent and emergency care?

“`The (NHS Direct) staff were friendly and understanding of my concerns. They both (particularly the nurse) seemed very experienced and were able to reassure me and provide practical advice.”`

“The care provided throughout was very thorough and covered all the main concerns that we had.”

“`I went to A&E in a lot of pain. What I wanted was urgent relief from the pain, for something to be done there and then, not just to be told to go back to my GP.”`

“`My mother, who is in her 90s, suffered what turned out to be quite a serious stroke. We had to wait with her for six hours until she was finally admitted to a hospital.”`

“`There was absolutely no follow-up at all. The nurse in the walk-in centre merely told me that I have to see a doctor. The nurse was unqualified to prescribe me anything. I am unsure if I would use a walk-in service again as I didn’t really achieve anything or get anywhere.”`

Measures of overall effectiveness

There is no simple measure of effectiveness that applies across all urgent and emergency care services. Even within services, measures that look at all types of care are limited.

One measure that we did use was the extent to which patients returned to urgent and emergency care services within a short timescale, excluding cases when the second visit was a planned appointment for follow-up treatment. However, the only services able to collect this data in a consistent way are A&E services, where the proportion of unplanned re-attendances varies from under 3% to over 7%. Similar data was also provided by 33 out-of-hours GP services, where the average level
Other measures look at the speed with which patients are dealt. A key measure of performance in A&E departments and urgent care centres is the proportion of patients dealt with (discharged home, admitted to hospital or transferred to another service) within four hours of arrival. The national standard is for 98% of patients to be dealt with within this timeframe (which allows for 2% of exceptions where this may not be appropriate). The national performance against this standard has improved significantly over recent years (figure 8).

For the review, we collected data from individual A&E departments and urgent care centres and then assigned it to local areas, rather than looking at total figures across NHS trusts. We found that performance was generally good, although performance in 21% of areas was below this standard.

There has also been an improvement in the proportion of patients admitted to hospital within four hours of arrival, with 95% of patients now admitted within the four-hour target during our data collection period (up from 83% in 2004). Similarly, patients’ perceptions of these waits have also improved, with the proportion reporting that they waited less than four hours increasing from 67% in 2002 to 72% in 2006 and 73% in 2007.

Out-of-hours GP services provide services both over the telephone and face-to-face in an assessment centre or in the patient’s home. Where these services provide care (rather than reassurance or advice on self-care), face-to-face contact is required. Therefore, the
speed with which face-to-face assessments are started gives an indication of how quickly care is delivered (as the majority of patients will be dealt with shortly after this contact starts).

National requirements for out-of-hours GP services state that urgent face-to-face assessments should start within two hours of the patient’s needs being assessed on the telephone, for both home-based and centre-based contacts. Both these requirements were “fully met” (met for at least 95% of patients) in 38% of areas and were at least “partially met” (met for at least 90% of patients) in a further 18% of areas.

Although this is a significant improvement in performance compared with 2006 when only around 15% of areas fully met each of these standards, we still found that 12% of areas either did not meet one of these standards or could not provide the relevant data. We also found variations (from under 4% to over 30%) in the proportion of these assessments prioritised as ‘urgent’, raising some concern over the consistency with which this data is collected.

**Care for specific conditions**

To understand in more detail the methods used to measure the quality of care, it is necessary to look at the care provided for particular conditions. The most established such measures relate to care for people who have suffered a heart attack, where national data has been collected for a number of years. This data looks at a number of aspects of care including the use and speed of two key treatments – primary angioplasty (a medical procedure to re-open the blocked coronary artery) and thrombolysis (the delivery of ‘clot-busting’ drugs). These treatments are known to be most effective within the first three hours of an attack (the effectiveness of thrombolysis decreases significantly after this time, whereas primary angioplasty may still provide some benefit).

Analysis of this data shows that the quality of care in England for people with heart attack is generally good and improving:

- In 2007/08, 66% of hospitals with their associated ambulance services reached or exceeded the English national target (68%) for the delivery of thrombolysis within 60 minutes of calling for professional help, compared with 64% in 2006/07.
- 71% of patients in 2007/08 received thrombolytic treatment within 60 minutes of calling for professional help, compared with 64% in 2006/07.
- More hospitals are providing primary angioplasty (54 in 2007/08, compared to 35 in 2006/07), although some perform a low number of procedures and access to this treatment is restricted in some areas.
- 22% of patients are being treated using primary angioplasty (4,472 in 2007/08, up from 3,148 in the previous year).

However, there are still opportunities for improvement, including increasing the number of patients who receive primary angioplasty, increasing the number of patients in rural areas who receive thrombolysis before they reach hospital, and encouraging patients to seek help quicker.

As part of our review, we supported two ‘mini-
audits’ of the care in A&E departments and larger urgent care centres, which was carried out in partnership with the College of Emergency Medicine (CEM). These looked at the provision of care to children who had suffered a broken limb and of older people with hip fractures, and collected similar data to that collected for our review of A&E departments published in 2005. We collected data on a number of aspects of care, including the time that patients wait for pain medication and X-rays compared to guidelines set by the CEM. (This part of the review was optional, and therefore these results could not be included in the overall scored assessments of each area.)

Although we found some small improvement in these measures, performance still varies widely between different A&E departments (figure 9). In particular, the proportion of children receiving pain medication following a limb fracture within 60 minutes of arriving at A&E varied from under 20% to 100% between different departments. The proportion of older people with a hip fracture receiving an X-ray within 60 minutes of arrival at A&E varied from 0 to 80%.

Other reports have also raised concerns about the quality of care provided in some areas. A recent audit of patients who are seriously injured concluded that better care was delivered in those A&E departments that treated more cases and where consultant staff had been available. These findings, along with the above findings about the availability of primary angioplasty, emphasise the need to plan specialist care for life-threatening conditions through regional networking arrangements.
Working together to provide effective care

**Systems to monitor and assure the quality and safety of care**

Although the overall clinical quality of services cannot be measured directly, we were able to collect data on the use of systems to monitor and assure the quality and safety of care. We looked at use of clinical audits and clinical performance indicators across all services, as well as some issues relevant to specific services.

While all services have some such systems in place, there are variations in the number of audits reported, the range of issues covered by clinical performance indicators and the frequency with which monitoring takes place (box 4). It is unlikely that such differences can be fully explained by differences in the cases seen by services or differences in how services are delivered.

<table>
<thead>
<tr>
<th>Out-of-hours GP services</th>
<th>Key findings</th>
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<tr>
<td>• Systems for auditing patient contacts (call-handling and clinical assessment).</td>
<td>• While 57% of services audit at least 1% of all completed assessments, only 36% audited 1% of all prioritised calls (in line with the recommendations of the Royal College of General Practitioners).</td>
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<td>• Extent of monitoring measures of quality and effectiveness.</td>
<td>• Only 46% of services reported all national quality requirements in full to the PCT on a monthly basis.</td>
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<td>• Systems for recruiting GPs.</td>
<td>• 61% of services monitored frequent users at least every six months.</td>
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<td>• The availability of information from previous assessments when a patient calls again.</td>
<td>• 60% monitored access to medication at least quarterly.</td>
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<td>• 92% had their own selection and induction process for GPs, separate from those of the local PCT.</td>
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<td></td>
<td>• 58% had systems in place so that staff undertaking assessments have full information for repeat callers (although 89% had this information for centre assessments).</td>
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</table>
A&E departments and urgent care centres

<table>
<thead>
<tr>
<th>Issues covered</th>
<th>Key findings</th>
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<tr>
<td>• The level of clinical audit activity.</td>
<td>• The number of clinical audits reported by A&amp;Es to the trust’s audit committee per year varied from one to over 40. For urgent care centres this figure varied from 0 to over 15.</td>
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<tr>
<td>• The extent of monitoring measures of quality and effectiveness.</td>
<td>• 29% of these units had undertaken joint audits with other urgent and emergency care services.</td>
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<td>• The extent to which pathways are in place to guide the delivery of care for patients.</td>
<td>• While 78% monitored the time it takes for patients to see a clinician on at least a quarterly basis, only 45% monitored the numbers of patients who do not wait for treatment.</td>
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<tr>
<td>• Whether recent guidance from the National Institute for Health and Clinical Excellence has been reviewed.</td>
<td>• 44% monitored frequent users of their services at least quarterly (including 18% where this is monitored at least weekly).</td>
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<td></td>
<td>• While all relevant A&amp;Es take part in the Myocardial Infarction National Audit Project (MINAP), only 43% reported that they take part in the national trauma audit.</td>
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Do services share information about patients effectively?

“The A&E staff sent me for an X-ray. The two services seemed to be well linked up and the notes and results were efficiently transferred.”

“The biggest problem (with NHS Direct) is that you need to speak to several people and give the same information.”

“The biggest problem is having to repeat your medical history and details of your medication time and time again to all the medical people you are passed to.”

Patients do not view the clinical aspects of their care separately from other elements – they ultimately want services to be organised and delivered in a way that meets their needs. This includes an expectation that staff and organisations talk to each other and share information as a patient’s care progresses. Effective sharing of data should also help to improve the safety of patients, by saving time and cutting down on the chance of errors occurring.

A report in *Which?* suggests that patients recognise the importance of informing their GP that they have used an urgent and emergency care service. Systems to support this are now well established in the majority of
out-of-hours GP services. In 79% of areas, the national quality requirement for transmitting details of out-of-hours assessments to a patient’s GP by 8am the next working day are “fully met” (that is, met for 95% of assessments or more) and a further 12% of areas “partly” meet this standard (that is, they meet it for between 90% and 95% of assessments). Only 9% of areas did not meet this standard (including some that could not provide adequate data). Indeed, many services now automatically send this data electronically.

There are also links between NHS Direct and out-of-hours GP services, which enable patients' data to be transferred electronically between these services. However, there is variation (between 24% and 86%) in how often this happens in practice in different areas. It is unclear why this variation is so wide, but one problem identified by NHS Direct is that up-to-date details on local services were not always available.

Sharing data is particularly important for patients who have long-term health conditions, as they are more likely to need urgent and emergency care and their pathway of care is likely to be more complex. For example, they may be more likely to be referred between services or to be using medication that needs to be taken into account while receiving urgent and emergency care. This was a common issue to arise in our work with patients, and a number reported that they felt ‘passed from one service to another’, and that when this occurred, they typically had to repeat their details as services did not pass on their personal information.

Patients with long-term health conditions should have a care plan in place that sets out the care they are receiving. These plans, where relevant, set out what action should be taken if there is an emergency or include other information that is relevant to any urgent care (such as the medication they have been prescribed).

Systems to share care plans with out-of-hours GP services are in place in 89% of service providers, although the number of plans held per 1,000 population varies from fewer than five to over 25. This is despite the fact that national requirements state that systems should be in place to “support and encourage regular exchange of up-to-date and comprehensive information (including, where appropriate an anticipatory care plan) between all those with pre-defined needs”.14 Such plans are particularly important for people receiving end-of-life care in order to ensure that they can access pain control and that they are not admitted to hospital against their wishes. Systems to share care plans with ambulance services and A&E departments are less well developed and are only in place in around 12% of areas.

We also looked at what other systems are in place to share data between different urgent and emergency care services, including whether:

- Out-of-hours GP services could send data electronically to ambulance services and local A&E departments.
- A&E departments could access the results of pathology tests and radiology results electronically; transfer data automatically to the main hospital IT system when patients are admitted or to GPs when
patients are discharged; and receive electronic data (for example, ECG readings) from incoming ambulances.

- Other urgent care centres could transfer data automatically to their local A&E department or to local GPs.

We found that most services could improve some aspects of their performance in this area (figure 10). For example, only 37% of urgent care centres were able to transfer data electronically to local A&E departments, only 20% of A&Es were able to receive electronic data from ambulance services and only 30% of these services reported that all local GPs were able to receive summary information electronically about patients seen in their unit.

![Figure 10: Systems in place to transfer data electronically between services](image)

Are ‘patient pathways’ integrated across services?

“Their manner was friendly and helpful... they told me about the local support service for people with HIV for the first time.”

“Woken 6am by severe breathing difficulty – took nebuliser – no relief – rang GP surgery expecting to be put straight through to out-of-hours service (as happened on previous occasions). Greeted by message saying no messages can be left at this number and which gave three or four different numbers to try at different times. Difficulty in assimilating information. Tried one number – no reply. Getting desperate – feeling panicky. Rang surgery again. Same message. Let it continue – another number given now.” (Diary extract from patient with chronic obstructive pulmonary disease)

Laura, who had a learning disability, was sick and had a high temperature. Her parents phoned her GP, but were told that no appointments were available, so they took her to the local walk-in centre. The receptionist at this centre told them that they should have gone to their GP. The receptionist then called the GP and was able to book an appointment. Her parents felt undermined and that they had a wasted trip.

The pathways that patients take through the urgent and emergency care system can be complex, particularly for patients with long-term conditions. If these pathways are to best meet the needs of patients, then different services need to work together to ensure that they are consistent, and that smooth handovers take place when patients move...
Working together to provide effective care

Tony, who has cerebral palsy and other complex needs, was vomiting and unable to keep any food down for three days. On Friday evening, his parents contacted the out-of-hours GP service and were advised to take him to a walk-in centre. They waited in the waiting area for 45 minutes, despite Tony’s condition rendering him highly susceptible to infection and the centre having no access to his medical history. They were given a prescription and sent home. The next day the situation was no better and they again returned to the walk-in centre. They then had to go through the entire procedure again, as the centre had no information from the previous night (except the notes the parents had taken themselves). The next day was a Sunday, and he was still no better so his parents took him to A&E, where they had to go through the same information again. He was eventually admitted to intensive care.

between services. PCTs and local urgent and emergency care networks (discussed further in the next section) have an important role in ensuring that service providers work together effectively and that pathways are joined up across services.

Most areas have developed pathways, along with the policies and protocols that support them, for common conditions and situations, such as chest pain (developed in 79% of areas) and end-of-life care (developed in 72% of areas). Pathways are less well developed for some other conditions such as chronic obstructive pulmonary disease, where pathways are in place in only 46% of areas, and for mental health disorders where pathways are in place in 63% of areas. However, these pathways do not always cover all relevant services. For example, 25% of pathways for end-of-life care do not cover the main relevant health and social care services.

Effective integrated working across services should help to cut demand for urgent and emergency care and also prevent avoidable emergency admissions. For example, a recent review by the National Audit Office concluded that crisis resolution home treatment teams could help people with acute mental health problems to avoid being admitted to inpatient wards, particularly where they are available 24 hours a day, seven days a week. Yet they also concluded that there are wide variations in the availability of these teams and that provision of services to help support home treatment is patchy. They also found that, within emergency medicine, only 11% of staff involved in referring people to these services felt they fully understood them.\textsuperscript{24}

Services which work well together should also be better able to ensure that ambulance services can treat more people without the need for transport to hospital. Nationally, it is recognised that potentially at least one million patients could benefit from swift advice and treatment at or closer to their home or scene of the incident, rather than being taken to A&E.\textsuperscript{15} It is difficult to measure this aspect of care directly, due to differences in how information is recorded (for example, when patients refuse to travel). However, the data we collected did show significant variation, from under 20% to almost 50% in different areas, in the proportion of incidents where the patient was not transported to hospital.

However, it is encouraging that many PCTs have introduced new services that aim to help people with long-term conditions to get quick
and easy access to urgent care, including dedicated telephone numbers for people with particular conditions and training for staff in residential and nursing homes so they better understand when and how to contact urgent care services. It is not yet possible to say which of these make the most difference to patients, but these initiatives do show that services are aiming to better meet the needs of these groups.

Some have also set up ‘single point of access’ telephone services to help arrange direct admissions to acute services or to help set up community-based alternatives to admission or attendance at A&E. However, provision of these services is patchy. For example, teams that arrange community-based alternatives to admission are available in only 61% of areas, and operate 24 hours a day, seven days a week in only 18% of areas. In 9% of areas, these teams are only available in normal office hours, severely limiting their ability to provide an urgent response. Similarly, while most A&E departments have protocols in place through which they can arrange urgent social care, such protocols are only in place in 45% of out-of-hours GP services.

**Conclusions**

We know that nearly all patients are dealt with by A&E departments and urgent care centres within four hours and the majority of patients requiring urgent face-to-face assessments by out-of-hours GP services are seen within two hours of being assessed on the telephone (and the majority will be dealt with shortly after this).

However, other measures of the quality and outcomes of care are more limited. The data available does show variations in the approaches taken by different services to monitor quality of care, as well as variation in the extent to which guidance is followed. This data also highlights the need to plan services, particularly specialist services, on a regional basis.

There is also room for improvement in how well services work together. Too often patients have to repeat their details or staff have to ask for information that should be to hand, as services do not always share data effectively. While links are generally in place between GPs and out-of-hours GP services, links between other urgent and emergency care services and primary and social care are limited. The Connecting for Health programme to provide IT links between services should support improvements in this respect.

While pathways of care are generally in place for patients with chest pain and for patients receiving end-of-life care, they are less developed in other areas, such as mental health and for patients with chronic obstructive pulmonary disease. As a result, opportunities to treat more people nearer to home may be missed.
How services are managed

An important element of the recent changes in how NHS services are managed has been to give primary care trusts (PCTs) the key responsibility for ‘commissioning’ (purchasing) local services. This means that PCTs have been given control over the majority of NHS spending, alongside responsibility for ensuring that services meet the needs of their population. But for most urgent and emergency care services, planning needs to look across wider areas. This has been addressed by creating urgent and emergency care networks and boards, as well as other arrangements where PCTs have shared their responsibilities for commissioning services (often through arrangements where one PCT in a network agrees to act as ‘lead commissioner’ for a particular service).  

If these arrangements are to function well, then commissioners need good information about the performance of services, both in terms of local trends and benchmarking data looking across services in different areas. They also need a good understanding of the patients’ views and the public’s priorities. Similarly, commissioners need to work with service providers to ensure that patients get ‘the right care, first time’ by simplifying how services are accessed and informing people about their local services.

Finally, a key test of effective management is whether the best use is made of resources. While measuring this aspect of services is complex, some measures do exist that highlight the potential for many services to get more out of existing resources.

Do services work together effectively?

The Government’s strategy for reforming urgent and emergency care services has recognised the need for services to work together.  

In particular, these reforms have acknowledged the importance of local networking arrangements, through which service providers and PCTs can discuss performance and plan for the future of services.

We looked at a number of aspects of these arrangements, including which organisations are involved in networks, what action these networks have taken and how ‘healthy’ local arrangements are (for example, whether meetings of the network are well attended).

Most PCTs took part in some sort of network (only 3 did not) and most of these networks included the main general urgent and/or emergency care services (ambulance services, out-of-hours GP services, local acute trusts and local GPs). Sixty-one per cent of networks also involved other relevant organisations such as NHS Direct, 86% involved local authorities (these are responsible for local urgent social services and have a role in scrutinising local NHS services), 75% of networks involved mental health services, and 31% involved community pharmacists. However only 52% of PCTs were part of a formal network or board involving another PCT. While these figures show some progress since the review of emergency care by the National Audit Office in 2004, there is still some way to go.

Networks also varied in terms of the type of actions they had implemented. Seventy-four per cent of networks had undertaken some
shared training or arranged staff secondments between services, 59% had carried out clinical audits across different organisations and 57% had carried out investigations of adverse incidents that looked across different services. In 71% of networks, some work had been carried out to develop consistent ways to assess patients’ needs, such as agreeing common methods to assess how urgently care is required and common categories for describing different levels of urgency.

Overall, around a third (34%) of areas took part in networks that appear to be active and well developed. In the other areas, while networks may exist, they do not appear to be functioning well (if at all). One reason for this mentioned by some PCTs was the amount of reorganisation that services had undergone in recent years (including mergers between many PCTs and across most ambulance trusts). But it is also interesting to note that, despite these changes, some areas have developed their networks significantly. For example, urgent and emergency care networks in 13% of areas have a formal role in commissioning services across a wide area. While service providers may support and advise these networks, their formal members are the PCTs.

Another important aspect of managing urgent and emergency care services is having a clear strategy for the future of services. Commissioners of urgent and emergency care need to set out their expectations and agree plans and targets for how services should be delivered and how demands for services will be handled.

We found a similar picture for strategies as we did for networks. While nearly all areas (96%) had a strategy in place or under development (often as part of local work linked to the NHS Next Stage Reviews), and had talked to the main urgent and emergency care services listed above, many had not discussed the strategy with other providers. For example, 30% had not discussed it with NHS Direct, 16% had not discussed it with mental health services and 42% had not discussed it with local pharmacists. There was also variation in whether strategies were informed by analyses of local trends in the use of services or whether patterns of use had been analysed to identify whether people from particular areas or groups were making greater or lesser use of services.

Is commissioning informed by data on performance and the views of patients and the public?

Data on performance
To enable networking and commissioning relationships to function effectively, they need to be informed by good information about the performance and use of services. How frequently this monitoring takes place will depend on local circumstances, such as whether services are facing particular problems or the state of relationships between commissioners and service providers.

We found that all PCTs did monitor performance against national standards for response and waiting times and all also looked at trends in the use of the main urgent and emergency care services. Many also regularly monitored (at least quarterly) aspects of the quality of out-of-hours GP services, such as patients’ complaints (74%)
and patient safety incidents (66%). However, fewer monitored similar measures for other services. For example, only 25% monitored complaints about ambulance services at least quarterly and only 30% monitored levels of patient safety incidents in A&E departments.

Overall, only a quarter of PCTs monitored at least 20 of the 23 aspects of services we looked at. We also found variations in how often commissioners reviewed information that may help them make better use of resources. For example, while 25% of PCTs monitored at least monthly the use of urgent and emergency care services by patients from different local GP practices, 44% do not regularly monitor this aspect of care.

Similarly, many contracts for services set out objectives to help cut the number of patients attending A&E or to improve services for particular groups, but performance against these objectives was not always monitored. Contracts rarely included either incentives or penalties (financial or otherwise) for performance against such objectives.

**The views of patients and the public**

Effective engagement with patients and the public should help services to identify areas for improvement, as well as to understand people’s preferences for how services should be delivered. Monitoring patient’s views is also a quality requirement for out-of-hours GP services, as well as being an issue covered in the Department of Health’s *Standards for Better Health*, which apply to all NHS services.

All the services we looked at had undertaken some work in the previous year to listen to the views of their patients, most often through surveys of patient’s views. Many also had some contacts in place with patient groups such as PALS services within acute trusts. Sixty-nine per cent of PCTs also reported that they had met with local voluntary or patient representative groups to discuss their views.

It was less common for services to use more dynamic ways to engage with users, such as focus groups. This may be a missed opportunity, as such methods can look at people’s individual experiences in more detail to identify where things had gone wrong and, as we found with our own work, many patients are keen to engage with services and help them improve.*

It is likely that this situation has improved, as consultation has been a major focus of the recently published NHS Next Stage Review led by Lord Darzi, which was informed by the visions developed by each strategic health authority. These contained the results of a great deal of consultation over the future of local urgent and emergency care services in particular, and further consultation will take place in autumn 2008 as these plans are taken forward.

**Is information about services available to patients and the public?**

Most PCTs (or urgent care networks) publish information for patients and the public on the range of urgent and emergency care services in their area either in a leaflet, on the internet or both. Only 10% did not publish such information in either form. We scored this*
information based on whether it included information such as:

- Guidance on when to use services
- Relevant telephone numbers
- Relevant locations (for example, A&E departments and local pharmacies)
- Guidance on when patients can safely deal with situations themselves (for websites only).

While 54% of areas published data that covered all or most of these, 46% of areas did not include important items of information. (Indeed, one PCT commented that the data collection required for this review had prompted them to review and improve the information they published).

**Increasing the public’s awareness and understanding**

A key element of national and local strategies for the delivery of urgent and emergency care is ensuring that people use ‘the right service at the right time’. A clear message from patient and public engagement work is that people are unsure about how to make such choices. One strategy for addressing this problem is through running initiatives aimed at improving people’s awareness and understanding of services.

Seventy-three per cent of areas had undertaken a general campaign to raise awareness of services, and a similar proportion had undertaken a campaign aimed at using services over bank holidays. These range from adverts in the local press encouraging people to pick up repeat prescriptions before a bank holiday to large-scale campaigns to build awareness of the full range of urgent and emergency care services. Fewer had undertaken campaigns aimed at specific groups, for example, 51% had aimed a specific campaign at people with long-term conditions and 40% had targeted staff in nursing and residential homes. However, only around 40% of these campaigns had been evaluated. Bank holiday campaigns and campaigns aimed at people with long-term conditions were most likely to be judged a major success.

While it is difficult to get clear national measures of people’s awareness of services, data from NHS Direct gives some indication of how awareness and understanding varies. For example, while their ‘0845’ service is provided in a uniform way across England, use varies from under five calls per 1,000 population in some areas to over 30 per 1,000 population in others. The proportion of calls closed within NHS Direct without referring a patient to another service (which may give an indication of how well users understand the service) also varies from 40% to over 60% between different areas.

**Are services making good use of resources?**

Finally, a key measure of how well services are managed is whether they are making good use of resources. However, measuring use of resources across urgent and emergency care services is complex. For example, it is possible to look at simple measures such as total spending per member of population, the cost of a service compared to its level of activity, or workload per member of staff. But such data is difficult to interpret. In part, this is because of concerns about the quality of some of the
data, such as the lack of data on the urgent care provided during the usual opening hours of GP practices, and difficulties taking account of local circumstances, such as extra travel costs in rural areas or differences in the type and severity of cases services deal with. Similarly, where services are well-integrated or operate from the same location, it may be difficult to disaggregate aspects of their activity or performance (which is currently necessary, given the inconsistent definitions and targets used in different services).

More fundamentally, while it is right to question where costs are very high or very low, there is no simple ‘right answer’. However, such data should be useful to local service managers and commissioners, who can compare their performance with other appropriate services and then talk to them to explore the differences that emerge.

Although there is no overall measure of how well urgent and emergency care resources are used, there are some measures that identify specific areas where improvement should be possible.

One such indicator aims to measure the number of patients admitted to hospital for conditions that could be better treated in other settings. It looks at the ratio of actual emergency admissions for a set of 19 “ambulatory care sensitive conditions” to the expected level, adjusted for the age and gender of the local population. These conditions (which include, for example, asthma, chronic obstructive pulmonary disease and hypertension) have been identified as ones where community care can avoid the need for hospitalisation. This shows that levels of admissions vary from 60% more than expected to 40% fewer (figure 11).

![Figure 11: Variation in levels of emergency admissions for 19 “ambulatory care sensitive conditions”](chart.png)

Note: Chart shows relative numbers of admissions, where 100 is the expected level based on the age, gender and size of the local population.

Another aspect of care where there is potential to make better use of resources is in ensuring smooth and timely handovers of patients when they reach A&E. This can be measured by looking at how long it takes from when an ambulance arrives at A&E to when the patient is handed over to A&E staff. However, few ambulance services could measure this directly. More could measure the time taken to when the ambulance is ready to respond to another incident. According to this data, the proportion of journeys for which this time exceeds 15 minutes varies widely, from

* There are a number of such lists but there is no clear consensus on which is best. We used the set used by the NHS Information Centre.
under 10% at some A&Es to over 90% at others.

This variation may reflect a number of issues, including pressures on A&E resources (particularly staff time and numbers of beds at peak times) and opportunities to improve how A&E departments and ambulance services manage the handover of patients. It is also likely to reflect inconsistencies in how data is collected by different IT systems. The Healthcare Commission will be working with the Department of Health and service providers to investigate these issues further and develop examples of good practice.

To help make better use of resources, some areas are developing ‘real-time capacity management systems’. These use a computer network to keep track of all the urgent and emergency care services in an area and collate data on issues such as how busy each A&E department is, the opening hours of different services, the availability of urgent primary and social care services, which diagnostic tests are available at different locations and where specialist staff are working. This data is then used to ensure that patients’ journeys are as smooth as possible and that best use is made of resources across the area. To work well, such systems need significant investment as well as the participation and support of all the relevant commissions and service providers to keep them up to date and fit for purpose. However, early results indicate that they can have a real impact on the services that patients receive.28,29

Conclusions

Overall, 30% of PCTs performed well across the aspects of the review that related to urgent and emergency care networks, strategies, monitoring performance and engaging with patients and the public. These PCTs appear to be coping reasonably well in their role as commissioners of local services.

Conversely, 40% scored poorly on two or more of these aspects of commissioning. Although PCTs and service providers in these areas may meet regularly, there is less evidence of joint action, effective monitoring or of a clear plan for how services will evolve.

Many commissioners and service providers could be making better use of data both on the performance of individual services and on how well services are working together. This includes data on the quality of local services and comparative benchmarking data looking across services in different areas. Many networks cover only a single PCT area, which limits their ability to plan how specialist services will be delivered and to compare performance across different providers.

There is also limited data on how well resources are used by urgent and emergency care services. Where it does exist, this data shows significant variations. If this is to be addressed, better data is required on the cost, capacity, use and outcomes of services. While all PCTs have taken some action to try to build people’s understanding of services, opportunities to identify when this work makes a real difference are often lost, as its impact is not evaluated.
Recent reorganisations have made work in these areas more difficult, but all areas now have the opportunity, through the NHS Next Stage Review plans and the data produced by this review, to improve this situation significantly. In particular, commissioners and providers need to ensure that they are fully engaging patients and the public in these plans, both through the NHS Next Stage work and using the recently established local involvement networks (LINks).
Conclusions

The overall results of this review are positive, with 60% of areas scored as “better” or “best performing”. The main reason for this is that most services are performing at or above the levels set in national targets and standards for access to services.

There have been significant improvements over recent years in the numbers of people dealt with within four hours in A&E departments and urgent care centres, the proportion of category A ambulance responses arriving within eight minutes and in the number of out-of-hours GP services meeting national quality requirements. These achievements have taken place despite the pressure from the significant growth in demand for many of these services.

But performance in the other aspects of the review is more variable. In particular, although most people understand the role of their local GP and of A&E departments, many are either less aware of, or less confident in using, the range of new services in between. In such an environment, our work with patients suggested that people’s preference is often to stick with the services they are familiar with.

In part, these problems may reflect a lack of awareness and understanding of the range of new services that have been introduced in recent years. However, our analysis has also found that many of the problems patients experience relate to the pathways they follow into urgent and emergency care. Where patients are dealt with by the initial service they contact, their care usually proceeds reasonably smoothly. But where patients are transferred or referred between services problems can arise, such as:

- Patients being told to call another service which then takes them to an answering machine.
- Patients having to repeat their details to each service they speak to.
- Delays handing patients over when an ambulance arrives at A&E or when they are admitted to hospital.

As a result, it is not surprising that some patients told us that they were left feeling confused, feeling that their care was poorly organised or believing that services were ‘passing the buck’.

There has been some progress in setting up local networks for planning and managing urgent and emergency care and all regions have now set out their visions for the future of these services. But, while some services are working well together to provide integrated care, at least to some patients, these examples are still the exception rather than the rule. For some people, accessing services and navigating between them can be confusing and complicated, and links between urgent and emergency care services and primary and social care are limited.

These problems can impact hardest on people who often need these services the most, such as older people and people living with long-term health problems or disabilities. Negative experiences of care for these patients can not only lead to frustration and anxiety, but can leave them upset – particularly where they do not feel that they have been treated with dignity and respect – and anxious about using services in the future.
Conclusions

These problems may also reflect that many of these services were set up at a time when investment was increasing and there was an acceptance that services should evolve to reflect patients’ choices. As a result, the purpose of these new services, as well as their role in relation to other urgent and emergency care services, may not always be clear. Similarly, developing more integrated ways of working may have been made more difficult by recent service reconfigurations as well as the lack of good data on the cost, quality, use and outcomes of services.

Next steps

PCTs are now in a good position to build on the successes achieved within individual services and to overcome these and other barriers to integrated working. The NHS Next Stage Reviews provide a platform for engaging with patients and the public and building a plan for the future of services. The data from this service review should provide a useful tool to engage with service providers and improve local monitoring of performance. Most PCTs have at least a basic urgent or emergency care network in place which could be developed into a powerful mechanism for driving improvements on behalf of local people.

Recommendation 1: PCTs should ensure that they have a clear plan for the delivery of integrated urgent and emergency care services across their area.

Urgent and emergency care services face some key common challenges, including increasing people’s awareness and understanding of services, making best use of their resources, tackling increasing demands on services, and meeting the needs of vulnerable patients and those from seldom-heard groups.

Delivering services in an integrated way should not be seen as yet another challenge. The key lesson from our work is that integration is the answer to these challenges: integrated services are easier for patients to understand and navigate, they are also more likely to make the most of their resources (for example, avoiding unnecessary journeys to hospital), and they are better placed to meet the needs of people with long-term conditions or disabilities, and whose pathways through care are likely to involve more services (and therefore more opportunities for things to go wrong).

Each strategic health authority has now published its vision for the future of its local healthcare services. As these visions are taken forward through planning and into delivery, commissioners should ensure that the resulting services are integrated.
Urgent and emergency care services should ask themselves the following questions:

- Are services easy for patients to understand and (if necessary) navigate? If not, how could they be simplified?
- Are services organised across a wide enough area to include all relevant specialist services, such as stroke, heart attack and major injuries?
- Are all commissioners across this area signed up to a common plan and working as part of an active urgent and emergency care network?
- Do contracts provide the stability and incentives to support the introduction of more integrated ways of working?

Does this plan:

- Include the delivery of urgent social care (including, for example, support when carers need emergency care)?
- Cover urgent primary care delivered in-hours (by GPs and urgent care centres)?
- Address the needs of people from vulnerable and seldom-heard groups?
- Set out how commissioning will adapt to reflect an integrated approach (for example, commissioning across services/along pathways of care)?
- Set out the role of each service?

...and does it map out the implications for:

- When services will be open?
- Which test will be available where and when?
- What levels of staff expertise are required (and how they will be accessed)?
- How services will differ across the area (for example, use of telemedicine in rural areas)?

Are clear, consistent pathways of care in place:

- For common conditions?
- That set out when ambulances will not take patients to the nearest A&E (for example, when patients should be treated at home or transported directly to a specialist centre)?
- That set out when and how patients will be referred between services (and how data about them moves when they do)?
The NHS Next Stage Reviews have provided an opportunity to clarify both the purpose of different services and how they fit together to provide care in an integrated way, including the subsequent implications for issues such as opening times, staffing requirements and the availability of diagnostic tests.

Clarity over the purpose of services should also enable PCTs to better monitor how each service is contributing to this vision and therefore evaluate whether services are providing value for money. Once the purpose of each service is clear, it will be easier to explain them to patients and the public and build people’s understanding of where, when and how to use them.

A common theme of the regional NHS Next Stage Reviews is simplifying how services are accessed. For example, most considered the introduction of a single telephone access number for urgent care services (an urgent care alternative to ‘999’). Such a service could potentially help ensure that patients get to the right service as quickly as possible. But such a service would also fundamentally change how services are delivered and will need to be developed with the full engagement of local health and social care services. It will be particularly important that such services have this support, as well as the necessary resources (including up-to-date information about local services) if they are to act as an effective gateway (rather than a bottleneck) to local services.

Plans to deliver integrated services need to re-think services from the patient’s point of view. For example, a ‘real-time capacity management system’ (discussed on page 49) could fundamentally change how people use services and how they work together, but it is unlikely to deliver its full potential if the only aim is to pool data on existing services.

**Recommendation 2:** PCTs should ensure that patients and the public are fully engaged in plans for the future of services, particularly those from vulnerable groups and those with complex needs.

The people best qualified to think about services from this perspective are, of course, patients themselves. Commissioners and service managers need to engage patients in identifying where they need to make improvements to existing services, and they need the views of the local population to shape plans for the future of services. People will also need to be fully involved in these debates so that they engage with the choices that need to be made and leave with realistic expectations.

It is particularly important that this work engages people with more complex needs, whose experiences in the future will provide a key test of whether current reforms have worked. Our experience is that these groups will be keen to contribute and will have a valuable contribution to make.

**Recommendation 3:** Service providers should ensure that they are fully engaged with PCTs in addressing the results of the scored assessment and in driving improvements to services.

Even though the configuration of local services may differ between local areas, all services should meet relevant requirements and standards. PCTs and service providers should now work together to ensure that performance against these standards and requirements is monitored and reported, and to address the issues highlighted in their local
scored assessment. To support this, all the organisations that took part in the review will receive the data used in the assessment in electronic form, along with a range of supporting indicators and software with which to investigate their assessment further.*

We do not give a full analysis of the performance of individual urgent and emergency care services, but our findings do highlight some common areas of concern.

<table>
<thead>
<tr>
<th>Services should ask themselves the following:</th>
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<tbody>
<tr>
<td><strong>All services</strong></td>
</tr>
<tr>
<td>• Are adequate systems in place to monitor and assure quality?</td>
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<tr>
<td>• Are services adopting more integrated ways of working?</td>
</tr>
<tr>
<td>• Are services meeting the needs of patients with long-term conditions and other complex needs (for example, can they access relevant care plans)?</td>
</tr>
<tr>
<td>• Is adequate provision made for patients whose first language is not English?</td>
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<tr>
<td><strong>Out-of-hours GP services:</strong></td>
</tr>
<tr>
<td>• Are all national quality requirements reported to commissioners? Are they fully met?</td>
</tr>
<tr>
<td>• Do services follow national guidance related to the provision of medication?</td>
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<tr>
<td><strong>A&amp;E departments and urgent care centres</strong></td>
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<tr>
<td>• Are patients kept informed about their care?</td>
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<tr>
<td>• Are adequate facilities in place for children?</td>
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<tr>
<td>• Are adequate facilities in place to meet the needs of people with disabilities?</td>
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<tr>
<td>• How long do patients wait to be seen by a member of staff who can treat them?</td>
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<tr>
<td><strong>Ambulance services</strong></td>
</tr>
<tr>
<td>• Are there opportunities to safely treat more people at home or using telephone advice?</td>
</tr>
<tr>
<td>• Are resources deployed to meet demands? For example, how do aspects of response (such as telephone answering times or response to Category B calls) vary between different areas or at different times of the day?</td>
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</tbody>
</table>

* This software allows users to analyse the data in a number of powerful ways and allows organisations to compare themselves with others. It also looks at a number of more detailed performance measures outside the review’s framework for scoring.
Reviewing the results of the local scored assessment should also highlight opportunities for service providers to learn from each other. For example, many out-of-hours GP services have good links with other primary care services (particularly around systems to deliver integrated end-of-life care); most A&E departments have strong links to networks of expert clinicians, and ambulance services have developed sophisticated systems to match resources to demands.

Service providers also need to ensure that they are engaged in wider plans to deliver integrated urgent and emergency care services. Indeed, much of the innovation currently taking place has been driven by providers, where a range of partnerships have grown up between services looking to work in more integrated ways. Providers also have a vital role in ensuring that the right performance measures and incentives are in place to encourage integrated working. For example, contracts need to provide sufficient incentives and stability if service providers are to invest in the systems required to support integrated working (contracts for out-of-hours GP services running for four or more years were only found in 11 local areas). The new models of commissioning services along pathways of care may also have an important role here.

**Recommendation 4**: PCTs should ensure that they are making effective use of information to monitor and improve urgent and emergency care services. This should include 'whole system' measures of outcomes and patients’ experiences, from initial contact to resolution of their problem.

**Recommendation 5**: Service providers should support PCTs in the design, collection and reporting of this information.

Effective and confident commissioning will be vital if these plans are to succeed. Lack of data and clear models of good practice may have contributed to the difficulties that some have experienced. The software used to distribute the data collected in this review will allow commissioners to see which other areas have performed well, and enables them to search for local examples, or examples from similar areas. This, together with the range of good practice highlighted in a number of recent reports, will help commissioners to improve their commissioning.\(^{28,31}\)

To support the delivery of integrated services, commissioners and service providers need data that provides a balanced picture of the performance of services.
### Aspects of care that require better data to support integrated working:

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
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</table>
| **Care pathways** | • Time taken to see a clinician/deliver pain medication/undertake a diagnostic test/start treatment  
• Handover of patients between services (for example, time taken to hand over patients arriving at A&E by ambulance)  
• Total use of services for different reasons (for example alcohol-related demand, use related to mental health issues)  
• ‘Whole pathway’ time to deal with urgent needs (from time of initial contact to time urgent need is resolved)  
• Access to medication  
• Number of patients referred/redirected between services  
• Time to reach a specialist centre  
• Sharing data electronically within and between services |
| **Quality of care** | • Results of clinical audits  
• Patient safety incidents  
• Unplanned repeat attendances within a short timescale (for example, one week) |
| **Outcomes**      | • Patients treated at home/dealt with by telephone advice  
• Patients who do not complete their care (for example, who do not wait for care in A&E or do not attend appointments at out-of-hours GP centres)  
• Emergency attendances and admissions  
• Patients’ views  
• Mortality/survival rates (adjusted to take account of differences in risk and case mix) |
| **Use of resources** | • Activity/demand for services  
• Deployment/configuration of services  
• Spending |
Conclusions

National targets and standards within each urgent and emergency care service have played an important role in driving improvements for patients. However, the challenge now is to develop measures which look along pathways and across services, such as measures of how efficiently patients are handed over between services, the proportion of patients treated by the most appropriate service and ‘whole system’ times from initial contact to resolution.

The details of such measures, as well as appropriate targets for performance against them, may be best developed through networks or as part of the NHS Next Stage Reviews, so that local circumstances can be taken into account. In some cases, these issues can be looked at across all types of care. However, others may only be meaningful and clinically relevant when applied to a particular medical condition or situation. Therefore developing such measures needs to be a part of wider work to implement integrated pathways of care across services.

The IT systems used by many service providers are increasingly able to produce meaningful analyses of many of these issues, but such information is not always collected using consistent definitions or used to monitor and improve performance. Better and more consistent data across services (including urgent primary care services delivered in office hours and related urgent social care) should also help local networks and boards to monitor progress towards integration.

**Recommendation 6: The Government should review what national action it can take to support integration across urgent and emergency care services and simplify how these services are accessed.** This action should include:

- Helping to ensure the organisational stability that PCTs and providers need to plan ahead.
- Supporting the planned pilots of a single telephone number for urgent care.
- Ensuring consistency in terminology, targets and standards across services.
- Reviewing how targets should evolve to support integration of services – including supporting the development of ‘whole system’ measures of outcomes and patients’ experiences.

There is also much that the Government can do to help commissioners and service providers. For example, some services have struggled to keep up with the pace of changes to organisational structures and responsibilities. Greater organisational stability should help to ensure that all commissioners adapt to their new roles and that the ambitious plans set out in the NHS Next Stage Reviews can be delivered.

The Government will also have an important role in supporting plans to pilot a single telephone number for urgent care services. This will include ensuring that pilot schemes are properly evaluated and dealing with the major technological and organisational issues related to rolling out such a scheme across the rest of England.

It should also ensure that policies look across services in an integrated way. For example, greater consistency in terminology (such as in the names given to urgent care centres and the terms used to prioritise patients’ needs)
should both support integrated working and make services easier to understand.

In addition, the Government should review how existing policies and targets (such as the quality requirements for out-of-hours GP services and the quality and outcomes framework for GPs) may be used to support and encourage more integrated ways of working. In part, this is about using clear and consistent definitions, such as rules for counting activity and measuring when key processes begin and end, which can be applied both within and across services. It is also about ensuring that, as far as possible, standards and targets are applied consistently across different services. Such moves should also help to improve both people’s understanding of, and their confidence in, local services. The Government should review whether targets for performance of individual services should, in the longer term, be replaced with ‘whole system’ performance targets (similar to the 18-week target for inpatient treatment).

**Recommendation 7: Government and national organisations, (such as the Ambulance Service Network, the Royal College of Nursing, the College of Emergency Medicine and the Royal College of General Practitioners) should support the development of better information on the performance of urgent and emergency care services.**

National professional organisations and the Government have an important role in supporting the development of better information on the costs, processes, quality and outcomes of care. Such measures should build on the work already undertaken by the College of Emergency Medicine (described on page 37) and the Ambulance Services Network. The development of a common reporting template would help achieve greater consistency in the reporting of quality requirements for out-of-hours GP services. Better information should also help national and local organisations to better understand the impact of differences in how services are resourced (such as how out-of-hours GP services are staffed and how ambulance resources are deployed) on outcomes for patients.

**Taking regulation forward**

The Healthcare Commission will be working with trusts in the “least well performing” areas over the coming months to ensure that areas of poor performance are addressed. We will also be supporting a series of regional workshops aimed at those who commission services, to explain how they can make the most from the data collected during the review.

We will also aim to pass on the key lessons from this review to the Care Quality Commission, who will take over the regulatory functions of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission from April 2009.

This review has been one of the most ambitious undertaken by the Healthcare Commission, looking at pathways across a wide range of services and delivering a unique area-based assessment aimed at PCTs in their role as commissioners of services.

The Care Quality Commission should therefore be in a strong position to take these lessons forward, through both its assessments of performance of commissioners and by ensuring that its assessments of providers...
look at how well different services work together. It will also be in a powerful position to look beyond urgent and emergency health services to how urgent needs for social care are met. This will be particularly important in looking at how well local health and social care systems are responding to the needs of people with long-term conditions and other more complex needs.
Appendix: the scoring framework for the review

<table>
<thead>
<tr>
<th>Question: Do services respond to phone calls in a timely fashion?</th>
<th>Scored indicators:</th>
</tr>
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<tbody>
<tr>
<td>• Time for out-of-hours GP service to answer phone calls</td>
<td></td>
</tr>
<tr>
<td>• Median time for ambulance service to answer 999 phone calls</td>
<td></td>
</tr>
<tr>
<td>• Public satisfaction with phone access to their GP surgery</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Question: Are assessments started in a timely fashion?</th>
<th>Scored indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Time for out-of-hours GP services to start telephone assessments</td>
<td></td>
</tr>
<tr>
<td>• Percentage of patients who see a clinician within an hour of arrival at A&amp;E/urgent care centre</td>
<td></td>
</tr>
<tr>
<td>• Ambulance response times for category A and B calls</td>
<td></td>
</tr>
<tr>
<td>• Priority 1 and priority 2 assessments started within target time by NHS Direct</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Question: Can people access services easily?</th>
<th>Scored indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Proportion of calls to out-of-hours service engaged/abandoned</td>
<td></td>
</tr>
<tr>
<td>• Public satisfaction with the opening hours of GP services</td>
<td></td>
</tr>
<tr>
<td>• Score for provision of medication out of hours</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: Can people access the services in ways that meet their individual needs?</th>
<th>Scored indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatients’ views of their experience of A&amp;E</td>
<td></td>
</tr>
<tr>
<td>• Score for systems to protect vulnerable children and adults</td>
<td></td>
</tr>
<tr>
<td>• Score for facilities for people with disabilities</td>
<td></td>
</tr>
<tr>
<td>• Sensitivity to the needs of people from different ethnic groups</td>
<td></td>
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</tbody>
</table>
### Theme: Working together to provide effective care

<table>
<thead>
<tr>
<th>Question</th>
<th>Scored indicators</th>
</tr>
</thead>
</table>
| Are people’s clinical needs met in a timely fashion?                    | • Percentage of urgent face-to-face out-of-hours GP assessments started within two hours of definitive clinical assessment  
 • Percentage of patients dealt with within four hours of arrival at A&E or urgent care centre  
 • Compliance with national target for the speed of thrombolysis          |
| Are systems in place to ensure care is clinically effective?            | • Score for quality assurance/safety in out-of-hours GP services  
 • Score for quality assurance/safety in A&Es/urgent care centres  
 • Score for quality assurance/safety in ambulance services              |
| Do people receive effective urgent care?                                | • Percentage of people who return to the A&E/urgent care centre within seven days                                                                 |
| Do services share information about patients effectively?               | • Percentage of out-of-hours assessments notified to patient’s GP by 8am the following working day  
 • Percentage of NHS Direct assessments passed to out-of-hours service where data was transferred electronically  
 • Score for development of systems to share care plans  
 • Score for ability to transfer calls and information between urgent care services |
| Are ‘patient pathways’ integrated across services?                      | • Score for developing pathways across services  
 • Ambulance non-transport and non-attendance rates                        |
<table>
<thead>
<tr>
<th>Question:</th>
<th>Scored indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do services work together well?</td>
<td>• Score for state of local urgent and emergency care networks/boards</td>
</tr>
<tr>
<td>Is a strategy in place for the future of services?</td>
<td>• Score for developing an urgent and emergency care strategy</td>
</tr>
<tr>
<td>Are patients/public involved in decisions about services?</td>
<td>• Score for monitoring views of patients and the public</td>
</tr>
<tr>
<td>Are services monitored effectively?</td>
<td>• Score for monitoring services at PCT level</td>
</tr>
<tr>
<td>Is info about services available to patients and the public?</td>
<td>• Score for the range of written/web-based information produced by the PCT</td>
</tr>
<tr>
<td>Are services influencing demands?</td>
<td>• Score for PCT initiatives to improve awareness and manage demand</td>
</tr>
<tr>
<td></td>
<td>• Public use and understanding of NHS Direct</td>
</tr>
<tr>
<td>Are services making good use of resources?</td>
<td>• Level of A&amp;E attendances for conditions which could be treated in other settings</td>
</tr>
<tr>
<td></td>
<td>• Percentage of ambulance turnaround times at A&amp;E over 15 minutes</td>
</tr>
</tbody>
</table>
Acknowledgements

The Commission would like to thank the following organisations and individuals for their help with this review:

**Advisory group**

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Chris Dowse*  
Department of Health

Simon Hairsnape*  
Formerly Herefordshire PCT, now Gloucestershire PCT

Will Hancock  
South Central Ambulance Service NHS Trust

Nicola Hewer  
Department of Health

Philip Hurst  
Age Concern England

Dr David Lloyd  
Harmoni Health Services and Ridgeway Surgery, North Harrow

Suzanne Mason  
Sheffield University and Sheffield Teaching Hospitals NHS Foundation Trust

Katherine Thackery*  
Nottingham City PCT, Nottingham University Hospitals NHS Trust

* In December 2007 Matthew Cooke, Caroline Brock and Simon Hairsnape left the group and Katherine Thackery and Chris Dowse joined.

**Trusts visited**

East Midlands Ambulance Service NHS Trust  
Wandsworth PCT

East of England Ambulance Service NHS Trust  
Nottingham University Hospitals NHS Trust

London Ambulance Service NHS Trust  
West Hertfordshire Hospitals NHS Trust

Lincolnshire Teaching PCT  
Wirral University Teaching Hospital NHS Foundation Trust

North West Ambulance Service NHS Trust  

Nottingham City PCT  

South East Essex PCT  

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Healthcare Commission Not just a matter of time
Organisations represented at the workshop held with patient representative groups

Alzheimers Society  Mencap
Arthritis Care  National Society for Epilepsy
Cancer Black Care  Parkinson’s Disease Society
Crossroads - Caring for Carers  RNID
Macmillan Cancer Relief  Royal Society of Health
Marie Curie Care  Which?

(see page 19 for a list of the organisations involved with our follow-up work with patients, their families and carers)

Other key contacts

Lynn Woods and Dr Alex Yeates  Adastra Software (part of the Advanced Computer Software Group plc)
Mr Jim Wardrope and Dr Stephen Nash  College of Emergency Medicine
Dr Nicholas Reeves  Department of Health
Marke Cooke  Formerly Ambulance Services Association
Eddie Jahn  Haroni Health Services
Dr Julian Redhead  Imperial College Healthcare NHS Trust
Helen Allanson  Medicines Management Network North West, Department of Health
Karen Morgan  Medway PCT
Alison McWilliam and Chris Mills  Nottingham Emergency Medical Services
Dr Agnello Fernandes  Parchmore Medical Centre, Croydon; Croydoc; NHS Direct; Royal College of GPs
Henry Clay  Primary Care Foundation
Tony Davies and Sarah Hill  Stardoc (St Albans and region doctors on call), now Herts Urgent Care
Nigel Wylie  Urgent Care 24 (Liverpool)
References

2. Department of Health, *Direction of Travel for Urgent Care*, 2006


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