URGENT AND IMPORTANT: THE FUTURE FOR URGENT CARE IN A 24/7 NHS

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CONTENTS

KEY OF ICONS

Commission member | Consultation | Case study | Miscellaneous

FOREWORD

Professor David Colin-Thomé

Chair

Urgent Care Commission

The past 15 years of healthcare policy for urgent out of hours services has been subject to a series of well-intended false starts. It is also complicated because services are provided by a wide range of organisations. This commission set out to focus on those services that face urgent demand (e.g. GPs, pharmacists and community nurses) but where, overnight and at weekends, there is a reduction in available clinical staff and in some cases no availability at all. This is a segment of the health service that has been often overlooked and has not connected well enough with the emergency services, which operate 24/7.

We understood that in much of emergency care (A&E, hospital in-patient services and ambulance services) the concept of 'out of hours' is irrelevant, although staffing in that period is usually reduced. We also acknowledged that it would be impossible to have a discussion about out of hours without context of the whole system. Many of our recommendations are therefore aimed at, and would enable, a 'round the clock' integrated service.

We are cognisant that the past sets a context.

The Carson Review of 2000 set ambitious designs for integrated provision, but struggled to make headway as the political focus moved to A&E waiting times, and the pattern of GP out of hours provision was substantially altered by the 2004 GP contract. The difficulty of rolling out systems for data sharing across NHS organisations also proved a brake on ambitions.

By the end of the decade, the new landscape in out of hours care was said by the National Audit Office to be a maturing market, but by the Public Accounts Committee one that was introduced in a "shambolic" manner. A change of Government in 2010 and subsequent major structural reform of the NHS led to a hiatus in which new bodies bedded in to their responsibilities.

Against this political backdrop, the challenges in out of hours care have been well documented. It is widely reported that these services are an undervalued part of the NHS, an 'add on' rather than fully integrated with in-hours hospital care, specialist mental health services and in-hours GP surgeries. The result in too many areas of the country is an urgent out of hours service, which is neither comprehensive nor integrated. In a series of commissioning reports in 2011 and 2013, the Royal College of GPs (RCGP) emphasised the need for less fragmentation in the emergency care system and better pathways. Clinical governance models for urgent GP out of hours care are currently target and monitoring driven. The sector appears to be falling behind much more established quality frameworks for in-hours primary care and emergency/acute hospital settings.

While patient experience of GP out of hours care is generally positive – a 2014 NAO report found two thirds of people rate out of hours services as very or fairly good – but commented that recent years have seen a downward satisfaction trend in patient surveys. The introduction of NHS 111 has had a positive impact on reducing the number of cases seen by the GP out of hours services, but while this relief of pressure is welcome, it remains true that ever since the 2004 contract change, recruiting and retaining quality GPs for out of hours work has been challenging.

The problem is straightforward; there is simply not enough supply in the workforce to meet growing patient demand. The 2014 NAO report found that urgent care providers are finding it harder than ever to recruit and retain GPs for out of hours work. This has caused us to ask questions around training, pay, conditions and perceptions of the sector more widely. How can we make GP out of hours more attractive to trainee GPs? Is the concept of out of hours services being mainly staffed by GPs still the right one? While Government has committed to training a further 5000 GPs, it is vital that those seeking a career in front-line primary care give due consideration to out of hours, as well as in-hours careers. There is huge untapped potential and this Commission believes passionately that GP out of hours is among the most rewarding, exciting work a medical professional can do. There is much to be learned and vital clinical experience to be gained from out of hours work as well as the opportunity to have an immediate positive impact for those being treated. The quality of care delivered by GPs out of hours was most recently acknowledged by the CQC, describing it as “effective, caring, responsive and well-led”.

The NHS has started planning for a 7 day NHS in hospitals – it is time to look at making a true 24 hour NHS in the community incorporating GP in and out of hours care. With imaginative workforce planning, integrated systems and removal of perverse financial incentives and contracts, many more people could get cost-effective, high quality medical help in or close to their homes. The recently published NHS Five Year Forward View calls for ideas for new, locally-led NHS organisations that are more flexible. There has never been a more important and opportune moment to make progress.

EXECUTIVE SUMMARY

It is clear that we have reached a critical juncture in the urgent care debate in England today. Sir Bruce Keogh's ongoing review of urgent and emergency care, coupled with Simon Stevens' vision for new models of care, demonstrate a strong indication of NHS England's intention to drive improvements in the quality of outcomes in this sector. There is now a strong imperative for action.

There are many challenges facing the urgent care sector and this Commission seeks to contribute solutions by defining what quality service provision looks like; establishing the structures needed to build an optimal, sustainable workforce; and identifying how we as a sector might work towards achieving interoperability across an extremely complex pathway.

Perhaps one of the most significant barriers we identified to achieving real change is the disjointed nature of the debate, with conversations taking place across Government; the NHS; private and third sector providers; clinicians and in the media. An emphasis on delivering practical support for providers and clinicians to make quality improvements a reality is now needed.

By convening a group of experts, inclusive of all key players, we have drawn together the threads of this debate and made a series of independent, evidence-based recommendations for service-wide improvements.

COMMISSION RECOMMENDATIONS

Call to action: This Commission passionately believes in the critical value of GP out of hours care, delivered as part of a high-quality, integrated urgent care sector. The value of out of hours care as a sector must have a stronger position through a more tailored and informed approach to workforce development, communications, commissioning and delivery.

1. A set of system-wide quality standards should be developed and implemented across all urgent care services. These quality standards must be clinically focused; patient-centred and build on existing experience gained in the application of the National Quality Requirements (NQRs).

2. System Resilience Groups – established by NHS England – should retain a critical focus on out of hospital, unscheduled and emergency care, and how this relates with in-hours care.

3. The relationship between commissioners and providers should be based on a mutual understanding of respective challenges and ambitions to enable closer working relationships and informed commissioning.

    i. A commissioning framework should be developed to guide optimal procurement of out of hours care. This should encourage intelligent, integrated service procurement and sustainable, high quality service design and should be based on any new quality standards.

    ii. Contracts should run over 3 – 7 years, with appropriate breaks for evaluation, review and alterations.

    iii. Commissioners should conduct the necessary due diligence prior to appointing an out of hours provider. This must include seeking assurances on pay, capacity, productivity and quality. Monitoring and reviewing of quality and adverse events should be an integral part of any contracting process and service management.

4. In order to ensure absolute clarity of accountability across the pathway, a single system integrator should be nominated. This integrator should be responsible for evaluating quality, monitoring adverse events and ensuring clear lines of communication and transparency across the pathway and delivery agencies. This system integrator should sit at the head of an integrated clinical governance model. The sector should look to the NHS 111 model of clinical governance as a role model for the wider system.

5. To better enable out of hours providers to work with A&E/acute providers, perverse incentives relating to the tariff and contracting system must be rectified.

6. Hospitals should be better integrated with out of hours providers to ensure a holistic service offering for the community. Front-ending A&E/ co-locating GPs in acute settings should be more widely modelled to allow for a better understanding of potential impact on outcomes.

7. Data sharing requires a national solution. This must rely upon agnostic, non-proprietor data systems, it must be user-defined and user-tested. Roll out should be supported by a national education programme to help patients understand how their data will be used and by whom.

8. Workforce planning is critical to the long-term sustainability of the urgent care sector, mitigating the risks posed by ongoing recruitment challenges.

    i. A multi-disciplinary approach must be taken to staffing urgent care services. The spectrum of advanced practitioners available to deliver services should be expanded to include pharmacists; nurses; physician associates; and healthcare assistants. Practitioners should then have the appropriate skills mix, enabling an out of hours team to call upon paediatric, mental health and long-term condition expertise at any one time.

    ii. Medical indemnity providers should take into account the quality and performance record of the provider when looking to associate levels of risk for the provider workforce.

OUT OF HOURS CARE: HOW DID WE GET TO WHERE WE ARE NOW?

AN NHS FIT FOR THE FUTURE

If the NHS is to meet the growing demands placed upon its services, the model must adapt to a constantly evolving national health economy. The service must now support growing numbers of people who are living longer with increasingly complex and multiple co-morbidities, including mental health conditions, dementia, diabetes and increasingly hard-to-treat cancers.

Of course, these demands come at a time of diminishing financial resource and mounting public and political scrutiny. The NHS funding gap, currently projected at £30 billion per year by 2021, must be met predominantly through system efficiencies but calls for additional Government funding have been heard from the healthcare communities and political leaders alike.

As this pressure mounts across the healthcare system, demand for services has been perceived by many commentators as spilling out of traditional in-hours healthcare settings and onto all urgent care providers – such as A&E or out of hours GP service.

The responsiveness of those services working to provide care out of hours and responding to urgent patient needs has therefore never been more critical. But do these services have the capacity and capability to respond?

Perhaps one of the most pressing challenges facing the urgent care sector is the changing face of the GP workforce, which is having a dramatic impact on the ability of these services to meet patient demand and expectation.

For example, we are seeing a move away from the GP partner model, towards a salaried GP model. The demographic is also changing, with more women opting to train as GPs. The challenge is how the out of hours sector responds to the expectations and aspirations of this modern workforce, so that it can be considered part of a well-rounded portfolio GP career.

> "Quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building."
>
> NHS England, Five Year Forward View 2014

THE EVOLVING STATE OF OUT OF HOURS CARE, 2000 – PRESENT

The out of hours landscape has evolved significantly over the last decade. We have seen GPs delivering services collaboratively via co-ops, where others have established commercial deputising arrangements. By 2004, approximately 70 per cent of GPs had delegated out of hours services to a GP co-operative and another 25 per cent had delegated the responsibility to a commercial provider.

This most recent evolution started in 2000, when the Carson Review set out designs for an integrated out of hours care service based on a set of core quality measures and a single accountability framework. Carson acknowledged that these measures would need to evolve over time, ensuring that the right things were measured at the right time. This ultimately led to a set of limited time-based targets in the form of National Quality Requirements (NQRs) for GP out of hours, published in 2006 and which remain in use today.

In 2004, the Government underwent a lengthy negotiation with the British Medical Association (BMA) leading to a revision of the GP contract. This was in part a response to reported low morale and recruitment challenges in the GP sector. The new contract introduced a pay increase, and promised greater flexibility and autonomy for GPs. In this new system, Primary Care Trusts (PCTs) were to commission services, while GP cooperatives were to work collectively to provide services. This new landscape led to major shifts in the market, with GP cooperatives experiencing mixed success and as a result evolving into different organisational forms, including social enterprises.

In 2013, the Health and Social Care Act introduced reform of NHS Commissioners. While this reform has been subject to ongoing public and political debate, it was the Coalition Government's stated intention to position patients at the heart of their care; place a renewed emphasis on outcomes not targets; and position clinical experts on the frontline of commissioning and designing services.

For out of hours, NHS operational reorganisations have led to further fragmentation of the system and offered patients little clarity as to where best to access urgent care, out of hours. The creation of new models of urgent care provision, including Walk in Centres and Urgent Care Centres, have established important new points of access for patients. Yet at the same time they have introduced new levels of complexity to an already hard-to-navigate system. The introduction of

> "If you want to use the car analogy, we have a car that we all recognise is running very hot and is close to failing the next MOT, and we recognise that we have got to do more than just change the gear box or the clutch; we have got to look at the whole car to ensure we get it running properly. That is only going to happen when the patients, the clinicians and everybody else designs the system together. We are at that point now, and I think everybody recognises that."
>
> Professor Keith Willett, Director for acute episodes of care, NHS England,
> House of Commons Public Accounts Committee on the urgent care sector (2014)

the NHS 111 triaging service was designed to signpost patients through this complexity, ensuring a seamless pathway of care.

In reality, only 50 per cent of out of hours services currently use NHS 111 as their front-end, and the strength of the A&E brand means patients are still drawn to its doors in an emergency. Recent revelations that increased risk of in-hospital mortality at the weekend (i.e. out of hours) could be as high as 11 per cent on a Saturday and 16 per cent on a Sunday, has only served to intensify the debate, placing urgent care firmly on the political agenda.

The "intense, growing and unsustainable pressure" on the system, coupled with these serious concerns around the quality of care available out of hours, led NHS Medical Director Professor Sir Bruce Keogh to initiate a comprehensive review of the NHS urgent and emergency care system in England.

There are many challenges facing the urgent care sector and this Commission seeks to contribute solutions by defining what quality service provision looks like; establishing the structures needed to build an optimal, sustainable workforce; and identifying how we as a sector might work towards achieving interoperability across an extremely complex pathway.

Perhaps one of the most significant barriers we identified to achieving real change is the disjointed nature of the debate, with conversations taking place across Government; the NHS; private and third sector providers; clinicians and in the media. An emphasis on delivering practical support for providers and clinicians to make quality improvements a reality is now needed. By convening a group of experts, inclusive of all key players, we have drawn together the threads of this debate and made a series of independent, evidence-based recommendations for service-wide improvements.

As part of this review, NHS England set out its ambition for urgent and emergency care in England, as follows:

- People with urgent but non-life threatening needs must have access to highly responsive, effective and personalised services outside of hospital.
- Services should deliver care in or as close to peoples' homes as possible, minimising disruption and inconvenience for patients and their families.
- We should ensure that people with more serious or life threatening emergency needs are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

Most recently, NHS England's Chief Executive Simon Stevens published a Five Year Forward View for the NHS. This long-term plan sets out the direction of travel for the NHS, critically laying the foundation for the ongoing review of urgent and emergency care. Stevens' plan emphasises the need to position the patient at the centre of care, helping people access urgent care at the right time and in the right place. Central to this proposal is the development of Urgent Care Networks, described as the "cornerstone" of change in urgent care.

WHAT DID WE DO?

In April 2014, an expert multi-disciplinary Commission, led by independent Chair, Professor David Colin-Thomé and supported by Care UK, set out to discuss and evaluate the current out of hours landscape as part of a wider urgent care sector.

The Commission's objectives were to:

A **Investigate** the way in which out of hours services are commissioned, designed and delivered in England today

B **Make independent, evidence-based, practical recommendations** on how these services might be further improved in order to ensure patients in England have access to a rapid, high quality and responsive service

The 17 expert members were drawn from across the urgent, emergency and out of hours sectors including representatives from public and private providers; policy makers; professional associations; education bodies; and individual GPs.

The project commenced with a comprehensive review of relevant out of hours and urgent care literature, conducted by the King's Fund library. Using this literature review to frame the discussion, the Commission members focused on three core areas:

- Re-defining quality
- Building the right workforce
- Pathway design and functionality

The Commission now proposes a set of nine evidence-based recommendations, designed to aid practical changes to achieve service improvement in out of hours care.

These recommendations are intended to be **aspirational**, but **achievable**, working within the confines of existing NHS structures, and therefore do not require further NHS reform.

These recommendations, developed over the course of 5 months, have since been shared for consultation with 10 relevant stakeholder organisations and have been presented to Professor Keith Willett, Director for Acute Episodes and the Urgent Care Delivery Review Group at NHS England.

DEFINING THE SCOPE OF OUR WORK

Within the overall umbrella of urgent care, the boundaries between out of hours and in-hours are being blurred.

Evidence of this includes the creation of daytime visiting services designed to reach patients at an early stage and thus prevent the need for an unplanned, urgent admission out of hours. Similarly, the Government have declared an aspiration for GP surgeries to extend their opening hours to cover 7 days a week and to include an extended day working. There has also been a proliferation of new models of care delivery, positioning GPs within frontline services such as A&E departments; Urgent Care Centres; and Walk in Centres. The adoption of new ways of working for GPs is perhaps to be expected; evidence suggests that GPs working in these healthcare settings provide safe, less expensive interventions when compared to their hospital doctor colleagues. If an integrated urgent care system is to become a reality, GP-led out of hours services will be expected to make a significant contribution reducing admissions to, and attendances at hospital.

For this to become a reality, out of hours will need to transition from being a reactive service to one that provides services for patients who choose to contact it; to a fully-integrated service that proactively manages a patients' journey through the urgent care sector.

Taking into account these shifting boundaries and rising expectations of out of hours services as part of an expanding urgent care sector, the Commission focused its deliberations on urgent out of hours care. However, the Commission remained mindful throughout of the wider urgent care context and made recommendations responding to the overarching ambition to create an integrated, 24/7 NHS service, including urgent out of hours and urgent in-hours care services.

Important definitions

Urgent care:
Urgent care refers to the provision of care for patients who require prompt attention but whose condition is not considered life-threatening. The sector is made up of multiple commissioners and providers. This includes GP out of hours services; Accident and Emergency departments; Walk in Centres; ambulance services; pharmacies; Urgent Care Centres; Clinical Commissioning Groups; and NHS England.

GP out of hours:
GP out of hours is one single part of the urgent care system. The out of hours period runs from 18:30 to 08:00 (including weekends), covering the period when GPs are not contractually obliged to see patents.

THE COMMISSION MEMBERSHIP

Professor David Colin-Thomé

Independent Healthcare Consultant

Chair of the Urgent Care Commission

Professor David Colin-Thomé has been an independent health care consultant since 2011 and is an Honorary Visiting Professor at Manchester Business School, Manchester University, and at the School of Health, University of Durham.

David practised as a GP at Castlefields Health Centre, Runcorn from 1971. He then served as National Clinical Director for Primary Care at the Department of Health from 2001 to 2007. He was then appointed National Director for Primary Care, and Medical Adviser to the Commissioning and System Management Directorate at the Department of Health in 2007.

Prior to being appointed National Clinical Director, he served as Director of Primary Care at the Department of Health's London Regional Office, and Senior Medical Officer at the Scottish Office NHS Management Executive. He was also formerly a member of Halton Health Authority, Cheshire Family Health Services Authority and served as a local councillor. He was awarded an OBE in 1997.

Dr Simon Abrams

Chair and GP

Urgent Health UK

Dr Simon Abrams has worked as a GP in inner city Everton Liverpool since 1997. The practice focusses on Social Inclusion and Drug Misuse and is embedded in the local community. He has a Doctorate in Child Health. In 1998 he was appointed Director of Clinical Governance for LiverDOC GP Co-operative. LiverDOC won the Liverpool OOH Contract in 2004, and Simon was appointed Medical Director of the newly commissioned service Urgent Care 24. In 2008 Simon was appointed as Medical Director of Urgent Health UK, Federation of 26 Social Enterprise OOH services serving over 40% of England, Wales and Northern Ireland. In 2014 he was elected Chair of Urgent Health UK. Since 2010, he has also been Honorary Secretary of the Family Doctor Association.

Mr Henry Clay

Director

Primary Care Foundation

After a background in manufacturing organisations, Henry has spent 20 years as a consultant to organisations in both the private and public sector. He has advised the Care Quality Commission and the Healthcare Commission, not just on their investigations into specific cases (such as the investigation into Take Care Now) but also in their wider evaluations of value for money (such as the report 'Not just a matter of time' into GP out of hour services). Work within the acute healthcare sector has involved him in A&E, Urgent Care services of all types, Diagnostics and Pathology, IT systems, Imaging, Medical assessment as well as in Health Insurance. In primary care, Henry has worked with many out of hour providers, particularly in benchmarking their performance and looking at the operation of numerous general practices, Walk in Centres and Minor Injury Units.

Professor Sir Alan Craft

Northern Institute for Cancer Research

Newcastle Univeristy

Professor Sir Alan Craft was, until 2008, the James Spence Professor of Child Health at the University of Newcastle upon Tyne. Sir Alan trained as a paediatrician and a paediatric oncologist and spent 25 years setting up and directing an oncology service for the North of England. At an international level, Sir Alan has been involved with the International Society of Paediatric Oncology as both Secretary General and President. Sir Alan has been Vice President and President of the Royal College of Paediatrics and Child Health and has also chaired the Academy of Medical Royal Colleges. He received a knighthood in 2004 for services to medicine.

Dr Agnelo Fernandes

Urgent & Emergency Care Lead

Royal College of General Practitioners

Dr Fernandes MBE FRCGP has been a GP in Croydon for 24 years, a GP trainer, appraiser and educational supervisor out of hours. He authored the RCGP "Guidance for Commissioning Integrated Urgent and Emergency Care – a 'whole system' approach" (2011) and led the development of the "Guidance and Competences for a Practitioner with Special Interest in Urgent and Emergency Care" (2008), and the "Urgent and Emergency Care Clinical Audit Toolkit" (2011) now used routinely by most urgent care services in the UK. He was previously a Director of the GP out of hour service in Croydon, a national medical adviser for NHS Direct and a senior clinical adviser to a Care Quality Commission Investigation into out of hour services. He was also Chair of the Croydon Federation, Croydon Healthcare Consortium and is currently the assistant clinical chair of NHS Croydon Clinical Commissioning Group and chair of the national Clinical Governance group for NHS Pathways. He was awarded an MBE for services to medicine and healthcare in 2004.

Dr Michael Harrison

Clinical Executive

Northern Doctors Urgent Care (NDUC)

Vocare

Dr Michael Harrison was one of the founders of NDUC and a member of the early Co-operative. He is also a GP partner at the Gables Surgery in Bedlington Station, Northumberland.

Dr Farah Jameel

Sessional GP

Dr Jameel is a Brighton based sessional GP, having completed her training in 2013. She was featured that year in the GP trade press as a top up-and-coming GP and has since been named as one of the top 50 most influential GP's in 2014.

She is a Council Member at the Medical Women's Federation and Deputy Chair of the BMA's Equality and Inclusion Committee. She was previously Chair of the South Thames Regional Junior Doctors Committee in 2012 and was an elected member of the British Medical Association's UK Junior Doctors Committee from 2010 to 2014. She is currently a member of the East Sussex Local Medical Committee and the UK General Practitioners Committee.

Dr David Lee

Former Medical Director Care UK

Care UK

A Manchester Medical School Graduate, Dr Lee is an experienced General Practitioner with a 26 year career as a GP. He has combined work in General Practice with Medical Leadership roles including FHSA, PCG and PCT work. As a commissioner, Dr Lee has worked in commissioning at all levels from GP Practice to Department of Health. As an out of hours GP, he has worked from the level of being "on call" for his practice, worked within a GP Co-operative and worked for commercial out of hours providers. He also has extensive experience as a management consultant.

Appointed as a Regional Medical Director for the East of England by Harmoni in 2011, he subsequently became Harmoni's National Medical Lead for 111 before being appointed to senior medical director roles within Care UK.

Professor Sheona MacLeod

Director of Education and Quality and Postgraduate Dean

Health Education East Midlands

Dr Sheona MacLeod graduated from Glasgow University and trained as a GP in Paisley. She moved to Derbyshire at the end of her training, and has been a GP in Ashbourne for 26 years. She has also worked in the local community hospital, and as an occupational health advisor and medical officer for HMP service.

She has been involved in local healthcare education since moving to Derbyshire. She has been a GP tutor, Programme Director and Associate Postgraduate Dean. She became GP Dean in 2009, was appointed as Postgraduate Dean in September 2012 and as Director of Education and Quality in December 2013. She was delighted to be awarded the position of Honorary Professor by the University of Nottingham earlier this year.

Dr Alan Maguire

Head of Clinical Services

Northern Doctors Urgent Care (NDUC)

Vocare

Before becoming Head of Clinical Services, Dr Maguire worked with NDUC as an out of hours sessional GP for many years. Prior to qualifying as a GP in 1993, he acquired valuable experience in hospital and hospice medicine. As well as his OOHs role, he is also a GP trainer and a GP partner at the Branch End Surgery in Stocksfield, Northumberland.

Mr Andrew McMylor

Director of Delivery and Development

Wandsworth CCG

Andrew has broad experience in urgent and emergency care having held the position of Planning Manager at Richmond and Twickenham PCT, before taking up the position of Head of Urgent Care for Wandsworth PCT. He became Director of Delivery and Development in April 2011. His role involves embedding and establishing a number of initiatives to keep patients with long-term conditions happy and healthy at home.

He has led a range of programmes from the Community Ward, which has demonstrated a reduction in emergency hospital admissions, to individual initiatives with community services and GPs, including an integrated NHS 111 and GP out of hour contract for seamless patient pathways. Andrew is currently working on community services transformation to integrate care between primary, community and secondary care services.

Dr Kat Noble

Emergency Medicine Task Force

NHS Health Education North East

Dr Noble is Joint Medical Director of NHS Pathways. She has extensive experience of urgent and emergency care and is currently a member of a multi-professional group tasked to consider workforce issues within the North East and Cumbria in delivering Emergency Care in line with The Keogh Urgent and Emergency Care Review. Prior to this she spent 3 months as acting clinical director of NHS Pathways; almost 3 years as National Advisor to the Department of Health for NHS 111; and 10 years as a GP with extensive clinical experience in emergency care, having completed a GP with a Specialist Interest accreditation.

Dr Steven Rawstorne

NHS 111 National Medical Advisor

NHS England

Dr Rawstorne spent nearly 20 years as a General Practitioner in Gloucestershire before joining the Great Western Ambulance Service NHS Trust as Medical Director in 2006. He held this position for 6 years, at which point Dr Rawstorne was appointed as NHS England's NHS 111 National Medical Advisor.

Dr Nicholas Reeves

Former Adviser to the Urgent & Emergency Care Policy Team

Department of Health

Dr Reeves is an historian who was a university lecturer for nearly thirty years. He served as a Lay Member of a PCG Board and an Associate Non-Executive Director of a Health Authority. He was the one lay person on the Carson Review of GP Out of hours Services (in 2000) and then worked part-time for several years as a member of the OOH Review Implementation Team at the Department of Health where his primary focus was on quality. He led the review of the OOH Standards, which led to the publication of the OOH Quality Requirements in 2004, and from 2005 to 2013 was an adviser to the Urgent and Emergency Care Policy Team at the Department of Health. He worked on the NHS 111 project from its inception and took the lead for the clinical governance of the new service until he left the Department in 2013.

Professor Wendy Reid

Director of Education & Quality and Medical Director

Health Education England

Professor Reid was appointed Director of Education and Quality for HEE in 2014, in addition to her role as HEE's first Medical Director. She was previously Dean of Postgraduate Medicine at London Deanery, and clinical advisor to the Department of Health on the European Working Time Directive. Professor Reid continues to practise as a consultant gynaecologist at the Royal Free London Hospital. She is keen to promote multi-professional workforce solutions for high quality patient care and to encourage wide participation across all healthcare roles.

Dr Jean Wang

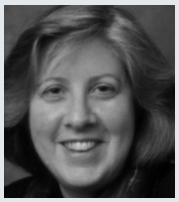
Clinical Fellow

Health Education England

Jean is an ST5 in Obstetrics and Gynaecology and is currently on the Medical Leadership Programme within Health Education England North West. She has always been interested in medical leadership and has a special interest in medical education, having always been involved in undergraduate and postgraduate teaching.

Jean has spent her last year as a Clinical Fellow on the NHS National Medical Director's Clinical Fellow Scheme by the Faculty of Medical Leadership and Management (FMLM). She was seconded to Health Education England (central) where she was involved in various projects and policies including the Shape of Training 4-nation scrutiny group, chairing the learners' forum for Technology Enhanced Learning and review of the Liverpool Care Pathway. She was also part of the strategic advisory board for the Agents for Change conference, a national conference for doctors in training with a focus on quality improvement.

Jean is currently leading on a national project to develop quality incentives in education and training for the healthcare workforce. She has also designed and organised a training day in Leadership, which has been delivered to Obstetrics and Gynaecology trainees across the country. She is currently undertaking an MSc in Medical Leadership and has completed an accredited Project Management Qualification by the Association of Project Management. She is a specialist advisor with the Care Quality Commission and is also a trainee representative for the FMLM North of England region.



Dr Fay Wilson

CEO – Group Medical Director

Badger Group

Dr Wilson has worked in out of hours care for 30 years, including as a single-handed principal and for over 18 years as a sessional out of hours GP. She qualified in Birmingham and was named the UK's 7th most influential GP in the GP Trade Press in March 2010. Dr Wilson is a member of the Birmingham Local Medical Committee and the UK GP Committee of the BMA. In 2011 she took up a role with the West Midlands Workforce Deanery's Professional Support Unit, assisting doctors in difficulties. She is interested in patient experience, training and workforce matters.

RECOMMENDATIONS

Call to action: This Commission passionately believes in the critical value of GP out of hours care, delivered as part of a high-quality, integrated urgent care sector.

Negative perceptions of out of hours care need to be publically, and consistently, challenged by the sector. Stronger positioning of the value of out of hours care as a sector must encourage a more tailored and informed approach to workforce development, communications, commissioning and delivery.

A CALL TO ACTION

Out of hours is considered by many who work in it to be an integral player in the wider urgent care system, providing a challenging and stimulating environment in which to practice medicine.

> "Out of hours is exciting, high quality and challenging."
>
> Professor Sheona MacLeod, Health Education East Midlands

In spite of this, there is a concern that outside of the sector there is a limited understanding of how out of hours care really works as part of an integrated urgent care system – be it amongst clinicians working solely in-hours; local commissioners; or patients themselves who, by the very nature of the service, only come into contact with it on a handful of occasions in their lifetimes.

> "There's much less aggravation than in mainstream general practice. You don't get continuity but you do get real patients, real medicine. Not constantly weighed down by shocking bureaucracy."
>
> Dr Fay Wilson, Badger Group

The real concern is that this lack of understanding is permeating the whole healthcare system, impacting on the quality of how out of hours services are commissioned; how healthcare professionals are recruited into and supported in out of hours; and how policy makers and commentators are actively shaping the out of hours debate.

There are numerous examples of exemplary care in out of hours, yet those working within the sector often feel isolated and subject to criticism. Many of the Commission members felt that if something goes wrong in an out of hours setting, the levels of personal scrutiny of professionals are greater than if that same incident was to occur during in-hours care.

> "Out of hours has always been the Cinderella part of the whole system."
>
> Agnelo Fernandes, Urgent & Emergency Care Lead – Royal College of General Practitioners.

The Commission posed the question whether this dichotomy is fuelled by the false notion that care received out of hours is "not as good" as care received in-hours, and how might this be challenged?

There is a strong belief that this often misguided fear has paved the way for more stringent regulation and monitoring of out of hours services than in-hours, all of which places a significant time and resource burden on commissioners and providers, but have proven out of hours care to be performing well and often better than other areas of the healthcare system.

This was clearly evidenced in the Care Quality Commission's 2014 report on out of hours GP provision in the NHS. The CQC's Chief Inspector of General Practice, Professor Steve Field said, "Out of hours services are often considered to be higher risk than those provided during the day by GP surgeries and we know that some have seriously failed people in the past… I am delighted that these inspections have shown that in most cases the care people receive out of hours is safe, effective, caring, responsive and well-led."

Central to this challenge is improving patient awareness of out of hours GP services; and when and where they should access these services, as part of a broad urgent care provision.

Yellow Man Campaign – Not always A&E
In 2013 Commissioning Support Units in North and East London created a campaign to raise awareness of the different services that are available in the NHS to ease the pressure on emergency and out of hours care services in 11 South London Clinical Commissioning Groups.

The campaign used a family of 12 seven feet tall, yellow sculptures to represent different common ailments. The sculptures were placed in public spaces across South London, supported by a creative advertising campaign and an accompanying microsite hosted at www.notalwaysaande.co.uk.

The aim of Not always A&E was to ensure that members of the public realise that A&E should only be for serious and life threatening emergencies, and that there are other alternative and more appropriate places to go when they have a minor illness or injury.

The campaign ran for eight weeks, and the evaluation of the campaign demonstrated:

- 40 per cent unprompted recall of campaign (suggesting significant resonance);
- 57 per cent of respondents prompted recall on the message 'A&E is for emergencies only';
- 58 per cent of people said they would change their behaviour because of the campaign.

"We shouldn't underestimate the role of further patient education; it has a large part to play in the patient's journey through the health service".

Dr Farah Jameel, Sessional GP

DEFINING QUALITY IN URGENT CARE

1 RECOMMENDATION

A set of system-wide quality standards should be developed and implemented across all urgent care services. These quality standards must be clinically focused; patient-centred and build on existing experience gained in the application of the National Quality Requirements (NQRs).

The Commission felt that critical to the future success of out of hours care is the creation of a system-wide quality framework that both measures and enforces a set of standards based on clinical outcomes and user experience. National policy-making over the past decade has been piecemeal in its approach to quality measurement, and has not allowed such a system to develop.

"The ability of services to work together is one of the most important features of an effective healthcare system. When systems fail or patient safety is compromised, the inability of services to transfer patients or share important information is often a key factor. There is a need to develop system-wide metrics, but it's also essential to understand the performance of each part of the system. The quality of the overall urgent care system depends on the quality of each service, as well as how they join together to provide seamless care; it's not one or the other but both."

Breaking the mould without breaking the system; new ideas and resources for clinical commissioners on the journey towards integrated 24/7 urgent care, Primary Care Foundation, 2011

ARE THE NATIONAL QUALITY REQUIREMENTS ENOUGH?

In 2000, the Carson Review provided a foundation for integrated out of hours standards. The review suggested that, to be successful, a clear accountability framework should support out of hours quality measures and that this must be applicable to everyone working within the system. Since then, this recommendation evolved into the current National Quality Requirements (NQR), approved in 2006.

Although the establishment of quality measures has been acknowledged as the right objective, varied interpretation of the NQR has caused inconsistent implementation across the sector. Additionally, the NQR has not been updated for eight years, and critics say they have failed to stay abreast of changes to the NHS landscape subsequent to 2006.

The NQR framework predominantly focuses on time allocation and targets; and quantitative measures, which do not specifically measure good clinical outcomes. Although patient satisfaction is linked to shorter waiting times, there are calls to amend the framework to avoid driving 'tick box' exercises.

The National Audit Office (2014) has shown that out of hours service providers are generally responsive, measured against the specified time frames. Although this reassures that patients are seen promptly, it does not set out any clinical measures to assess the quality of their care. For example, all NQR-measured providers complied fully or partially with the requirement to pass emergencies onto the ambulance service. This means that in the areas covered by these contracts, at least 90 per cent of patients with life-threatening conditions were passed to an ambulance within three minutes. Yet their clinical outcomes were neither recorded nor measured.

Many providers are meeting basic quality requirements, but are not incentivised to exceed them. While the requirements are designed primarily to set out the minimum standards that out of hours providers must achieve, good commissioners have always worked alongside their providers in supporting them to deliver continuous improvement in the quality of their service.

ARE OTHER QUALITY MEASURES WELL ALIGNED?

Meanwhile alternative systems of measuring and incentivising quality have been introduced. In 2004, a new GP contract system not only fundamentally altered the out of hours responsibilities of GPs but also initiated the Quality and Outcomes Framework (QOF). This was designed to drive quality via a regularly reviewed, points-based system of financial incentives. The focus for QOF has been on the management and diagnosis of prevalent chronic disease such as depression, dementia and chronic kidney disease.

The introduction of NHS 111 in 2010 changed all parts of the NHS. It was set up with its own targets, which did not directly align with existing NQRs. As a result the service has become increasingly fragmented, with providers often working to contradictory targets. In some instances NHS 111 targets will be undermined by NQRs, recommending a very different interpretation of urgency.

Locally aligned quality measurements

While progress has been slow nationally, some areas of the country have taken the initiative. For example, in Croydon the urgent care centre shares quality measures with the emergency department.

In practice, the urgent care centre and the emergency department work together on the same computer system sharing daily reports and dashboards, which details the activity and performance of both areas. Further to this clinical and management teams meet weekly from both services to discuss progress and reports.

The Commission agreed that inadequate and competing quality measurements need to be resolved if urgent and out of hours care is to get acknowledgement and consistent improvement.

> "You have to be wary of reinventing an arbitrary timeframe, which would increase target driven performance, compromising quality. If the only correlation with patient quality is speed, then one could meet all their targets but also kill everyone."
>
> Dr Fay Wilson, Badger Group

WHAT KIND OF ENVIRONMENT WOULD PRODUCE QUALITY?

The success of any quality standard depends on an accountability framework, led by clinicians, which aids consistent measurement across the service.

Although the NHS 111 implementation has been met by challenges, the Commission agreed that the clinical governance model underpinning the system was a good example of integrated clinical governance driving agreed quality measurements, which should be replicated. The governance model was agreed to have supported the right environment for the service to meet its quality standards. [See Creating an integrated urgent care pathway; recommendation 4].

This Commission recognises that recommendations must be underpinned with clear principles. In 2010 sector experts attempted the revision of the NQR, however for political reasons these plans were dropped. Now, in light of further changes to the system, a revised set of standards must be considered.

This Commission recommends that quality measures are set across the whole system and should be designed following a set of clear principles, as follows:

WHAT WOULD IDEAL QUALITY MEASUREMENT FOR THE URGENT CARE SECTOR LOOK LIKE?

This Commission recommends that quality measures are set across the whole system and should be designed following a set of clear principles.

WHOLE SYSTEM APPROACH

There should be one set of national standards to outline the minimum standard of care. Standards should apply to all parts of the NHS that come into contact with urgent and emergency care including general practice and community pharmacy.

Consistent standards, responsibility and accountability should apply across the pathway in the manner in which the NHS responds to people's urgent and emergency needs, regardless of the service provider that delivers the response.

Both the provider and commissioner should be held to account. Where there are multiple providers working across a single pathway, they should be able to hold one another to account as well as being accountable to the commissioner.

MEASURE A WIDE RANGE OF PATIENT NEEDS

Quality measures should include standards to specifically address:

- Matching capacity to demand;
- Meeting special needs (e.g. mental health, palliative care, chronic conditions);
- The recruitment, induction, education and support of staff;
- Medicines management;
- Risk management and incident reporting;
- Local and specific service needs.

All standards should be regularly updated to reflect the current working of the system.

INVOLVING PEOPLE WHO USE THE SERVICE AND WHO RUN THE SERVICE

Staff performance should be appropriately reviewed using a properly validated tool (such as the RCGP Urgent Care Clinical Audit toolkit), with effective reporting to both individual members of staff (with appropriate and agreed action where necessary) and the commissioner.

Independent, validated surveys should be used to understand the experience of people using the service, for example; "mystery shopper" exercises and patient surveys.

The public should be involved in the planning, evaluation and development of their local service to ensure user experience is prioritised.

EASE OF ADOPTION AND USE

To reduce ambiguity, each standard must be simple, clear and accompanied by a detailed commentary to outline the exact expectation.

Standards should encourage the effective exchange of clinical data.

Local services must be given extra support to adapt to minimum standards to ensure local success.

2 RECOMMENDATION

System Resilience Groups – established by NHS England – should retain a critical focus on out of hospital, unscheduled and emergency care, and how this relates with in-hours care.

FROM URGENT CARE WORKING GROUPS TO SYSTEM RESILIENCE GROUPS

Following the pressure placed on services during the winter of 2012/13, NHS England published the A&E Recovery Plan. The plan brought together national and regional 'A&E tripartite' panels, comprised of representatives from NHS England, the NHS Trust Development Authority (NHS TDA), Monitor, and the Association of Directors of Adult Social Services (ADASS). The plan also called for the creation of Urgent Care Working Groups (UCWGs).

UCWGs were set up to drive all parts of local health and social care systems in an attempt to join-up care. Their roles have recently been expanded to cover both elective and non-elective care. This shift is reflected in the change in name of UCWGs to System Resilience Groups (SRGs).

NHS England describe SRGs as: "the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery including; capacity required to ensure delivery, oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers".

The Commission welcomes the notion of the SRG focus on integrated care, however it expressed concern at their broad remit and questioned whether they would have sufficient capacity to deliver against it. Currently, some SRGs have not factored out of hours into their systems planning, which poses a practical problem in the integration of the services. The Commission agreed that all SRGs must factor out of hours care into their planning.

The Commission noted the importance of holding the progress of the resilience groups to account, learning from the challenges of previous country-wide roll outs, where a variation in implementation has caused system difficulties and ultimately patient disruption. To overcome this, SRGs should be assessed through system-wide metrics enforced by commissioners to ensure clarity and accountability.

> "The SRGs need to be assessed by commissioners to ensure clarity and accountability."
>
> Professor David Colin-Thomé, Commission chair

Clinical Commissioning Groups (CCGs) will be expected to lead the new SRGs, however Dr Steve Kell, co-chair of NHS Clinical Commissioners, said that "the top-down guidelines are not helpful to CCGs, merely increasing bureaucracy at a time when there is decreased capacity".

Capacity was an issue raised by both the Commission and consultees, suggesting that it is increasingly difficult for local providers and commissioners to meaningfully contribute to the many organisations and groups of this ilk.

The Commission emphasised the importance of learning from earlier and existing models such as urgent care boards and cancer networks. These networks generally successfully controlled resources across a large geographical region, managing and supporting service design and delivery by multiple players. Critical to the success of the SRGs will be their ability to meet the needs of the local health economy, while remaining open to ideas of best practice and external scrutiny.

> "Feedback from NHS Ambulance Trusts indicates that the maturity and productivity of these groups varies around the country, but there is a common theme in respect of the difficulties for ambulance services in being able to appropriately resource all the groups and networks in their regions due to operational pressures as well as the sheer number of them.
>
> ACE would support proactive monitoring by System Resilience Groups of a standard set of key evaluation indicators in relation to out of hospital, urgent care provision to identify the impact of embedding new initiatives and integrated care on local health economics and access pressures, and the benefits in respect of patient outcomes and experience. This relies not only on commitment from all commissioners and providers being engaged in the group, but also on IM&T systems that support the ability to easily gather outcome measures and follow patients through and around the system."
>
> Association of Ambulance Chief Executives, Urgent Care Commission consultation, 2014

CREATING AN INTEGRATED URGENT CARE PATHWAY

A common challenge for all healthcare systems is the design and delivery of consistently high quality care, by multiple commissioners and providers. Even once there is consensus on what good might look like in a single part of the service, the question of how that quality is delivered, monitored and assured across a whole pathway of care poses a significant, perhaps more pressing challenge.

In urgent care this is particularly pertinent. Urgent care has become increasingly fragmented, delivered within a diverse range of settings and involving multiple players – out of hours GP surgeries, Accident and Emergency departments, Urgent Care Centres, and now NHS 111 – often on short-term contracts that frustrate the building of strong teams. All of which is taking place under acute time pressure, with often limited staffing and financial resources. This complexity is likely to be further compounded by Government's plans for in-hours GP services to remain open until 20:00. The question for patients, commissioners and providers alike will be how this service will dovetail with out of hours GP provision that in theory should be available from 18:30, through the night.

For the patient this raises questions about where they should go in the system; where their care is best delivered; and ultimately who is responsible for the care they receive. There is evidence that many of those procuring out of hours services have a limited understanding of how the service needs to work, particularly as part of a wider urgent care provision.

Growing financial pressures have resulted in out of hours procurement resembling a "race to the bottom", with commissioners expecting providers to deliver "more for less". Yet some would argue that this cost-cutting imperative can be to the detriment of quality and patient experience.

So how can this trend be challenged? The Commission agreed that the key to the delivery of a consistently high quality, integrated service, is consistently high quality commissioning and strong accountability through the pathway. All providers, when working across a single pathway, must work collectively under the NHS badge, in the interests of patients.

For this to become a reality, there are several core tenets, including a strong, long-term working relationship between commissioner and provider, based upon a clear understanding of the needs of the local health economy.

> "A provider lost their contract because a competitor made a "better" bid, cutting costs by 10 per cent. The cuts meant that clinicians working for £80 per hour now worked for say £70 per hour. The cheaper provider didn't have a large base in the region, with little to show in the way of a local database of healthcare staff to fulfil such a large contract. After they had won the contract, there were teething problems with the staffing rotas. This makes one question efficiency but also patient safety during the transition phase."
>
> Commission member

3 RECOMMENDATION

The relationship between commissioners and providers should be based on a mutual understanding of respective challenges and ambitions to enable closer working relationships and informed commissioning.

1. A commissioning framework should be developed to guide optimal procurement of out of hours care. This should encourage intelligent, integrated service procurement and sustainable, high quality service design and should be based on any new quality standards.

2. Contracts should run over 3 – 7 years, with appropriate breaks for evaluation, review and alterations.

3. Commissioners should conduct the necessary due diligence prior to appointing an out of hours provider. This must include seeking assurances on pay, capacity, productivity and quality. Monitoring and reviewing of quality and adverse events should be an integral part of any contracting process and service management.

THE COMMISSIONER / PROVIDER RELATIONSHIP

Perhaps the most significant barrier to high quality commissioning and service delivery is a poor working relationship between the commissioner and the provider. For this relationship to work well, it must be based on a mutual understanding of both the resource available to the commissioner and the needs of the local health economy that the provider will be expected to meet. It is vital that once contracts are awarded, providers then work collaboratively to support the delivery of the best possible patient journey. This is a cultural challenge, but one that should be encouraged if true integration is to be achieved.

> "Intelligent procurement for out of hours services needs to consider the whole patient pathway into separate services."
>
> Association of Ambulance Chief Executives, Urgent Care Commission consultation 2014

As well as a cultural shift, the commission agreed that procedural change is needed. For example the service specification should be considered a critical asset to the success of the procurement process and ultimately the service it commissions. It can also make the commissioning of a fully integrated service a realistic expectation, an aim now often frustrated due to multiple commissioners holding a stake in a single out of hours contract.

By developing a strong service specification in the first instance, commissioners are better able to ensure providers can meet their expectations and work within a proposed budget. Furthermore, by providing absolute clarity on what the service must look like, commissioners are then empowered to evaluate tender proposals purely on cost.

> "A good commissioner should understand how they want their out of hours service to work and what the price is likely to be. You should develop, with your clinicians and stakeholders, what your specification should be and then have it priced. When you know what the price is then the due diligence can be very comprehensive. You get into a position where the provider, with a 5-year contract, or two years with a break, understands where it needs to involve the system, which drives accountability with the partners."
>
> Mr Andrew McMylor, Wandsworth CCG

DUE DILIGENCE

Once a clear service specification is in place and a provider has been identified, commissioners can then conduct a comprehensive due diligence process. In doing so, commissioners can readily hold providers to account, ensuring they are equipped and able to deliver the service they have committed to providing. If the lead commissioner can effectively challenge a provider on their proposals prior to awarding the contract, the end result is more likely to meet the needs of the local health economy.

Face to face dialogue sessions between the commissioner and potential providers should also be part of this due diligence process. This will bolster the selection process, adding a degree of transparency and allowing for a full and frank assessment of each providers capability and capacity to deliver.

"These contracts are worth millions of pounds, there should be a greater process of due diligence."

Dr David Lee, Care UK

This due diligence exercise should address the following issues:

- **Capacity:** does the provider have the necessary workforce and skill mix to deliver this service?
- **Integration:** how does the provider propose to work with other parts of the system i.e. NHS 111; local hospitals; A&E departments; in-hours services etc.
- **Evaluation:** Has the proposal considered how both patient and clinician feedback will shape the service?
- **Record:** What is the provider's previous record on quality and delivery?
- **Ways of working:** How will the relationship between the commission and provider work?
- **Cost:** Has the provider suggested a cost, which is a realistic price for the service it has proposed?

INVESTING IN THE LONG-TERM

Providers need to position themselves as healthcare partners, delivering a service that responds and evolves to the changing needs of the local health economy. A short-term, competitive tendering process does not make this possible. To nurture the creation of mutually-beneficial partnerships between commissioners and providers, extended contracts were considered by the Commission to be desirable.

"A 3-year contract is not sufficient. On the railways, the minimum contract time is 7 years, and for some things it's longer than that."

Dr Fay Wilson, Badger Group

"Having contracts of 3-7 years would be good for service stability"

BMA GP Committee, Urgent Care Commission consultation 2014

This approach would allow providers to develop their offer over a longer period of time and in turn deliver greater stability and continuity in the system. A longer-term agreement would work on the condition of an annual review, enabling the ability to assess progress and make changes where necessary.

"INTELLIGENT COMMISSIONING"

For the Commission, the above tenets form the basis of "intelligent commissioning". To support this a robust commissioning framework for out of hours, services should be developed.

This should aim to support commissioners in the following:

1. The development of a robust service specification based upon system-wide urgent care quality standards;
2. Managing a strong working relationship between commissioner and provider;
3. Delivering a comprehensive due diligence process, conducted prior to awarding contracts.

The Commission suggested that the NHS 111 commissioning framework was an example of best practice:

"Commissioning is very rigorous for NHS 111 but it isn't always the case for out of hours, even though over a third of patients' time is spent there."

Mr Andrew McMylor, Wandsworth CCG

DEFINING A "SYSTEM INTEGRATOR"

4 RECOMMENDATION

In order to ensure absolute clarity of accountability across the pathway, a single system integrator should be nominated. This integrator should be responsible for evaluating quality, monitoring adverse events and ensuring clear lines of communication and transparency across the pathway and delivery agencies. This system integrator should sit at the head of an integrated clinical governance model. The sector should look to the NHS 111 model of clinical governance as a role model for the wider system.

A possible mechanism for achieving greater consistency of care across the urgent care pathway would be to establish the role of a "system integrator" – providing strong clinical leadership; ensuring that the patient journey through the system is seamless; and that the system itself is held to account for the care it delivers.

This could be a single organisation or an individual commissioned to manage the overall urgent care budget for a defined health economy, sub-contracting out to other urgent care providers. Alternatively, it is possible to look to the organisational levers already in place within the national system. While in reality NHS 111 has had a mixed impact to date, it was originally intended to sit at the head of the urgent care system and signpost patients through the system, managing their journey accordingly.

The impact of NHS 111 has been applauded by the National Audit Office – its recent report suggesting a drop in the number of cases seen by GP out of hours services since the triage service's inception. Although only 50 per cent of out of hours providers are currently using NHS 111 to support their front-end service, the NHS 111 model of clinical governance is worth closer analysis.

LESSONS TO BE LEARNT FROM NHS 111

The NHS 111 clinical governance model is based on "meaningful and effective local clinical leadership". It is tasked with looking at the whole patient journey, bringing together stakeholders that make up the local health economy to understand how the whole urgent care system is working, and how it might be improved. It is this holistic, whole-system approach that the Commission considered to be a marker of best practice – a model that should be strengthened and used more widely.

A key concern of the Commission was the sense that out of hours services are kept distant from the rest of healthcare because measurements of success, information and links to other services are not properly shared. Unintended consequences of how finances move around the system also create professional and organisational barriers.

The role of local NHS 111 clinical governance lead (CGL) is of particular interest – a job role that is largely aligned with that of the Commission's proposed "systems integrator".

Central to this model of clinical governance and the role of CGL are the following principles. While still to be proven in practice, there was consensus amongst the Commission members that this framework should be supported:

- The development of relationships across the whole urgent care network;
- Clinical credibility in order to work effectively in a complex environment;
- Responsibility for holding the provider to account for clinical standards;
- Bringing together the NHS 111 service itself with all the NHS and social care providers to whom patients may be referred, enabling all to develop a real sense of ownership of their local service;
- Developing a policy setting out the way in which adverse and serious incidents will be identified and managed, ensuring that the clinical leadership of the NHS 111 service plays an appropriate role in understanding, managing and learning from these events;
- Managing clear and well-publicised routes for both patients and health professionals to feedback their experience of the service, ensuring prompt and appropriate response to that feedback with shared learning between organisations;
- Facilitating regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional insight into the quality of the NHS 111 service;
- Regular review by the CGL of the quality of the calls, with the involvement of other partner organisations, especially where their outcomes have proved problematic;
- Provision of accurate, appropriate, clinically relevant and timely data about the NHS 111 service to ensure that it is meeting the NHS 111 Commissioning Standards.

(NHS 111, Commissioning Standards, 2014)

"**We believe this would be a positive step, to identify individuals who have overall responsibility for specific pathways in a health community** – all agencies involved in that pathway would be held to account by the integrator, e.g. the nursing director for an ambulance service could be an integrator for specific pathways of care – ensuring the pathway is agreed, documented and signed off by all involved and performance managed/evaluated thereafter. Whilst individual organisations still need their own clinical governance framework, the integrators coordinating governance for different care pathways could sit within different agencies, with all integrators being part of an overarching clinical governance structure. Establishing clinical governance in this way would help overcome situations where, for example, a paramedic wanting to admit a patient directly to a community hospital bed for respite care, is hampered by who will take clinical governance responsibility for that patient – at the moment the Consultant in that hospital is still required to come to the hospital to assess and take responsibility of that patient to allow admission to proceed.
This approach would fit well with a model for commissioning of complete pathways."

Association of Ambulance Chief Executive, Urgent Care Commission consultation 2014

"**The BMA GPC acknowledges the benefits of having somebody overseeing and ensuring that the system is working safely across providers…** Undoubtedly, there should be robust clinical governance procedures and policies, but they should not add a further tier of bureaucracy for organisations. It must be valuable, proportionate and worthwhile. Quality and safety should be at the heart of this.

- How will this single integrator interact and unite all organisations?
- How will it assure itself of participation or that it is robustly fulfilling this role?
- What levers/actions could it take if provider(s) fail to engage or act on recommendations?
- What would be the mechanisms by which a lack of confidence/concerns about the 'integrator' could be raised?"

BMA GP Committee, Urgent Care Commission consultation 2014

IRONING OUT PERVERSE INCENTIVES

5 RECOMMENDATION

To better enable out of hours providers to work with A&E/acute providers, perverse incentives relating to the tariff and contracting system must be rectified.

If getting community and hospital sectors to join up with out of hours services is a desirable outcome, then finances will be an important part of making it happen. Currently too many hurdles exist in how different NHS organisations are paid and this is frustrating attempts to create the pooled budgets to meet shared outcome measures and integrated working. In particular, the clash between the payment-for-performance systems that are characteristic of the GP setting versus the payment-for-activity based systems commonly found in hospital sector.

To create multi-organisation, whole system care requires vision and committed leadership from commissioner(s) and providers. This will require not just a set of system-wide quality standards but it will also be necessary to utilise whole system commissioning technologies (e.g. alliancing contracts and/or prime provider leadership) and optimally a whole system single budget.

Currently there are different methods of payment for the key providers, which is often cited as a barrier to integrated working, but the commission believe local examples of integration already exist. Hospital services and GP out of hours services are both commissioned by CCGs and despite contrary expressed views, CCGs, even before the advent of co-commissioning, can commission primary care even if the contracts are held nationally. Contracting and commissioning are not synonymous.

The recently published NHS England Five Year Forward View offers a more amenable environment for locally funded integrated care and out of hours care would be a high value area to generate local innovation through these freedoms.

It says **"urgent and emergency care services will be redesigned to integrate A&E departments, GP out of hours services, urgent care centres, NHS 111, and ambulance services. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget and national leadership of the NHS provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied."**

WORKING MORE EFFECTIVELY WITH HOSPITALS

6 RECOMMENDATION

Hospitals should be better integrated with out of hours providers to ensure a holistic service offering for the community. Front-ending A&E and co-locating GPs in acute settings should be more widely modelled to allow for a better understanding of potential impact on outcomes.

A recurring challenge for the out of hours sector is the perception that it provides a "contingency" or "overflow" service" for when A&E becomes too busy. Ensuring that patients receive the right care and in the most appropriate setting is a real challenge for urgent care; A&E should not be considered the default provider. If patients are to access consistent care, irrespective of whether it is a busy Saturday night or a quiet Monday morning, it is vital that hospitals and out of hours GP services are more aligned in the way they work.

The widespread inability to refer patients directly from out of hours services into hospital departments was identified as a major weakness of the current system. The tendency for hospitals to require admissions to enter via A&E creates a doubling up of triage and a significantly worse experience for the public.

The Commission felt that the case for locating GPs in hospital emergency departments needed more analysis to prove the concept workable, as mixed views were expressed. The role of GPs effectively taking on a triage role was widely considered to be a positive benefit and that their use was seen as holding potential to reduce hospital admissions. The Commission felt that evidence for this was currently limited and that hospital admissions alone, while an appealing metric to policy makers, should not be the sole driver to wide-spread adoption. It was noted that a "one size fits all" approach would not be desirable, and that any model would need to take into account regional variations, in particular if the setting is rural or urban. It was therefore agreed that a broader understanding of the impact on patient outcomes was needed.

The recent NHS Five Year Forward View was explicit in suggesting a locally developed organisation of providers that get different parts of the health service working more closely together and breaking down traditional boundaries. The Commission discussion and consultation response reveal a clear goal that out of hours be prioritised for this kind of service innovation.

Sharing more quality metrics was agreed as a means to achieving better integration. The out of hours sector across the UK is already widely using the Urgent & Emergency Care Clinical Audit Toolkit (jointly developed by RCGP, College of Emergency Medicine and RCPCH), but that commissioning of the hospital sector has been slower to respond.

This is particularly pertinent to paediatrics where ways of working better across in hours and out of hours have been developed:

"In spite of children never being healthier there has been a huge increase in demand for them to be assessed when they are, or are perceived to be unwell. Most such children require a short period of observation of around 4 hours at the end of which an experienced assessment can rule out the majority of serious issues. Short stay assessment units are now widely available for this purpose. However, staffing these out of hours can be problematic especially for small populations. Public education to use services within the hours that they are open has been shown to be possible in a number of places, and only the very occasional child needs to be seen outside of these hours when they might have to travel to a more regional unit which can justify being open 24 hours a day. Increasingly the model is for a regional or sub regional 24 hour units surrounded by 8 till late 'ambulatory' units. Examples of this include Sunderland/South Tyneside; Gloucester/Telford; Grantham/Nottingham and the Greater Manchester conurbation."

Professor Alan Craft, Newcastle University

NHS CROYDON

NHS Croydon undertook a major re-design to integrate its urgent and emergency care services in March 2012. The GP out of hours contract was changed to an NHS contract for urgent care, with one provider running the GP out of hours service and the Urgent Care Centre, both of which were co-located at the front of the A&E department at Croydon University Hospital.

At the same time NHS 111 was commissioned to be the front end of the GP out of hours service. When patients call the GP out of hours service they are assessed by NHS 111's trained health advisers using NHS Pathways and booked directly – without re-triaging by a GP – into the out of hours service for either GP telephone advice, an appointment at the centre, or a home visit, depending on the outcome of the assessment.

This service re-design has reduced contacts with the GP out of hours service by nearly 50 per cent while continuing to meet the national quality requirements (NQRs) for out of hours services. Moreover, while the number of patients seen in the emergency department (ED) has remained constant while meeting the 95 per cent in 4hrs seen standard, the number of patients seen in the urgent care centre has steadily declined by about 8-11 per cent since the changes.

The QIPP savings to the CCG have been significant due to a combination of fewer contacts with GP out of hours as well as the other urgent and emergency care services, and the fact that 40-50 per cent of adults and 60-70 per cent of children attending the A&E are now seen and treated in the Urgent Care Centre by a multidisciplinary workforce at a lower urgent care tariff cost.

Continuous quality improvement has been maintained with a contractual requirement for routine audit of consultations using the RCGP Urgent and Emergency Clinical Audit Toolkit in NHS 111, the GP out of hours service and the Urgent Care Centre.

"If the whole unscheduled care system in an area is truly integrated, and professionals with a wider skill mix are employed within the service, this could potentially work even within the current confines. There is far too much duplication, silo working at the present time. One could even argue going a step further and having GPs/highly experienced emergency department medical staff and nurses on clinical desks in ambulance settings."

BMA GP Committee, Urgent Care Commission consultation 2014

"AACE strongly believes there will be clear benefits from providers within health communities working in a more integrated way to provide the most appropriate patient pathways – these may include Single Point of Access Directory of Services; ambulance clinicians working alongside GPs both in their practices and in the community and GPs based in ambulance control rooms; stronger communications between hospital clinicians and paramedics to ensure patients receive timely access to the right care rather than filtering all patients through EDs e.g. direct admission to stroke and coronary care units."

Association of Ambulance Chief Executives, Urgent Care Commission consultation 2014

7 RECOMMENDATION

Data sharing requires a national solution. This must rely upon agnostic, non-proprietor data systems, it must be user-defined and user-tested. Roll out should be supported by a national education programme to help patients understand how their data will be used and by whom.

INFORMATION SHARING

The sharing of data was highlighted as desirable to:

1. Enable speedier identification of underlying health conditions, which may influence clinical decision-making;
2. Support a better national epidemiological understanding of disease prevalence to support planning and understand risk;
3. Enable GPs, who are currently accountable for people >75 and next year for all patients, to potentially track patients through the system.

The issue of sharing patient records has long been a hot-button issue both on technical obstacles and on perceived issues around consent. The Commission were very clear that a national IT solution would be doomed to technical failure and would never deliver a system that worked for everyone on the ground. However, an agreed national standard of data collected and shared between NHS services would be desirable. As would a nationally agreed set of IT specifications that enabled different organisations to be more agile in connecting databases rather than facing hard barriers of propriety systems. The Summary Care Record is a good example of this. In spite of being strongly advocated in the Carson Review, integrated health records are still not a reality in the NHS.

Some Commission members suggested that locally agreed shared IT systems had been successful and should be encouraged if they made sense within a defined health economy. But this had to be developed from the bottom up rather than imposed at a national level and be fully tested by clinicians to ensure they serve better clinical consultations rather than actuarial calculations. NHS Scotland was cited as an example of how a national NHS service had opted for a single IT framework, which much could be learnt from and applied in England.

The issue of consent for patient record sharing has recently focused on privacy and the possibility of records going outside the NHS system. The Commission felt that concerns about consent were now holding back efforts to integrate information across NHS organisations when most people would assume and find it desirable for those treating them to have the right information to hand. The Commission agreed that a concerted national public information campaign would help overcome this stumbling block to information sharing.

One example of how data sharing is being trialled at scale, and could prove a test-bed for the rest of medicine, is in palliative care. The Coordinate My Care (CMC) initiative is being run out of the Royal Marsden for the whole of London for these services. The system enables people undergoing palliative care for a terminal condition to have their notes and wishes shared across out of hours providers. However, even this advanced approach does not formally link to the summary care record.

SUMMARY CARE RECORD

The Summary Care Record (SCR) is a centrally stored, electronic record that has been created to provide healthcare staff with faster access to key clinical information when treating patients in an emergency or out of hours.

The SCR contains critical information on patients' allergies, medications and adverse reactions, and it is Government's intention that patients will have online access to their records before April 2015.

Although patients have the option to opt out of the scheme, more than 40 million patients in England have a record, and the SCR has been implemented in A&E, NHS 111, and GP out of hours services where clinicians are using the SCR more than 19,000 times a week.

More information:
http://systems.hscic.gov.uk/scr

In their consultation response the BMA GPC helpfully suggested some key questions that need to be addressed if data-sharing technology is to be rolled out. They suggested that there should be careful information governance policies around how access would be enabled:

- Who would have access?
- What levels of data would be provided?
- Would it be read only or would there be capability to update the system?
- What auditing mechanisms would be in place to assure appropriate use?
- Where will funding come from?
- What would be the timescales?

"In Derbyshire Health United's RightCare service, the in-hours GPs created patient care plans with the patient's permission and that plan was shared with out of hours providers."

Professor David Colin-Thomé, Commission Chair

"It seems clear that compatible patient data systems remains a critical aspect that needs addressing to gain consistency across the health and social care services if service provision is going to be transformed in a safe and effective way. In addition the compulsory use of the NHS number as the primary identifier will facilitate access to GP records etc. although this currently poses logistical challenges within the 999 system.

Involvement in and ready access to integrated care plans is essential for ambulance clinicians in providing expedient and effective assessment and treatment for patients, and not only enhances outcomes, but the patient experience overall. This is not yet widespread."

Association of Ambulance Chief Executives, Urgent Care Commission consultation 2014

COORDINATE MY CARE

Coordinate My Care (CMC) was developed in 2012 to give people with chronic health care conditions and/or life-limiting illnesses an opportunity to create a personalised urgent care plan in order that they might express their wishes and preferences for how and where they are treated and cared for.

This care plan can be shared electronically with all legitimate providers of urgent care, especially in the emergency situation and is fully integrated with London NHS 111, London Ambulance Service and OOH GP providers.

All the organisations involved have signed formal agreements that govern how care plan information is used and protected, and they undertake to provide CMC with updated lists of staff that are trained and authorised to access the system.

At the heart of CMC is a care plan that is developed with a patient by their nurse or doctor if and when both feel it is appropriate. The care plan contains information about them and their diagnosis, key contact details of their regular carers and clinicians, and their wishes and preferences in a range of possible circumstances.

This care plan is uploaded to the CMC system to which only trained professionals involved in their care can have access. These include ambulance control staff, NHS 111 operators, GPs, out of hours GP services, hospitals, nursing and care homes, hospices and community nursing teams. Over 17,000 personalised care plans have been created across London, and the outcomes show that 80% of patients with a CMC care plan have died in their preferred place and where patients had a CMC record 83% died outside of hospital; nationally 54% of patients die in hospital.

For more information:
www.coordinatemycare.co.uk

> "As more end of life care plans are incorporated into Coordinate My Care, with visibility to GP out of hours, the ambulance service, NHS 111 and Emergency Departments, the numbers of patients on the end of life pathway dying in hospital in London has markedly declined."
>
> Dr Agnelo Fernandes, Urgent & Emergency Care Lead – Royal College of General Practitioners.

> "In certain areas in Sussex, the palliative care team and the musculoskeletal team have begun using a common and popular IT system. This means that any visits or patient updates are shared and immediately available to view by the practice. It's an efficient way of recording and making the patient journey visible to clinicians in the community."
>
> Dr Farah Jameel, Sessional GP

CREATING A SUSTAINABLE WORKFORCE

Getting the right workforce in place within the out of hours sector is a vital part of improving the outcomes for patients. Some conditions are particularly badly served by the system including mental health, child health and chronic long-term conditions. However, caseloads are too small to justify standing teams of specialists. With GPs few in number and the service under ever increasing pressure, coordinated workforce planning and the diversification of skills in the service will be central to ensuring the delivery of high quality care out of hours.

The Commission looked at the barriers and opportunities that exist in achieving this and concluded that workforce planning was an area where big improvements could be realised to ensure urgent and out of hours care is served by a skilled and sustainable workforce.

GP WORKFORCE – THE FACTS

- Despite a commitment from the Department of Health policy to increase GP training numbers in England to 3,250 per annum, GP recruitment has remained below this target, at around 2,700 per annum, for the last four years.
- This recruitment shortfall is being further compounded by increasing numbers of trained GPs leaving the workforce, most significantly GPs approaching retirement and women in their 30s.
- Whilst the number of GPs per 100,000 head of population across England increased from 54 in 1995 to 62 in 2009, it has now declined to 59.5.
- Areas of high deprivation, where healthcare needs are typically greater, have fewer GPs per head than the UK average.
- 54 per cent of GPs over the age of 50 are intending to quit direct patient care within five years.
- There is a disproportionate number of older GPs nearing retirement in the more densely populated urban areas, areas where unmet health needs are already a national concern.
- Funding for general practice in England has reached its lowest point on record – down to just 8.5 per cent of the NHS budget compared to 10.95 per cent eight years ago. This has happened at a time when demand for GP services has risen dramatically – from 300 million in 2008 to an estimated 340 million today.

The challenge: to meet future demand, 50 per cent of medical students need to become GPs by 2015.

> "In many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving."
>
> NHS England, Five Year Forward View, 2014

8 RECOMMENDATION

Workforce planning is critical to the long-term sustainability of the urgent care sector, mitigating the risks posed by ongoing recruitment challenges.

1. A multi-disciplinary approach must be taken to staffing urgent care services. The spectrum of advanced practitioners available to deliver services should be expanded to include: pharmacists; nurses; physician associates; and healthcare assistants. Practitioners should then have the appropriate skills mix, enabling an out of hours team to call upon paediatric, mental health and long-term condition expertise at any one time.

2. Medical indemnity providers should take into account the quality and performance record of the provider when looking to associate levels of risk for the provider workforce.

The BMA GPC agreed in their consultation response but expressed caution that more needs to be done to understand if the willingness of other professionals is there:

"Many hospital pharmacists enjoy working as part of acute in-take teams, but GPC understands that many can get cold feet when working autonomously. We need to assure ourselves of what staff can and will do. There is too much variability, so more must be understood about where staff fit into the jigsaw."

BMA GP Committee, Urgent Care Commission consultation 2014

GETTING THE RIGHT SKILLS MIX – A NEW WORKFORCE?

Getting the right mix of skills for out of hours services emerged as a major concern for the Commission. While it was agreed that having the full multidisciplinary team staffing out of hours services would be inefficient, access and pathways into specialist care should be more easily and systematically available when needed.

Availability of high quality GPs has been an ongoing problem for urgent out of hours for many years. Ideally a service would be staffed by GPs within the geographic region, familiar with the local health service and with a long term commitment to remaining within the area. But frequently services need to cast further afield and pay high locum rates.

This fragmentation of the out of hours workforce has led to some members of the workforce being under-regarded or providing a default out of hours service but not being commonly recognised and integrated. Pharmacists in particular were noted as a resource and whose urgent care training was not currently well captured.

While it was acknowledged that diversification of roles and skills in the workforce should be encouraged, this is not being consistently applied across the country. For example, some services have looked at the potential of physician assistants, paramedics and advanced nurse practitioners roles, where others have insisted upon a GP-only service.

It is important to recognise that with workforce diversification will come additional complexity for the management of services. Using healthcare professionals with extended roles can be invaluable to the efficiency and effectiveness of a service. However, there will be limits to their professional ability, and there will be instances where a trained GP will need to be deployed. To get the most out of a diverse workforce, the provider will need to ensure the service is well choreographed, deploying the right clinical skills, at the right time to meet the needs of the patient.

The Commission's view on the future of the urgent care workforce are aligned with NHS England's ambitions, as outlined in its Five Year Forward View;

"Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals."

NHS England, Five Year Forward View, 2014

"When using multiple agencies, it is vital that new staff receive a formal induction process is in order to maintain high standards."

Dr Farah Jameel, Sessional GP

UNINTENDED IMPACTS OF WIDER COMMISSIONING

The impact of commissioning on workforce planning is considered a critical issue. The challenge is two-fold: firstly looking at how the commissioning of other services impacts on workforce planning for out of hours; and secondly how that planning for an out of hours workforce should take into account an appropriate mix of skills that will secure the future of the service in the longer term.

The Commission found that out of hours frequently experienced ebb and flows of work that were based not on a clear definition of its role, but the commissioning state of other services. Where services such as district nursing have been decommissioned, it is out of hours services that pick up the caseload as a "provider of last resort". Likewise, NHS 111 as a new service has been attributed as the cause of a dramatic drop in GP out of hours cases.

These unintended consequences of commissioning decisions elsewhere in the system make workforce planning for out of hours unpredictable and challenging. What became clear is the view that good commissioning involves knowing how out of hours fits into the wider local urgent care strategy. When planning for an urgent care workforce, commissioners and providers must first consider the future demands of the healthcare economy, and then which professions would be best placed to deliver this service. They should plan for flexibility in roles and consider interrelated services such as A&E and general practice, where the workforce may already reside and would ultimately need to work alongside.

> "We find people forget it [workforce planning]. When we're talking about workforce and we say 'how are we going to get the workforce we need?' we get, 'someone else is looking after it'. If someone doesn't think about education and training, there is no sustainability."
>
> Professor Sheona MacLeod, Health Education East Midlands

PRINCIPLES OF GOOD WORKFORCE PLANNING

Good workforce planning is central to high quality commissioning for urgent care. It encourages the consideration of which professional groups would be best placed to deliver an urgent care service fit for now and the future, allowing for the appropriate commissioning of education and training for healthcare professionals.

The core principles of workforce planning are as follows:

- **Whole-system approach:** Workforce planning is the responsibility of the urgent care system as a whole and cannot be conducted in isolation. Commissioners and providers must work together to ensure a whole-system approach is taken to training, education and recruitment.
- **Forward-planning:** Workforce planning must be built on the basis of a clear vision of what future services need to look like in order to meet the needs of the local health economy. This will require commissioners and providers to work together to map demand and supply in the long-term.
- **Short-term and long-term view:** Developing a 10-year plan is advisable, allowing for the time required to train highly skilled healthcare professionals. However, where there is an urgent need, planning for 2 year and 5 year intervals is also recommended.
- **Accounting for regional variation:** There are significant variations in the make-up of health economies across regions. Building a workforce planning model for urgent care must take into account the different types of service-need in rural, urban and mixed populations.
- **Planning for the pathway:** Workforce planning using care pathways works well in that it considers the requirements of the patient on their journey and who's best placed to deliver the services. It also allows for consideration of the inter relationships between professionals and between services.

Health Education England has published Framework Fifteen, designed to guide the investments, decisions and actions the healthcare system will take in the short, medium and longer term to ensure the right numbers, skills, values and behaviours are in place to provide high quality care.

More information:
http://hee.nhs.uk/wp-content/uploads/sites/321/2014/06/HEE_StrategicFramework15_final.pdf

MEDICAL INDEMNITY AS A BARRIER

If out of hours service of the future is going to mean access to specialists across multiple provider organisations then getting the medical indemnity framework right will be important. GPs working in out of hours operate with high levels of personal professional exposure and low support resources to mitigate those risks. The Commission expressed concern that indemnity providers are focused on mitigating against the risk of a single, rare case that will have significant financial consequences. The result is soaring costs of indemnity in out of hours, which has led to many healthcare professionals stepping back as the work offers low financial incentive. The challenge is how indemnity providers might work with urgent care providers to seek assurances on how this heightened risk is effectively managed.

The indemnity outlook for other healthcare professionals is currently unclear and the Commission established that there was little consensus on whether post-graduate medical trainees working outside of hospitals were adequately covered by Crown indemnity.

> "Out of hours is a risk sink. If you are in an environment with high exposure reflected in the indemnity, then what we've got is a risk management system where the resources available don't allow us to reduce that risk."
>
> Dr Fay Wilson, Badger Group

RAISED PROFILE IN GP TRAINING

The Commission believe that more support for GP trainers and the deaneries was needed to ensure out of hours was given the focus it warrants on the curriculum and as part of any in-training programmes. Trainee organisations are currently not sufficiently involved in deciding what out of hours training should look like, which compounds the lack of engagement from potential candidates.

Central to this challenge is ensuring that the workforce is prepared to respond to the breadth and complexity of patients they are likely to see in an out of hours setting. The profile of patients coming through out of hours increasingly represents an ageing population, with multiple, complex comorbidities. On the other end of the spectrum, they will see a high number of paediatric patients. The challenge in this case is differentiating between a child who is unwell, and who will most likely get better in a matter of hours; with a child who is unwell and likely to decline over night. The prevalence of mental health conditions is also rising; requiring specialist knowledge and experience. Currently the training available to GPs and their practical exposure to out of hours services is limited and therefore we have a workforce ill-prepared to meet the demands placed upon out of hours services.

The Royal College of GPs produced a competency framework for GP out of hours, in conjunction with partners at the General Medical Council, the British Medical Association and the Department of Health. However, following the 2004 contract change, out of hours lost a significant share of its trainers as out of hours training was no longer considered compulsory.

The current situation, whilst varied from region to region, suggests a reduced emphasis on out of hours for trainee GPs, posing a real risk to the future sustainability of the service. Professional bodies such as the Royal College of GPs are best placed to position greater emphasis on enhanced urgent care training within the mandatory curriculum for trainee doctors. Once qualified, all urgent care practitioners should have access to advanced and ongoing training and professional development. Individuals within the RCGP and College of Emergency Medicine could act as "curriculum champions" to ensure adequate coverage during training. It is imperative that Health Education England's Local Education and Training Boards (LETBs) and regional specialty schools have this on their agenda as a way to ensure they deliver a GP out of hours workforce for the future.

> "…Ongoing CPD is useful and revalidation requires GPs to include reference to whole practice appraisal. GPC agrees that greater emphasis is needed on enhancing urgent care training for GP trainees. Too many are not adequately trained to practice autonomously in urgent care settings."
>
> BMA GP Committee, Urgent Care Commission consultation 2014

A REWARDING CAREER

There is currently no recognition of how rewarding and valuable a training experience in GP out of hours care can be. This is particularly stark when compared to how out of hours care in the acute sector is perceived as a great way to rapidly gain varied clinical experiences. Healthcare organisations at a national and local level need to be better at valuing and recognising those working within GP out of hours settings. Out of hours work is a different way to be a GP offering greater problem-solving and immediate impact on patients than the longer term management of in-hours care.

"**Paramedics now have the skills and equipment to deliver treatments that would only have been done by doctors 10 years ago.** With these capabilities and by working closely with improved community services, ambulance clinicians can safely manage many more patients at scene, either treating them in their own home or referring them on to other appropriate community based health or social care services.

There are opportunities for extending provision of training of paramedics to increase capacity of advanced and specialist paramedics with enhanced responsibilities, allowing them to assess, prescribe for and manage patients with exacerbations of chronic illnesses.

The distribution of funds across, and general coordination between, health and social care education and training is uneven. HEE, Skills for Care, NHS Employers and professional representative groups should ensure that there is recognition of the need for health and social care training to be more closely connected, to facilitate a joint approach.

HEE need to take on responsibility for these considerations within national workforce planning and ensure that core NHS funding is in place to deliver sufficient capacity within the paramedic pool for NHS ambulance trusts, allowing access for paramedics to bursaries and financial support as with other AHPs."

Association of Ambulance Chief Executives, Urgent Care Commission consultation 2014

APPENDIX I: TERMS OF REFERENCE

PROJECT BACKGROUND

This multi-disciplinary expert Commission has been convened, with the support of Care UK, to investigate out of hours care provision in England, and make independent, evidence-based recommendations for service improvement. These recommendations will be aspirational but achievable; they will work within the confines of existing NHS structures and not require further major reform.

The core focus of the Commission's deliberations will be out of hours care. However, it is critical that this element of service provision is not considered in isolation, but within the wider parameters of the urgent care sector.

PROJECT OBJECTIVES

This Commission supports NHS England's ambition for urgent and emergency care in England, namely that:

- People with urgent but non-life threatening needs must have access to highly responsive, effective and personalised services outside of hospital;
- Services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families;
- We should ensure that people with more serious or life threatening emergency needs are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

In light of NHS England's ambition to instigate a system-wide transformation of urgent and emergency care, this expert Commission aims to:

A Investigate the way in which out of hours services are commissioned, designed and delivered in England today;

B Make independent, evidence-based, practical recommendations on how these services might be further improved in order to ensure patients in England have access to a rapid, high quality and responsive service.

SCOPE

The Commission acknowledges that this area of healthcare provision is broad and complex. It is therefore agreed that the scope of the Commission's investigation will fall within the following parameters:

1 Re-defining quality

- What are the defining quality standards of high-quality out of hours care?
- How should we accommodate possible tensions between local commissioning freedoms and the aspiration for consistent quality standards?
- How should we differentiate quality across the spectrum of urgent care services?

2 Building the right workforce

- What skills are required of an optimal out of hours care workforce?
- What structures need to be put in place in order to establish and mature this optimal workforce?
- How might the existing accreditation and appraisal mechanisms be better tailored to the workforce?
- What does the out of hours care sector need to do in order to maintain and grow the workforce?

3 Pathway design and functionality

Patient engagement and empowerment

- How do we support patients to become more aware, and have a better understanding, of urgent care provision?
- How do we best engage patients in the commissioning and design of urgent care and ensure that the patient view is reflected?

Interoperability

- What are the primary information governance challenges faced by urgent care providers? How might these challenges be overcome?
- How might we foster greater service integration across multiple providers?

07.04

METHODOLOGY

The Commission will be led by independent Chair, Professor David Colin-Thomé.

The Commission is made up of 17 independent experts, drawn from across the urgent care sector including both public and private providers; policy makers; and independent GPs.

These 17 experts have been drawn into two groups (Group A and Group B) who will meet on two separate occasions (9 and 30 July).

Each group will take on different roles. Group A will commence the discussion and make initial recommendations; Group B will review Group A outputs before a final set of recommendations is put out for comment to the whole group and wider consultation. By facilitating two separate discussions, we have a mechanism for internal review and ratification, giving each group the opportunity to reflect upon outputs and challenge/strengthen where necessary, both in the meeting and via email after individual reflection.

The Commission will be mobilised as follows:

1 Develop evidence base

- The King's Fund conducted a comprehensive literature review of content relating to the three core research topics as outlined above in the Terms of Reference scope
- This evidence has been translated into a briefing pack for all Commission members, designed to support discussions and the development of evidence-based, informed recommendations

2 Meeting 1 (Group A) – 9 July

- Group A will initiate discussion on the Commission's research questions, and commence the development of recommendations at their meeting on 9 July

3 Share and review initial outputs (online)

- Secretariat to collate Meeting 1 outputs and share with Group A and Group B for review and comment

4 Meeting 2 (Group B) – 30 July

- Group B will advance the discussion on the Commission's research questions and Group A's outputs, and develop further recommendations at their meeting on 30 July

5 Recommendations development (online)

- Secretariat to collate outputs from Meeting 1 and Meeting 2; and the intervening review period and share with all Commission members for review and comment
- Secretariat to work with Commission members to develop a set of agreed recommendations

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6 Consultation (mid-August – mid-September)

- Secretariat to consult external organisations on draft Commission recommendation

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7 Report development (August – September)

- Secretariat to work with Commission members to draft and approve report

MEMBERSHIP

Professor David Colin-Thomé
Independent Healthcare Consultant & Commission Chair

Dr Simon Abrams
Chair and GP, Urgent Health UK

Mr Henry Clay
Director, Primary Care Foundation

Professor Sir Alan Craft
Department of Child Health, Newcastle University

Dr David Lee
Former Medical Director, Care UK

Dr Alan Maguire
Head of Clinical Services, Northern Doctors Urgent Care, Vocare

Dr Nicholas Reeves
Former Adviser to the Urgent and Emergency Care Policy Team, Department of Health

Dr Farah Jameel
Sessional GP

Dr Agnelo Fernandes
National Lead Urgent & Emergency Care, Royal College of General Practitioners

Dr Steven Rawstorne
NHS 111 National Medical Advisor, NHS England

Dr Jean Wang
Clinical Fellow, Health Education England

Dr Fay Wilson
CEO and Group Medical Director, Badger Group

Dr Michael Harrison
Clinical Executive, Northern Doctors Urgent Care, Vocare

Mr Andrew McMylor
Director of Delivery and Development, Wandsworth CCG

Professor Sheona MacLeod
Director of Education and Quality and Postgraduate Dean, Health Education East Midlands

Dr Kat Noble
Emergency Medicine Task Force, NHS Health Education North East

Professor Wendy Reid
Medical Director, Health Education England

DECLARATION OF INTEREST

The Commission will be supported by a professional secretariat (Portland). This service will be funded by Care UK via an unrestricted research grant. Care UK will retain no editorial control

APPENDIX II: CONSULTATION

ORGANISATIONS THAT HAVE BEEN APPROACHED DURING THE CONSULTATION PROCESS

#	Organisation
1	Age UK
2	Association of Ambulance Trust Chief Executives (AACE)
3	Association of Directors of Adult Social Services (ADASS)
4	British Medical Association – Consultants Committee
5	British Medical Association – General Practitioners Committee
6	Faculty of Medical Leadership
7	Foundation Trust Network
8	General Medical Council
9	Independent Age
10	Joseph Rowntree Foundation
11	Local Government Association (LGA)
12	Medical Protection Society
13	Mental Health Foundation
14	Mind
15	NHS Clinical Commissioners (NHS CC)
16	Parliamentary and Health Service Ombudsman
17	Sainsbury Centre for Mental Health

CONSULTATION ON URGENT CARE

This document contains the recommendations that we are seeking your views and comments on.

These recommendations have been developed by an independent expert commission, chaired by myself and supported by Care UK.

This multi-disciplinary group is made up of 18 experts, drawn from across the urgent and emergency care sector, including: GPs; providers; commissioners; managers; academics: and policy-makers. The Commission has met on two separate occasions.

As you will know, we have reached a critical juncture in the urgent care debate in England today. Sir Bruce Keogh's 'blueprint' for urgent and emergency care, and the subsequent Urgent Care Review, are a strong indication of NHS England's intention to drive improvements in the quality of outcomes in this sector. In light of NHS England's ambition to instigate a system-wide transformation of urgent and emergency care, this expert Commission set out to:

A **Investigate** the way in which out of hours services are commissioned, designed and delivered in England today

B **Make independent, evidence-based, practical recommendations** on how these services might be further improved in order to ensure patients in England have access to a rapid, high quality and responsive service

There are many challenges facing the urgent care sector and we believe there is a job to be done to:

A define what quality service provision looks like;

B establish the structures needed to build an optimal, sustainable workforce; and

C identify how we as a sector might work towards achieving interoperability across an extremely complex pathway.

Perhaps one of the most significant barriers we've identified to achieving real change is the disjointed nature of the debate, with conversations taking place across Government, the NHS, the clinical community and in the media. An emphasis on delivering practical support for providers and clinicians to make quality improvements a reality is now needed. By convening a group of fellow experts, inclusive of all key players, our ambition was to draw together the threads of this debate and make independent, evidence-based recommendations for service-wide improvements.

Your organisation has been selected to comment to ensure these recommendations are both aspirational and achievable, offering practical solutions to deliver real change.

We ask you to review the recommendations in this document and provide your views and comments to ensure that they are valid and relevant to the current landscape of urgent care.

Following your feedback, the Commission will finalise the recommendations ready to share with an audience of policy makers, Government bodies, healthcare providers and professional bodies.

We appreciate that your time is limited, so any feedback or comments you might be able to share would be greatly appreciated. We will be accepting feedback until 5pm on **Monday 6th October 2014**.

Should you have any questions, please do not hesitate to contact [redacted] at the Commission Secretariat at [redacted] or [redacted].

Thank you in advance for your contribution to this important debate.

Professor David Colin-Thomé
Chair, Commission on Urgent Care

URGENT CARE COMMISSION 2014
SUPPORTED BY CARE UK

For an online version of the report go to: careuk.com/futureforurgentcare