PA Consulting Group

Healthcare for London

Study of Unscheduled Care in 6 Primary Care Trusts

Central Report

April 2008

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Contents

1 Executive Summary

The aim of the study was to assist Primary Care Trusts (PCTs) in developing effective strategies for commissioning unscheduled care which will enable development of responsive, integrated and effective systems of care that better meet the needs of patients and the public.

'Healthcare for London: A framework for action' highlighted that every year millions of Londoners have non-life threatening short-term illnesses or health problems for which they need prompt and convenient treatment or advice. A much smaller number suffer from serious illness or have a major injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery. To meet these needs, the NHS in London needs to provide access to timely and appropriate unscheduled care, information and advice across the 24-hour period.

A Framework for Action (2007) highlighted a number of areas where the provision of unscheduled care in London could be improved. This included the highest A&E attendances (and admissions) in the country, poor access to alternatives, duplication of services and poor public awareness of the unscheduled care service offering. In response, the Healthcare for London Programme has initiated an Unscheduled Care Project which has developed a programme of work to attain deeper insight into current systems, how they work and how they could be improved. This Unscheduled Care Study is one element of the project and aims to assist PCTs in developing effective strategies for commissioning unscheduled care which, informed by the outcomes of the consultation, will enable development of responsive, integrated and effective systems of care that better meet the needs of patients and the public.

PA Consulting Group was selected to work with NHS London and 6 PCTs who were selected to participate following expressions of interest. The six PCTs were Barnet, Camden, Hammersmith and Fulham, Kingston, Newham and Waltham Forest.

The study placed emphasis on examining the whole system and 'real-time' data to improve understanding of key access points. This involved the assessment of more than 5,200 patients by clinicians, 780 detailed patient and public surveys conducted by Ipsos MORI and six in depth focus groups, over 100 detailed service surveys and interviews with more than 180 stakeholders.

The approach developed with Healthcare for London and the six PCTs was innovative in that it combined the three dimensions of patient opinion surveys, clinical assessment of patients presenting at access points and analysis of existing data sets. This emphasis on a whole systems approach and prospective data collection provides for a much greater degree of richness in the analysis that has been conducted consequently than would have been the case if the study had relied on existing data sets alone.

In designing and implementing the data collection approach, sufficient sample sizes were collected to draw reliable conclusions and to ensure that they were representative of the socio-demographic profile of the patients across the PCT and of patients using each access point. The approach was based upon triangulating different data sets to ensure that results were truly comparable. So for instance A&E data was collected from local systems to ensure that the conditions patients presented during the live data collection period were the same as the conditions presenting at a particular Accident and Emergency (A&E) department during the course of a whole year. However, in interpreting and applying the conclusions of this study it is important that commissioners consider them in the context of local models of care and socio-demographic factors.

The model for providing unscheduled care services is broadly consistent

The model of unscheduled care provision across the six PCTs is broadly consistent however there are some differences in operating models, in particular the presence of primary care front ends to A&E and Walk in Centres (WICs), which do in part, explain different levels of usage at A&E.

While the majority (75%) of unscheduled care attendance occurs at GP practices and pharmacies, nearly half of all commissioning costs rest with 999 and A&E services and there are clear cost advantages in shifting patients from A&E to alternative access points.

How patients access unscheduled care services

There are high levels of repeat attendance at GPs, A&Es and pharmacies, with patients visiting multiple access points for the same condition. 20% of patients visiting A&E has been see their GP within the previous 3 days, whereas 7% of patients in A&E have been to an A&E department within the past 3 days. There is evidence to suggest that attendance at A&E could be reduced by establishing a primary care front end, however there is also some evidence to suggest that total attendance across the system may also grow as a result.

Provision of unscheduled care across the system could be better aligned to when patients require care. There are peaks in demand for unscheduled care in the mornings and evenings which do not always match the opening hours for some services.

There is a propensity for the older people to use A&E and parents of the very young to use both A&E and telephone access points. There is also an indication that Black and Minority Ethnic (BME) groups have a greater propensity to access unscheduled care at their GP or A&E compared to White British patients.

GP clinicians' assessment of the unscheduled care system

Only around 1 in 3 non-major patients presenting at A&E were assessed as requiring treatment by an A&E clinician, whilst 75% of patients presenting at A&E with non-major conditions could have appropriately presented at an alternative access point.

1 in 4 unscheduled patients visiting their GP could have been seen in a scheduled appointment

GPs involved in the A&E triage exercise thought that unscheduled care attendances could be reduced significantly through an urgent care telephone service and improved information flows across access points.

Patient behaviours and views about unscheduled care

Overall patients are satisfied with the services they receive: GP practices - 91%; pharmacies - 96%; WICs - 88%; and A&E - 86%.

Around 1 in 3 patients said they had sought treatment for the same condition previously at an unscheduled care access point within the previous 7 days. Of those, 55% had previously sought treatment or advice from their GP (who may of course have subsequently referred them on). More than 1 in 5 patients presenting at A&E said they had previously sought treatment for the same condition at an A&E access point.

Patients know about and are willing to use alternative access points to A&E but do not always do so. The key reasons for not doing so concern access and the ability to get GP appointments at times that are convenient.

In order of priority, patients consider: standard of care; location; speed of diagnosis and treatment; and opening hours as key factors when choosing an access point.

When asked how they would like their unscheduled care needs to be met in the future, patients highlighted a requirement for quicker services and less waits. Patients commented on both the need for GP appointments to be more readily available and in addition the need for them to extend their opening hours.

The study has revealed that there are significant opportunities for improvement across the unscheduled care system.

Whilst the clear majority of patients surveyed as part of this study are either satisfied or very satisfied with the care they receive from the unscheduled care system the analysis of the survey data, patient feedback and stakeholder interviews show there are significant opportunities for improvement, many of which mirror those described in 'A framework for action'. In discussing these with key stakeholders, three overriding improvement goals consistently emerged. They are:

- Prevention: concerned with supporting patients in avoiding the need to enter the unscheduled care system through wellbeing or better self management interventions
- Improving access: concerned with ensuring that when patients do need unscheduled care they are able to access it at the most appropriate setting and at a time and location that is convenient
- Improved system navigation: concerned with supporting patients in finding access to unscheduled care at the most appropriate setting, active management of access to A&E departments and redirection of unscheduled care patients to scheduled care settings where appropriate.

The report describes eight opportunities for improvement including: improving the support provided to patients in managing their own care; joining up services through more streamlined telephone access; providing improved access to GPs and better use of the capability of pharmacies; and, the provision of new centres for urgent care aligned to A&E and in the community. In addition to these areas of opportunity there are a number of straightforward steps that could be taken to improve current models of provision.

Whilst some of these opportunities are supportive of the proposals set out by 'A framework for action', as these are currently subject to a consultation process, this report makes no assumptions about the outcome of this process.

This short study was conducted with tremendous support from all the organisations across the six PCTs that took part. Without their efforts, often at short notice, this study would not have been possible.

2 Background and context

This section details the background and context to the Unscheduled Care Study. It sets out the rationale for the work, how the study was carried out and how the study fits within the overall Unscheduled Care Project. This section also sets out what is contained in the remainder of this report and how to use the pack of reports produced by the study.

2.1 Healthcare for London context

In 2006 London's Strategic Health Authority, NHS London, asked Professor the Lord Darzi[1] to lead a review of London's healthcare. He set out his findings from this review in a document entitled 'A Framework for Action'. [2] This report makes evidence based recommendations for change, setting out a ten year vision for healthcare in London.

In response to a Framework for Action, a Healthcare for London programme team has been set up to manage the delivery of the associated work programme. The London Commissioning Group (LCG)[3] is responsible for leading the delivery of the programme and is accountable to all London Primary Care Trust (PCT) Boards and NHS London.

A public consultation was launched on the 30 November 2007, to gain the view of Londoners on how health services could really be improved over the next ten years.

Without prejudice to the outcome of the consultation the LCG, has identified six priorities for further exploration. Project teams were therefore established to look at:

- Developing an improved major trauma pathway
- Developing an improved stroke pathway
- Developing the polyclinic model and identifying potential pilot sites
- Establishing local hospitals clinically and financially
- Establishing a baseline across London for demand and provision of unscheduled care
- Improving models of care and commissioning for diabetes.

[1] Professor the Lord Darzi, KBE, FMedSci, FREng (Hon) The Paul Hamlyn Chair of surgery, Professor of Surgery and Head of Division Surgery, Oncology, Reproductive Biology and Anaesthesia, Honorary Consultant Surgeon St Mary's Hospital and The Royal Marsden Hospitals NHS Foundation Trust.

[2] NHS London, A Framework for Action, (London: NHS London, 2007)

[3] Membership of LCG - representatives from PCTs, NHS London, the Mayor's Office, Local Government, the Clinician Advisory Group and the Patient and Public Advisory Group

2.2 Overview of the Unscheduled Care Project

'A framework for action' highlighted that every year millions of Londoners have non-life threatening short-term illnesses or health problems for which they need prompt and convenient treatment or advice. A much smaller number suffer from serious illness or have a major injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery. To meet these needs, the NHS in London needs to provide access to timely and appropriate unscheduled care, information and advice across the 24-hour period.

A Framework for Action makes significant recommendations for improving unscheduled care in response to evidence presented in the Case for Change and the supporting Acute Care Working Group[4] paper that current arrangements are not as good as they could be.

A Framework for Action highlighted that the NHS in London needs to improve access to timely and appropriate unscheduled care, information and advice. It identified the following:

- London has the highest rate of A&E attendances (and A&E admissions) in the country.
- There is potential duplication and poor utilisation of unscheduled care services.
- Whilst there are many points of access for unscheduled care patients, the evidence to date suggests that Londoners do not always know about all of them nor which service is most appropriate.
- Access to GP services outside of normal working hours is poor.
- Action to improve unscheduled care has the potential to make a significant contribution to other priorities for improving care.

To address the issues identified and to meet patients' needs in relation to unscheduled care, a Framework for Action proposes:

- Establishing Urgent Care Centres in community settings (e.g. polyclinics) and at the front end of hospitals, staffed by multidisciplinary teams including GPs, nurses, emergency care practitioners and others
- Streamlining telephone access via a single non-999 telephone number for urgent care with call handlers determining the most appropriate course of action from self-care advice through to transfer to emergency services and ambulance response
- Improving pathways for major trauma, stroke and complex surgery
- Improving management of long term conditions, to reduce the incidence of unscheduled care needs arising
- Developing the role, skills and capacity of the London Ambulance Service
- Developing the role of community pharmacies

The Unscheduled Care Project, as part of the Healthcare for London programme, has identified two overarching objectives in response to the issues and recommendations raised in 'A framework for action'; to develop a commissioning framework for unscheduled care services and improve patients' utilisation of the system. The project team has initiated a programme of work that will inform the necessary developments.

This Unscheduled Care Study forms an early part of this programme of work.

[4] http://www.healthcareforlondon.nhs.uk/backgroundFurtherInfo.asp

2.3 Background and rationale for the Unscheduled Care Study

Following a competitive tendering, PA Consulting Group were commissioned by NHS London to undertake a study into the current unscheduled care provision in a small number of local health communities in London.

The aim of the study was to assist PCTs in developing effective strategies for commissioning unscheduled care which, informed by the outcomes of the consultation, will enable development of responsive, integrated and effective systems of care that better meet the needs of patients and the public.

The study ran from 28 January 2008 to Monday 31 March 2008 across a number of PCTs in London.

The PCTs involved in the study were selected following expressions of interest. Selection was informed by the strategic importance of unscheduled care in the local healthcare community. The six PCTs were: Barnet; Camden; Hammersmith & Fulham; Kingston; Newham; Waltham Forest

2.4 The Unscheduled Care Study team

A combined team of project and data leads from PA and PCT staff, both administrative and clinical, was established for each PCT. Additional programme management support was provided centrally to coordinate the overall activity. The PCT teams liaised and built relationships with key stakeholders in each PCT/health community. These teams were co-located which enabled the work to progress quickly and effectively.

As part of this work and to ensure that progress and findings were communicated to relevant stakeholders, two central workshops and ten local PCT workshops were held during the study, as well as numerous stakeholder meetings. The project deliverables and methodology were designed with input and signed off by clinicians and the Unscheduled Care Study Project Board.

The study team reported progress and delivery against milestones and objectives into the Study Project Board on a weekly basis.

We would like to take this opportunity to thank everyone who was involved in this study, especially the Project Board, PCT project teams and staff; and the clinical advisers who provided support and guidance, Professor Sir George Alberti, Dr Marilyn Plant, Professor Peter Hutton and Dr Simon Walford.

2.5 Purpose of this report

This report sets out the evidence base obtained as part of this study and considers what this means for the way in which unscheduled care could be delivered more effectively and efficiently in the future.

This report can be read as a stand alone document. However, greater value will be gained if it is read as part of the series of reports generated by this study for each participating PCT. The PCT-level reports set out the local picture of provision, activity, patient and stakeholder views about the unscheduled care provision.

The remainder of the report is set out in the following way:

Section 3 - explains the methodology and approach employed through the study

Section 4 - sets out how unscheduled care services are commissioned and provided across the six PCTs included in this study

Section 5 - sets out how patients access unscheduled care services

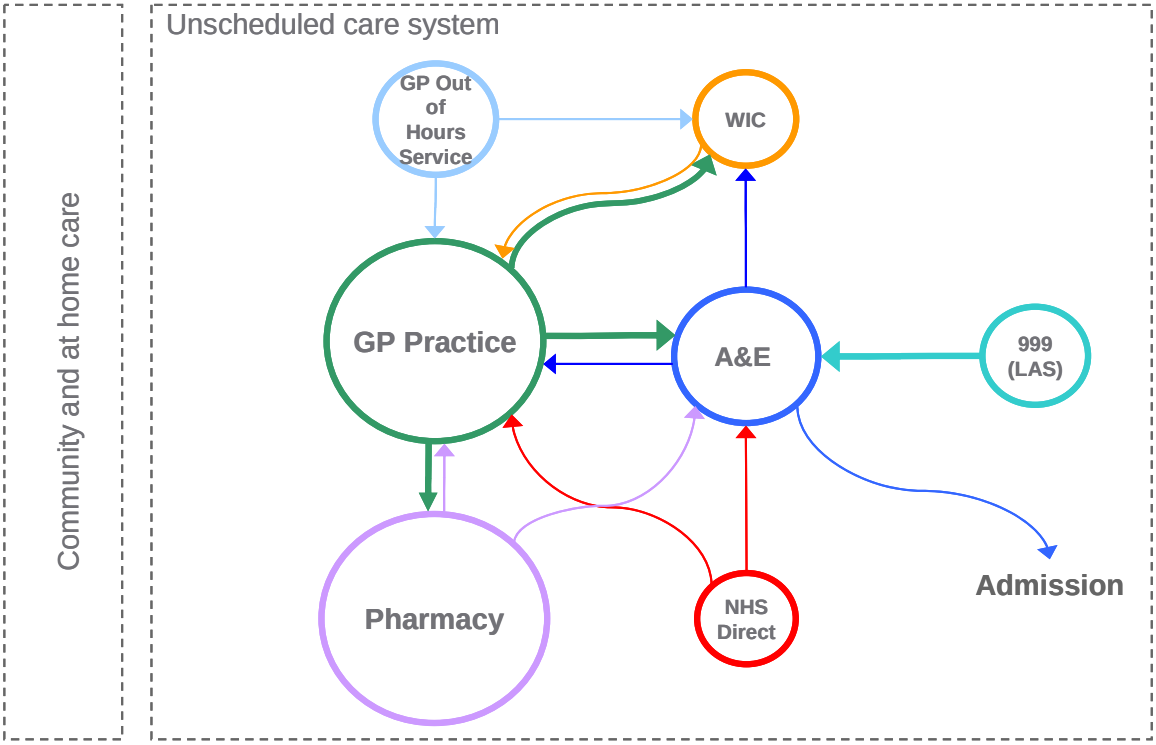
Section 6 - describes the results of the assessment of patients entering the unscheduled system conducted by clinicians

Section 7 - sets out patients behaviour within and views about the unscheduled care system

Section 8 - describes the overall improvement opportunities highlighted by this study and sets them in the context of the proposals made by 'A framework for action'

Section 9 - proposes the key next steps.

At the front of sections 5, 6, 7 and 8 the key messages are summarised using the unscheduled care system model below. This simply sets out the seven access points in scope and the flows of patients between them.



3 Approach and Methodology

This section sets out the approach and methodology designed and used by the Unscheduled Care Study.

3.1 Overview of approach

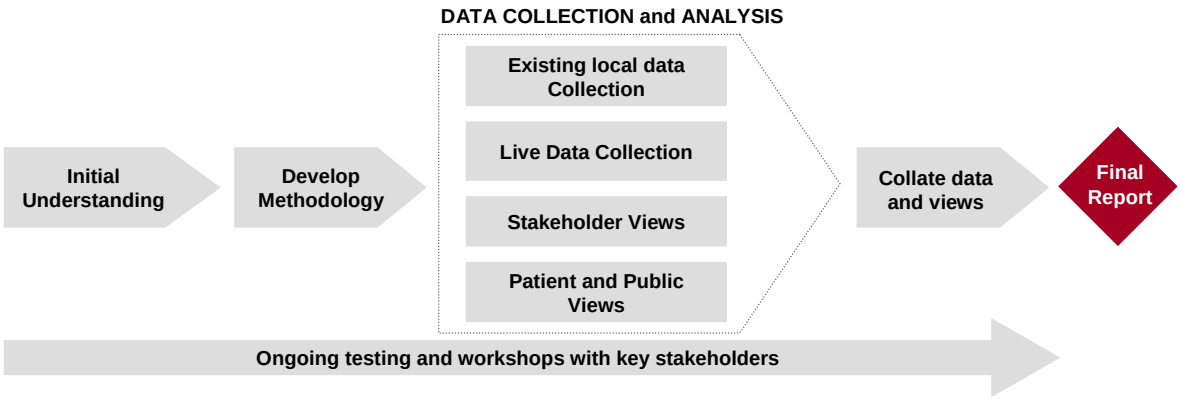
Our approach to data collection and analysis for the Unscheduled Care Study focused on collecting the following key pieces of information:

- Socio demographic details of individual PCTs
- The existing provision and usage of unscheduled care within the six PCTs (including activity volumes, the flow of patients between various access points and the effects of any recent changes to unscheduled care provision)
- An understanding of the behavioural factors that affects patient and public use of unscheduled care and whether these behavioural factors can be altered by policy drivers
- An understanding of potential alternative unscheduled care provision for presenting conditions
- Stakeholder views about existing provision and potential areas for improvement.

Fundamental to PA Consulting's approach was the need to work directly with clinical and professional staff within PCTs in order to gain as broad a knowledge as possible about unscheduled care provision. Building up these networks of trust within PCTs and across the London healthcare community enabled PA to develop and test the approach and findings throughout the process with clinicians and other professionals.

The overall approach to the Unscheduled Care Study is illustrated and explained in Figure 1

Figure 1: Unscheduled care study methodology



Key elements of this process were:

- **Initial Understanding** - Identification of available local data sources, unscheduled care provision and unique local socio-demographic or other factors with key stakeholders within the PCTs. This initial understanding was tested with key stakeholders.
- **Design/Develop Data Collection Methods -** Identify from initial understanding the gaps in the existing data set and develop robust tools and processes to provide the data and information to fill these gaps. This included defining unscheduled care for the purposes of this study. The tools developed with key stakeholders were tested across the PCTs
- **Data Collection and Analysis -** The data collection methodologies used are explained briefly below. The purpose of collecting data using a variety of methodologies was to minimise the risk of analysis being based on data that was not robust. By collecting data from a variety of sources at each access point type it was possible to validate one set of findings with another. This was particularly important where data sets were small but could be compared with larger data sets for validation.
- **Existing local data collection -** Identification and collection of local data extracts including information on activity volumes and trends, patient profiles and condition.
- **Live data collection** - In a variety of access points, live data was collected by clinicians on the patients that presented to the access points. It captured activity volumes, patient profiles and condition
- **Collection of stakeholder views -** This was achieved in two ways. Firstly, through structured interviews with stakeholders (clinical, managerial and administrative) to seek their views on the successes and challenges of the local unscheduled care provision and to understand their views on potential future improvements. Secondly, by sending surveys to GPs and Pharmacists asking for their views on activity, patient profiles and condition at their access point.
- **Collection of Patient and Public views -** Working with Ipsos MORI, surveys were developed that were then used at all access point types. Patients were asked questions relating to their access choices, condition and understanding of the rest of the unscheduled care system. The public views were collected through 'focus groups' in each PCT and via public interviews.

Table 1: Access points & data collection coverage

	Local Data	Live Data Collection	Service Survey	Stake holder interview	Patient interview	Public Interviews	Focus Group
A & E Departments	✓	✓		✓	✓		
WIC / EUCC	✓			✓	✓		
GP		✓	✓	✓	✓		
GP (OOH)	✓			✓		✓	✓
Pharmacies		✓	✓	✓	✓		
L.A.S.	✓			✓			
NHS Direct	✓			✓			

- **Final collation and interpretation of data and views -** The new and existing data sets, findings from patient surveys and views sought in stakeholder interviews were collated and analysed. The outputs were then interpreted taking into account stakeholder views and the HfL proposals. Initial findings were tested with key stakeholders in a series of workshops.
- **Local testing and workshops -** throughout the whole process the methodologies, surveys, definitions and initial outcomes were tested with stakeholders either individually or in workshops.

In designing and implementing the data collection approach, sufficient sample sizes were collected to draw reliable conclusions and to ensure that they were representative of the socio-demographic profile of the patients across the PCT and of patients using each access point. The approach was based upon triangulating different data sets to ensure that results were truly comparable. So for instance A&E data was collected from local systems to ensure that the conditions patients presented during the live data collection period were the same as the conditions presenting at a particular A&E department during the course of a whole year. However, in interpreting the conclusions of this study it is important Commissioners take them in context of local models of care and socio-demographic factors.

3.2 Methodology for data collection and analysis

Our methodology was designed to enable the following categories of information to be established:

- The current provision of unscheduled care (including number of access points; opening hours; number of staff; location; facilities and services; commissioning arrangements and costs; information systems; and the history of the access point)
- Current unscheduled care activity - volumes and flows
- Alternative options for unscheduled care
- Stakeholder views
- Patient and public views, and
- Future options for unscheduled care.

To ensure robustness and reliability and to enable cross-checking, our methodology guaranteed that for each of the categories and sub categories above, there were at least one and preferably two sets of data and information collected per access point. Appendix L sets out the complete list of data coverage.

A variety of tools and data collection techniques were developed in order to maximise understanding and results from the study. These are described in further detail in the following sections of this report.

All of the tools developed as part of the study went through a rigorous process of testing with clinicians, professionals and experts at a PCT and central level.

3.2.1 Local Data Collection

Obtaining local data from the access points provided the study with a rich understanding of the retrospective activity and usage trends for that specific access point, where appropriate. Local Data provided information about activity volumes and flows in the various access points, including information on the demographics of the patients and the types of conditions that were being presented. It also allowed verification of data collected from other sources particularly because of the larger data extract.

The challenge with local data was primarily its availability which was compounded by concerns from some access points regarding the quality, consistency of definitions and recording criteria. This was mitigated by grouping and retaining the original wording. This reinforced the importance of developing a single list of conditions for the live data collection, to facilitate easy mapping and comparability.

Patient level data sets were collected from access points including, NHS Direct, London Ambulance Service, A&E departments, WICs and GP OOHs services (where relevant) in each of the PCTs. Although data is collected locally by GPs and some pharmacists the information was not useful for the purposes of this study because, in most cases, the distinction between scheduled and unscheduled appointments was not made clear in their data sets.

An initial review of these data sets was conducted by the study's data specialists to build a picture of the information which already existed. Bespoke data collection tools were developed to fill the gaps in this information. Where necessary the team then agreed Caldicott Guardian sign-off to collect and compile the required data set for this study. The data was then securely emailed to an NHS.net account to allow analysis of all PCT data in a single location.

3.2.2 Live Data Collection

The live data collection, supported by the service surveys, helped the study to understand in more detail information regarding:

- access point's activity trends and patient demographics (validated by local data sets)
- conditions patients presented with at the access point
- a clinical (GP) opinion of the skill-mix required to treat the patient
- a clinical opinion (GP) of which alternative access points could have been more appropriately used to see and treat the patient
- possible preventative options

Therefore, in addition to filling the gaps in data, where local extracts were not available or of sufficient quality, this exercise also added a significant insight into clinical opinion about where else the patient could be treated. As shown by the table in section 3.1, live data collection was used in A&E, GP surgeries and pharmacies.

The need to, as far as possible, allow comparability between access points was another important factor when designing the methodology for the live data collection. This shaped the way the forms were designed. In particular, the condition lists and level of urgency required as much consistency as possible.

Agreement of 'condition' types

The purpose of this process was to identify a set of conditions that was comparable across the various access points.

An initial working list of conditions was drawn up by the PA unscheduled care project team (including the clinical advisor) with the Unscheduled Care Project Board clinical representatives. This list was then amalgamated with A&E diagnosis codes published by Connecting for Health[5] to ensure there were conditions listed for primary and secondary care.

Level of urgency

There were five levels of urgency used for the live data collections exercise. These were developed in order to be able to conduct meaningful analysis, and to provide clear distinguishing categories for people completing forms. The choice of two hours for Urgent was made to distinguish it from the four hour A&E target. If four hours had been used on the form this could influence all A&E reviewers to select that box.

It should be noted that some pharmacists had difficulty interpreting the urgency statement, with a number ticking the <10 minutes box because patients did not want to queue as opposed to an urgent medical need. To mitigate this, urgency was not used in the pharmacy analysis.

The forms developed were similar. However there were minor differences in the methodologies developed in the collection of data at different access points.

A&E Live Data Collection

Time period	2 days (mixture of days and times) in all A&E departments except Kingston which was 7 days to ensure that the samples from other A&Es were representative
Reviewer	GPs. The GPs observed patients who presented for minors triage between the hours of 0800 - 2300. Ambulance arrivals were included where possible, if they were assessed to be minors. The GPs made judgements only from observation of the triage process. All the GPs were individually briefed prior to their session.
Description	The approach was piloted at UCLH using a data collection form that was amended prior to roll out in other trusts. Considerable similarity remained allowing comparison with other hospitals.
Issues	There were inconsistencies in the way the alternative access, treatment and skill-mix questions were answered with some reviewers only ticking single boxes others multiple. The issue was mitigated by considering responses in totality It was difficult to capture ambulance arrivals and in some sites children, for example,

[5] Accident and Emergency Diagnosis Codes, Commissioning data set Version 6, Type 010 Accident and Emergency Commissioning Data Set

Kingston and Charing Cross, because of the separated triage processes.

GP Live Data Collection

Time period	10 days recording in at least three GP practices in each PCT
Reviewer	GPs
Description	GPs recorded details of patients who accessed an appointment that was not pre-scheduled. This included consultations by telephone. Scheduled appointments were not recorded Participating GPs were asked to record a minimum of 10 unscheduled patients per day, some GPs recorded more. After explanations to the participating GPs at the start of the exercise, interim findings were gathered after 3-4 days of data collection to enable analysis and interpretation to commence.
Issues	Some practices deliver the majority of appointments on a 'walk-in' basis. Where this created an unrealistic work burden, GPs were asked to record information from a random sample of patients through the day. This approach was utilised to minimise any impact on the GPs and on the study.

Pharmacy Live Data Collection

Time period	10 days recording in at least three pharmacies in each PCT
Reviewer	Pharmacists
Description	The form used was reviewed by the LPC chair in Kingston and endorsed by other local LPC chairs in some of the PCTs. Pharmacists were asked to record data on patients who attended for advice. Patients attending for prescriptions or purchases with no advice were not included. The approach was explained to pharmacist before commencing data collection and in most examples interim results were collected after 3-4 days to enable analysis and interpretation of the results to commence.
Issues	The style of form used was slightly different from the A&E and GP forms. This was to speed completion of the form. A tick box version was developed which can be found in the separate document The question relating to urgency was not answered consistently, as explained previously. This meant that these results were not used.

3.2.3 Stakeholder Views

The stakeholder views were collected in two ways, services surveys sent to all GP practices and pharmacies in the PCTs and structured stakeholder interviews. These are explained in more detail below:

Service Surveys were developed in order to fill in the 'gaps' left by historical electronic data and to work in support of the live data collections. The surveys were developed to capture a view of the unscheduled care activity at GPs surgeries and pharmacies. The forms were designed to be easy to complete, asking participants for access point details, an estimation of activity levels and patient profiles from experience. The 'service surveys', sent to all pharmacies and GPs across the PCTs were important to the study for a number of reasons:

- To understand the capacity to handle unscheduled care
- To understand the level of unscheduled care activity
- To get a view of the typical demographics of patients seeking unscheduled care
- To get a wide range of clinical opinion

The response rate achieved was not high, particularly for the GP population. This was for two reasons. Firstly, the survey was circulated at a high pressure period of the year with financial year end and contract negotiations taking place. Secondly, a number of other surveys were circulated within similar timescales that caused confusion about which to complete and how the data was to be used. As a result of this low response rate, the data was used mostly to validate other data sources.

Stakeholder interviews were an important way of gathering a wide range of views from stakeholders across the PCTs about:

- How unscheduled care works currently within the PCT
- How the unscheduled care system was working in the various access points; and
- How the structure/ system could be improved

To promote consistency of interviewing between stakeholders and across PCTs, a questionnaire was developed (this can be found in the separate document containing all the questionnaires used during the study). This provided specific questions about each of the above categories. It was recognised that stakeholder interviews would all be individually unique but the questionnaire allowed consistency and comparisons between views collected.

Stakeholder interviews covered the whole range of unscheduled care provision across the PCTs. Interviews were held with GPs, GP Practice Managers, A&E representatives, community services representatives, mental health, pharmacists, PCT stakeholders and commissioners, local social services and other key figures from the unscheduled care community.

3.2.4 Patient and Public Views

The patient and public views were collected using three discreet methods; structured interviews at access points, interviews with the general public and focus groups. These were conducted by Ipsos MORI with material developed jointly with the PA team.

Structured patient preference surveys were designed to capture patient preferences about a number of issues:

- General views about unscheduled care provision;
- Patient knowledge about the unscheduled care system;
- The patient's reason for choosing a certain access point;
- The patient's reason for not choosing an alternative access point.

Data from these surveys has been used to illustrate and consider the behaviour of patients that drives use of unscheduled care in the capital; and how unscheduled care models might be structured in the future to reflect the behavioural factors uncovered by the surveys.

The patient preference survey was conducted face-to-face among the patients at pharmacies, GP surgeries, WICs and A&E departments across the six PCTs.

Wherever possible, the interview was conducted with patients after they had completed their treatment, or had received advice. In some circumstances this was not always possible, for example, in A&E with some interviews being completed post-triage, rather than post-treatment. Interviewers were instructed to conduct as many interviews as possible, and no quotas were set. Patients were to be selected at random.

Public Interviews - in each of the PCTs Ipsos MORI conducted structured interviews with the general public. The interviewers positioned themselves in a busy public place and identified individuals to interview at random.

The interviews were similar to those used for the patient interviews without questions on the provider they have accessed. The questions probed public understanding of the various access points and the factors that influenced their behaviours

Focus Groups - Ipsos MORI conducted six focus groups among the general public in the six PCTs. Within each discussion group, quotas were set on age, working status, ethnicity, and whether or not there were children in household. An additional quota of educational attainment was set for the Kingston focus group, to reflect the distinct nature of the local population.

This design was derived, and the demographic quotas set, using PCT level population data produced by the Ipsos MORI Sampling Department. This was supplemented by additional Urgent Care service usage data taken from a 2006 quantitative study conducted for NHS London.

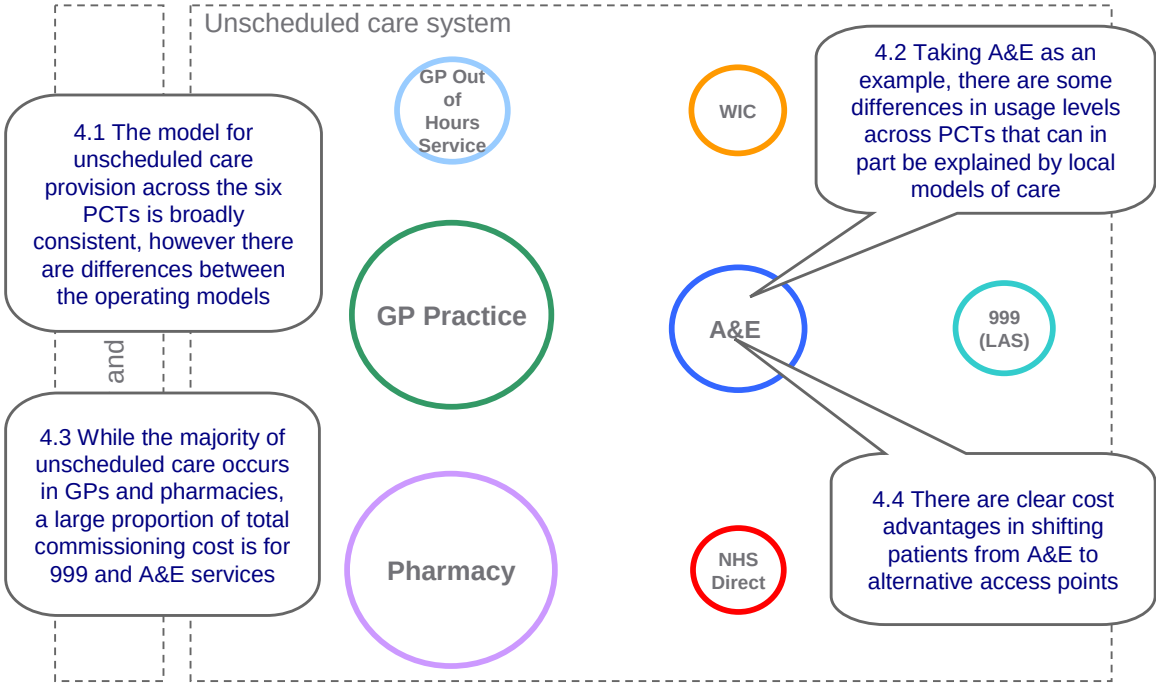
The group participants were recruited face-to-face, using an agreed recruitment questionnaire, by Ipsos MORI recruiters.

Members of the Ipsos MORI Social Research Institute moderated the focus group, using a discussion guide designed with PA Consulting, reflecting the key objectives of the study. A copy of the discussion guide is appended separately.

It must be remembered when interpreting qualitative results that they are not based on quantitative statistical evidence. The findings are based on small samples of London residents, and are thus illustrative rather than statistically representative. The qualitative findings recorded are perceptions, not facts – participants may hold views that are based on incorrect information; it is these perceptions which are reported here.

4 How unscheduled care services are commissioned and provided

This section provides information on the services available in each PCT for patients who want to access unscheduled care. Models of unscheduled care are summarised; activity levels through the different access points; and costs associated with each of the access points are compared. Appendix A provides further detail around the unscheduled care system in each PCT. The diagram below shows a high-level view of the unscheduled care system and summarises key messages regarding the provision of unscheduled care services and commissioning costs



4.1 The model for unscheduled care provision across the six PCTs is broadly consistent. However there are differences between the operating models

The table below summarises which of the access point types are available to patients in each of the PCTs. Only the major provider types are included in the table:

Table 2: Unscheduled care provision across each of the six PCTs

(The number of ticks in each box indicates the number of each access type within the PCT)

	A&E	GP	GP OOH	WIC	UCC	Pharmacy	Mental Health
Barnet PCT	✓	✓	✓	✓✓		✓	✓
Camden PCT	✓✓	✓	✓			✓	✓
Hammersmith & Fulham PCT	✓✓	✓	✓	✓	✓	✓	✓
Kingston PCT	✓	✓	✓			✓	✓
Newham PCT	✓	✓	✓	✓		✓	✓
Waltham Forest PCT	Emergency centre only	✓	✓		✓	✓	✓

Table 2 shows that the greatest variation in the whole system is the provision of WICs and Urgent Care Centres (UCCs). However, there are other significant differences in the way unscheduled care is provided in each of the PCTs. All PCTs are considering some evaluation of a primary care led 'front end' to A&E. These plans are at various stages of development ranging from tendering the service (Newham) to feasibility and design discussions.

Whipps Cross has the most developed UCC of all the PCTs in the study. There has been a move away from the typical A&E model to an Emergency Care Centre and UCC. Access to the ‘Emergency care centre’ (most acute setting) is only via the UCC or via ambulance. Patients are triaged and streamed depending on clinical urgency. GPs and nurses are a key element of the UCC staffing. Physically the two units are very close. The UCC has become the 'gatekeeper' to the hospital emergency services.

The location of the Newham WIC on the main hospital site allows for some flow and transfer of activity between the two sites. The central location, supported by strong transport links, makes the service very accessible. The Parson's Green service is relatively small and services a largely residential population. The staff rotate between the Charing Cross 'WIC' and this site resulting in a highly skilled workforce.

4.2 Taking A&E as an example, there are some differences in usage levels across PCTs that can partially be explained by local models of care

The estimated level of A&E use varies from 330 to 468 attendances per 1000 population per year (see Table 3). This suggests that A&E attendance levels per population are 40% higher for Hammersmith and Fulham residents compared with Waltham Forest residents.

Table 3: A&E attendances per head of PCT population

	Barnet	Camden	Hammersmith and Fulham	Kingston	Newham	Waltham Forest
Total no of A&E attendances per population per year	107,785	67,525	72,796	47,910	97,712	75,396
Estimated no of A&E attendances per 1000 population per year	**375**	**335**	**468**	**411**	**440**	**330**

Whilst deficiencies in the availability of A&E data from some A&E departments may explain part of this variation, the overall variation is still significant. The low level of A&E attendances for Waltham Forest may be partly explained by the Emergency and Urgent Care Centre (EUCC) at the 'front end' of A&E, treating patients with minor injuries or ailments hence the lower A&E attendance figures. The relatively high figures for Hammersmith and Fulham PCT can be explained by patients attending A&E at Charing Cross being treated in the Walk-In/Urgent Care stream within the A&E department. In other words, both people who attended the Walk-In/Urgent Care stream and those attending A&E are counted in the above figures.

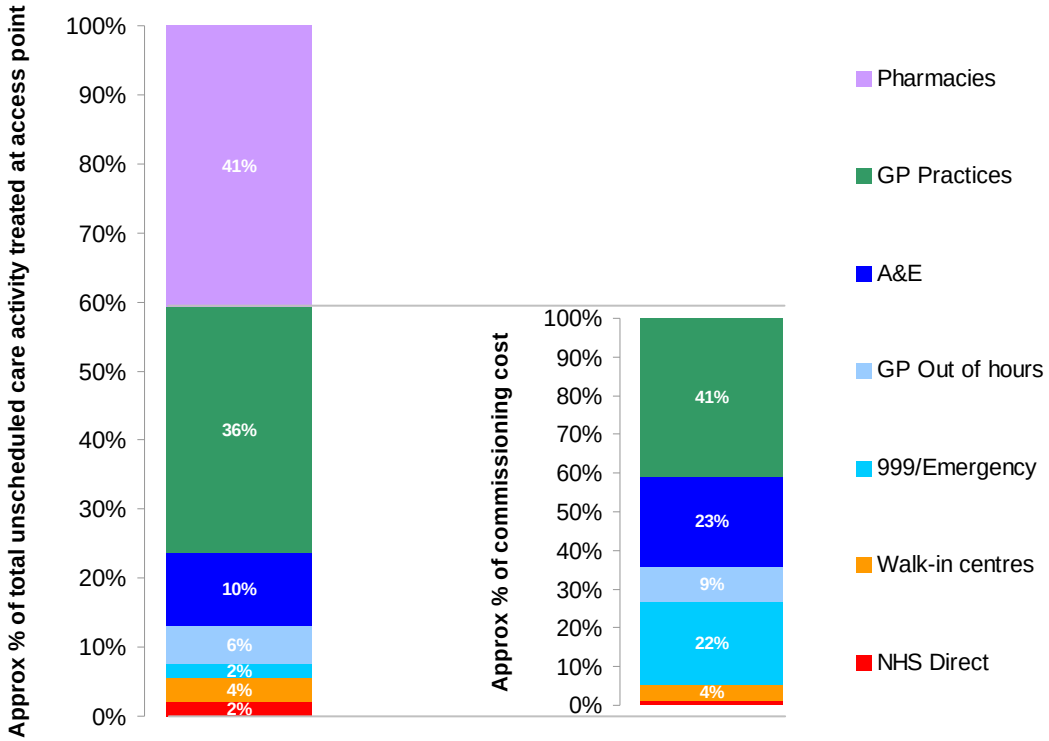
However, differences in the low number of attendances per 1000 population for Camden PCT against other PCTs in the study are unlikely be explained by the characteristics of the local unscheduled care system alone. For instance, Camden PCT does not have WICs or a primary care front end to local A&E departments to divert demand yet attendance figures per head of population are low. Similarly, Kingston is a relatively affluent borough, with, one would expect, higher than average health levels yet, A&E attendances are proportionally the third highest in this study.

A wide range of external factors such as socio-demographic differences in the PCT populations (affluence, age profile, and ethnicity), whether the A&E target is being met and patients' perceived quality of local A&E provision will also impact outcomes. Due to the varied and large range of influences present, it is difficult to say whether a model of care alone explains a particular difference in usage or whether the difference is due to external factors.

4.3 While the majority of unscheduled care occurs in GPs and pharmacies, a large proportion of total commissioning cost is for 999 and A&E services

High level analysis of unscheduled care activity shows that approximately 75% of care needs are met in a GP and pharmacy setting whilst A&E departments appears to cater for only 10%. The chart below on the left shows how total unscheduled care volumes are split across various access points. Given the large volumes of unscheduled care provided by GPs and pharmacists, models of care that encourage even a small proportion of these patients to visit alternative access points can have a significant impact across the system.

Figure 2: indicative profiles of total unscheduled care activity and cost across unscheduled care access points



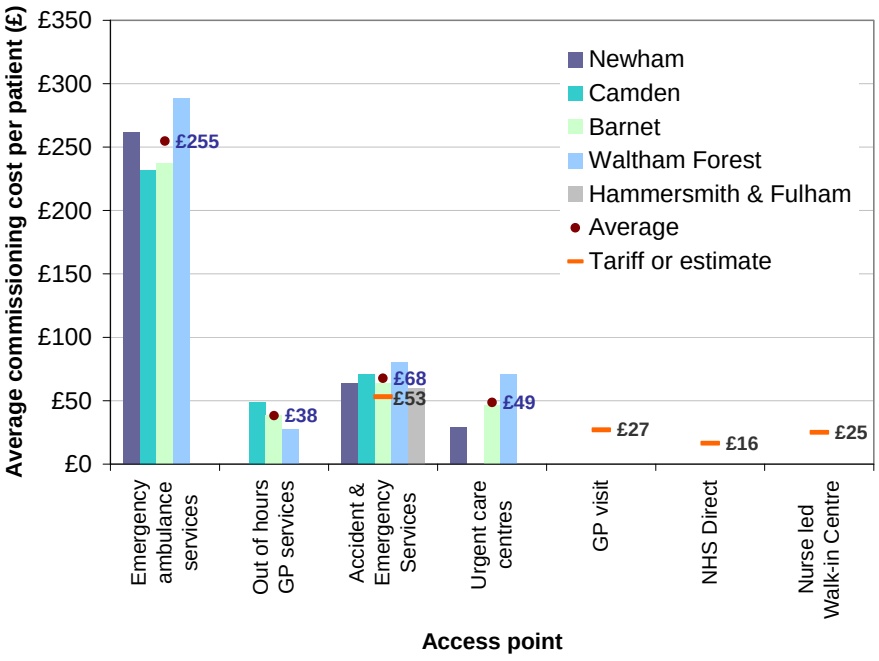
The bar chart on the right shows, for the services PCTs commission, how total unscheduled care commissioning costs are spread across access points. The analysis shows that 999 services provide care to only a small proportion (2%) of patients however it makes up approximately 22% of total unscheduled care commissioning cost. Pharmacies are not included in the right hand bar because, apart from the Minor Aliment Scheme, they are not commissioned services.

Activity figures have been derived using a combination of local data and unscheduled care activity estimates from GP and Pharmacy service surveys. Commissioning cost estimates have been derived using total activity and actual spend information for 2006/2007 (paid for under PCT contract) submitted by PCTs to the Healthcare Commission. For those access points where PCT information submitted to the Healthcare Commission was unavailable, estimates have been calculated using tariff cost (for A&E), national comparators or drawn from local studies.

4.4 There are clear cost advantages in shifting patients from A&E to alternative access points

The average commissioning cost per patient varies significantly across unscheduled care access points with the greatest costs associated with the provision of the most acute care. Figure 3 shows, using the same source data as the analysis in the previous section, average commissioning prices paid by PCTs for each patient treated by each access point.

Figure 3: Average commissioning cost per patient by PCT and across all PCTs



In the above chart, Healthcare Commission data for Kingston was not available so it is not included. It is important to note that these figures represent the price the PCT pays for the service and they do not reflect true cost of operating the service. Costs for A&E, some UCCs and WICs are casemix driven through existing tariff. Ambulance care is the most expensive at an average cost of £255 per patient followed by A&E at an average of £68 per patient. Analysis at a national level suggests that the average cost of seeing a patient in an unscheduled GP appointment is between £15-30. The cost of delivering UCC (this Healthcare Commission category also captures WICs) and to a lesser extent GP OOH services vary markedly across similar access points in different PCTs. This variability will reflect the wide range of services, for example, some have WICs and some do not, and operating models these access points are able to provide.

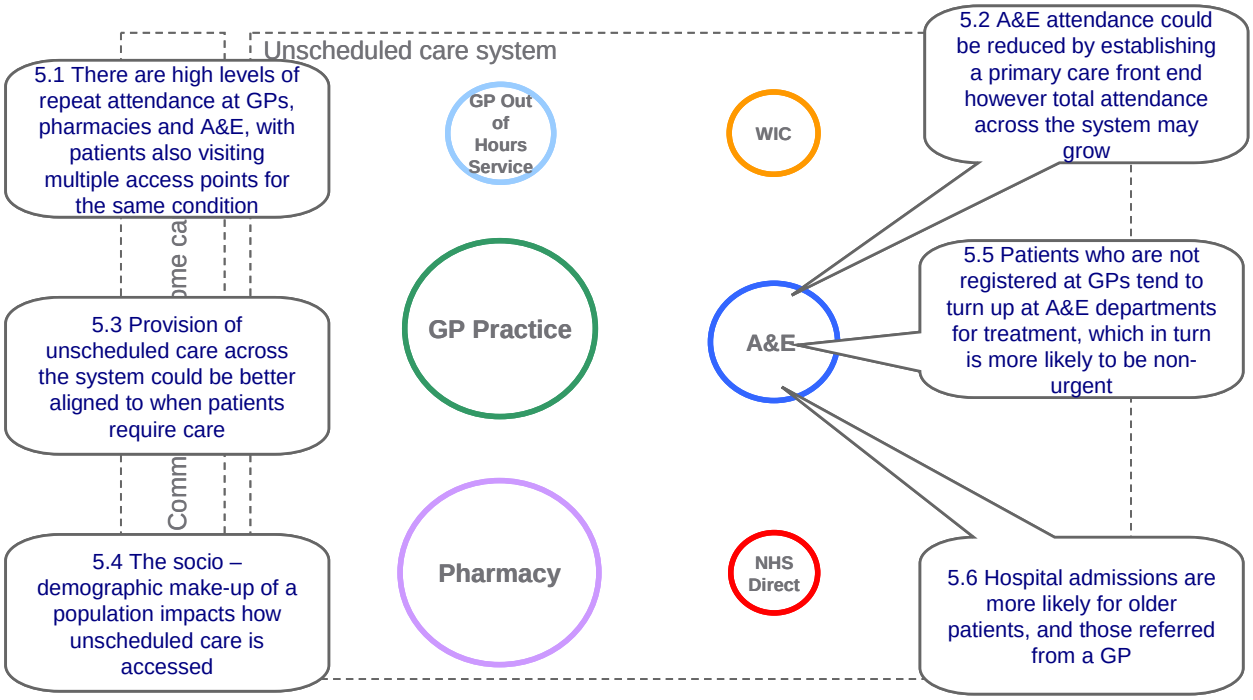
The PCT data submitted to the Healthcare Commission shows the average commissioning cost per patient in Whipps Cross A&E in Waltham Forest PCT (over £75 per patient) to be higher than other A&E departments. It also shows the average cost per patient in Whipps Cross EUCC (over £60 per patient) to be higher than some A&E departments, and all WICs where data is available.

The former is not surprising as the EUCC treats patients with minor injuries and ailments, thus preventing their attendance at A&E. A&E is therefore left with more acute patients, who require more complex and costly care.

At first glance the latter statistic is surprising as the EUCC is said to be working well by the PCT. More recent data obtained as part of this study suggests a significantly lower average treatment cost per patient case (as low as £35 per case). Obtaining more accurate data is currently a concern within the PCT, and the disparity between the different figures prevents a more meaningful commentary.

5 How patients access unscheduled care services

The activity and flow of patients within the unscheduled care system is discussed and the key characteristics of patient demand for care are outlined. An assessment of which patients access the system, when they access it, and initial analysis around why is also made. Commissioners will need to consider factors such as these when they are designing and commissioning services. Further analysis on the unscheduled care activity is contained in the appendix C. A summary of the key messages is shown in the diagram below.



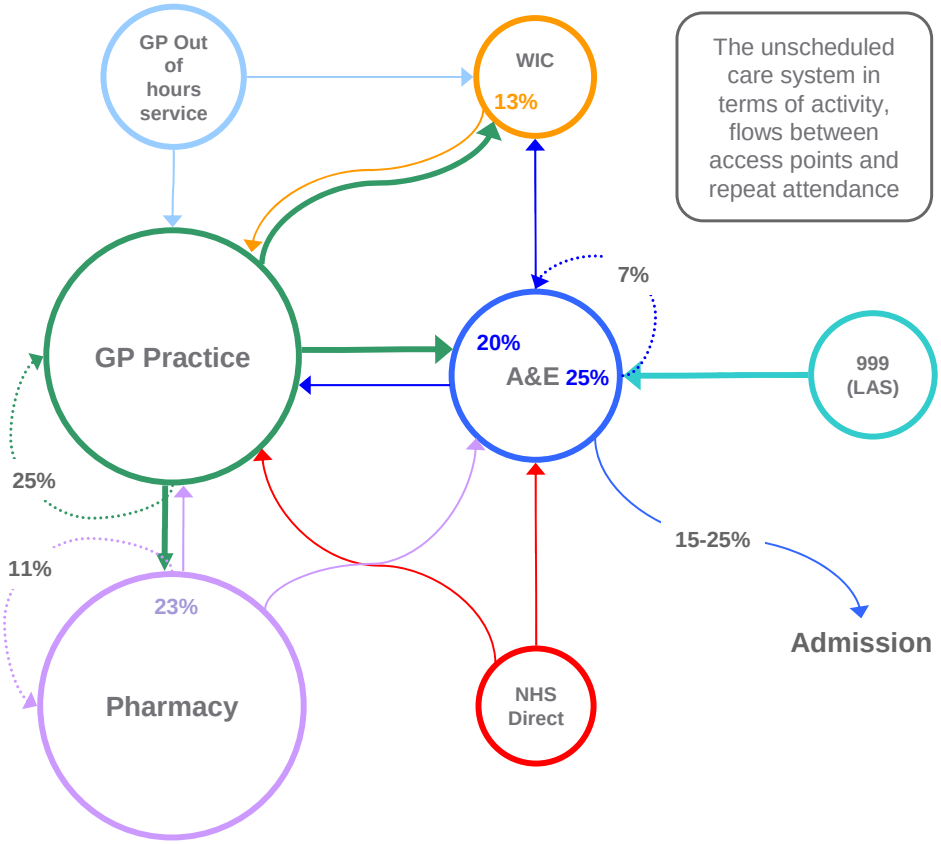
5.1 There are high levels of repeat attendance at GPs, pharmacies and A&E, with patients also visiting multiple access points for the same condition

A summary picture of unscheduled care provision across all PCTs is shown in Figure 4. The diagram shows the key access points and quantifies flows and repeat attendance across these access points for patient seeking treatment for the same condition within the last 3 days. Flows are quantified in terms of the proportion of the destination access point's activity that has come from (not gone to) a different access point. Repeat attendance is shown via dotted arrows and flow between access points is shown by thin arrows is between 1-3% (e.g. 1-3% of A&E attendances have recently called NHS Direct). Access point volumes are also indicatively shown by the size of the circles in the system diagram.

To illustrate how the flow diagram should be interpreted, the 23% figure in the pharmacy bubble shows the percentage of patients in pharmacists for advice or treatment who had previously visited their GP within the last 3 days for the same condition. The figure DOES NOT show the proportion of patients who have seen their GP who then go on to visit a pharmacist. Interpreting the flow diagram correctly is important to ensure the right conclusions are draw, for example anecdotally 10-20% of patients who have called NHS Direct go on to visit an A&E department and this proportion may seem large. However, because A&E volumes are approximately five times greater than NHSD volumes, the diagram shows that as few as 1-3% of patients in A&E departments have come from NHS Direct.

Figures are calculated across all 6 PCTs and have been quantified and verified through live assessment of patients by GPs, patient interviews and surveys with GPs and Pharmacists.

Figure 4: Unscheduled care system - flow diagram



5.1.1 Patient flow: 20% of patients visiting A&E had been to see their GP within the past three days

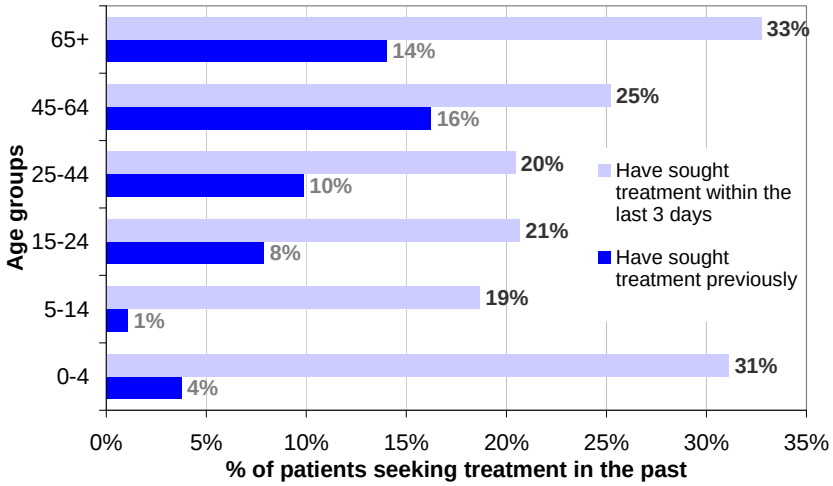
Figure 4 illustrates that large number of patients seeking unscheduled care from more than one access point for the same presenting condition. The major flows are:

- 20% of patients visiting A&E had been to see their GP within the past three days (some of these patients will have been referred)
- 13% of patients visiting WICs had also seen their GPs previously
- 25% of patients in A&E had attended via an ambulance
- 23% of patients seeking pharmacist advice/treatment had previously seen their GP

Further work should aim to understand why these large flows exist, in particular the large number of patients in A&E who had previously been to see their GP, and assess the potential for reducing unnecessary flow through the system.

Patients flow from NHSD to A&E and GP practices and from GP OOH services to GP and WICs. The reason for these flows could be that NHSD are a national/regional service, and do not have a good local knowledge of services such as WICs to refer people on to, whereas GP OOH services are locally run and would have access to this information. The proportions of patients arriving from GP OOH and NHSD at the major access points (GP, WIC, A&E) are relatively low in terms of the total number of patients using these access points (1-3%). This suggests the impact of telephone services, particularly NHSD, in increasing in patient attendance at A&E departments and GP practices is limited.

Figure 5: Proportion of patients attending A&E who had previously sought treatment for their condition elsewhere



Approximately 1 in 4 patients attending A&E had sought treatment for their condition in the last 3 days. Elderly patients and young children are more likely to attend A&E having already been to a previous access point to seek treatment for their condition. This finding could reflect the casemix of conditions the elderly or very young present with e.g. do chronic conditions amongst the elderly result in greater repeat attendance. Equally this may also in part reflect the behaviours of these groups e.g. parents of young children will seek multiple opinions to minimise perceived risk to their child.

5.1.2 Repeat attendance: 7% of patients in A&E have been to an A&E department three days previously

Repeat attendance for the same presenting condition occurred across all major access points. The highest of these was seen at GP surgeries, and is maybe to be expected given the nature of the services a GP provides to patients, it should be borne in mind that this figure includes those people attending GPs as scheduled patients previously, so will include patients whose conditions had worsened after an initial visit to a GP.

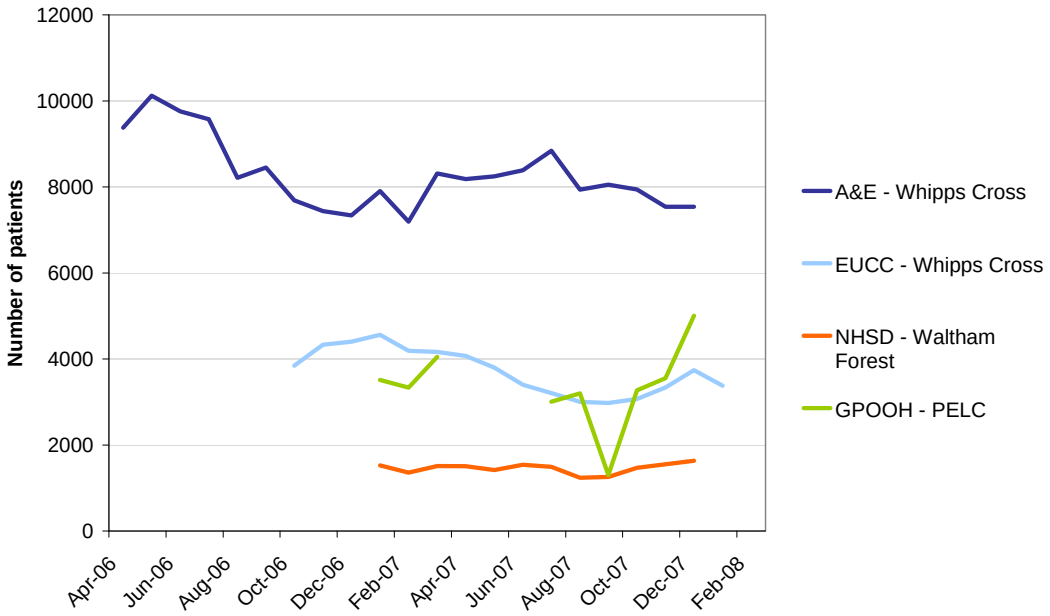
Although A&E showed the lowest repeat attendance figures across the 3 access points, the 7% repeat attendance is significant in activity and cost terms. Whereas GPs would ask patients to return if their conditions worsened, at A&E people would tend to be kept in for observation.

It is interesting to note the repeat attendances to pharmacists, since people who got an initial treatment from a pharmacist would maybe be expected to attend a different access point if their condition did not improve.

5.2 There is evidence to suggest that attendance at A&E could be reduced by establishing a primary care front end, however this also suggests that total attendance across the system may grow

Analysing changes in a model of care over time can help to isolate and evaluate the impact of the care model. Whipps Cross A&E volumes have fallen by 20% or approximately 2000 patients per month since the introduction of the EUCC in November 2006 which is located at the front end of the A&E department. However the EUCC is seeing about 4000 patients per month so total patient demand across these two access points has grown by approximately 2000 patients per month

Figure 6: Whipps Cross monthly unscheduled care attendance



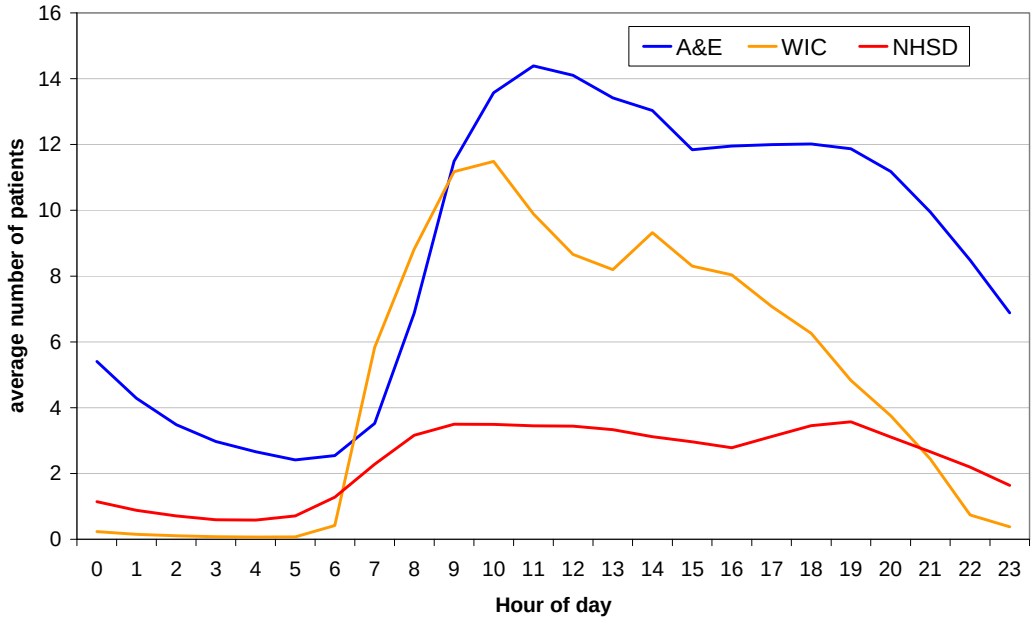
The increase in total A&E and EUCC activity could be due to the diversion of demand from other access points within the unscheduled care system or it could be due to increased demand from patients who would have self treated or accessed scheduled care. The EUCC provides a range of specialised services not provided in most WICs and this may partly explain the increase in activity.

5.3 Provision of unscheduled care across the system could be better aligned to when patients require care

5.3.1 There are peaks in demand for unscheduled care in the mornings and in the evenings

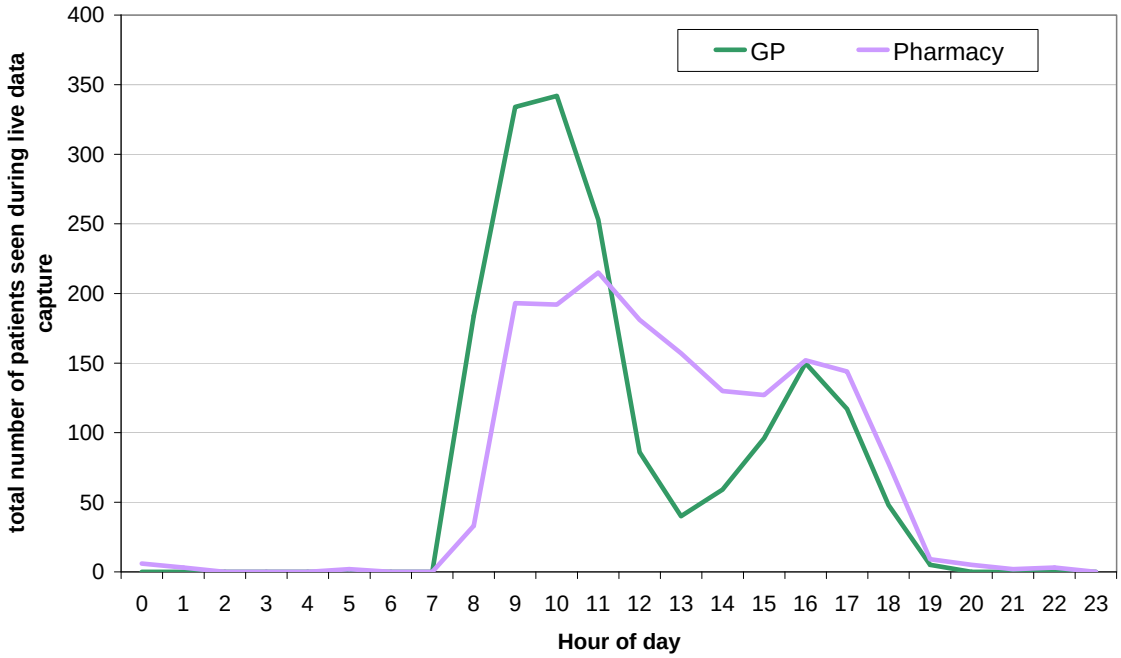
An analysis of unscheduled care system capacity and patient demand over time provides commissioners with useful insight to help them deliver more effective and appropriate unscheduled care provision. Figure 7 and 8 show there are morning peaks in activity for most access points A&E, WIC, as well as GPs and Pharmacies.

Figure 7: Peaks in demand for unscheduled care across A&E, WIC and NHSD



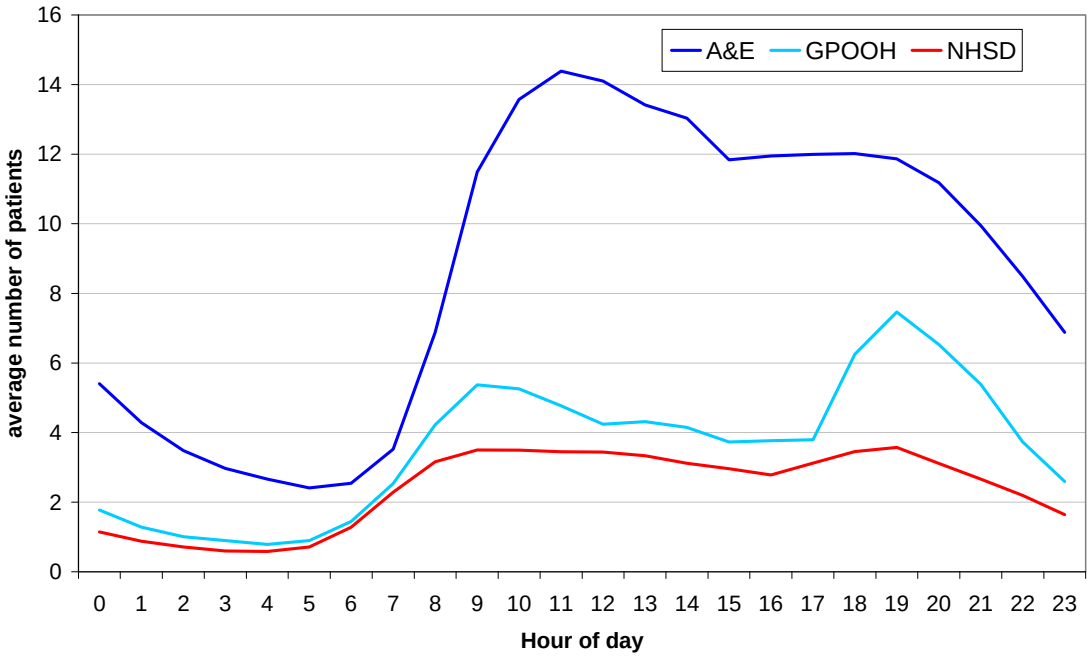
Services which are available for 24 hours (A&E, NHSD) see a second peak in the evening (7pm), between 5pm and 9pm, potentially occurring when people return from school or work. However this peak is not fully covered by the opening hours of two of the major unscheduled care access points (GPs and Pharmacies).

Figure 8: Peaks in demand for unscheduled care across GP and Pharmacy



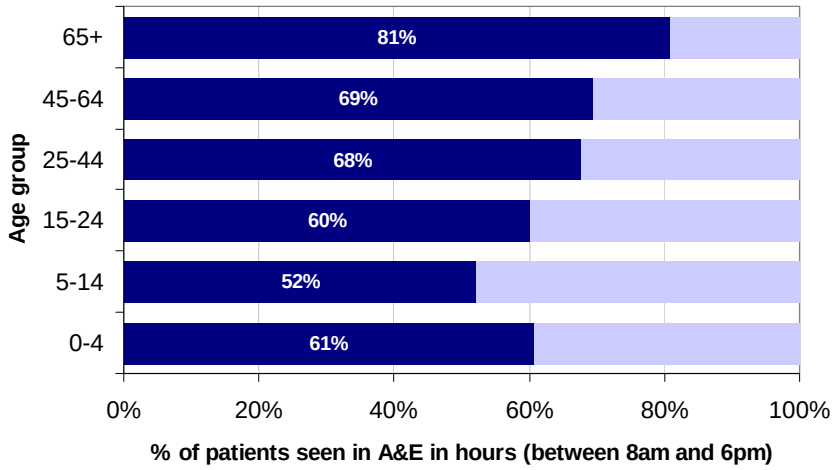
The live data capture exercise shows the second peak (at 4pm) in unscheduled care activities for GPs and Pharmacies (see Figure 8) running up to their closing times (6-7pm). Figure 9 suggests that when GPs and Pharmacies close, patients may then shift to using GP OOH and A&E services.

Figure 9: Peaks in demand for GP OOH services



Further analysis of who is accessing care during the course of a typical day shows that users of A&E out of hours tended to be children and young adults (see Figure 10). This may be due to both an inability to access in hours care during the work and school day. There are multiple barriers for the 5-14 year old age group in particular to access in hours care. 5-14 year olds will need time off school and their parents are likely to need time of work and as many as 38% of patients in this group access out of hours unscheduled care. A better knowledge or greater propensity to use out of hours services amongst the young may also explain these findings. Further analyses also shows the most common conditions presented at A&E out of hours were respiratory conditions (see appendix F).

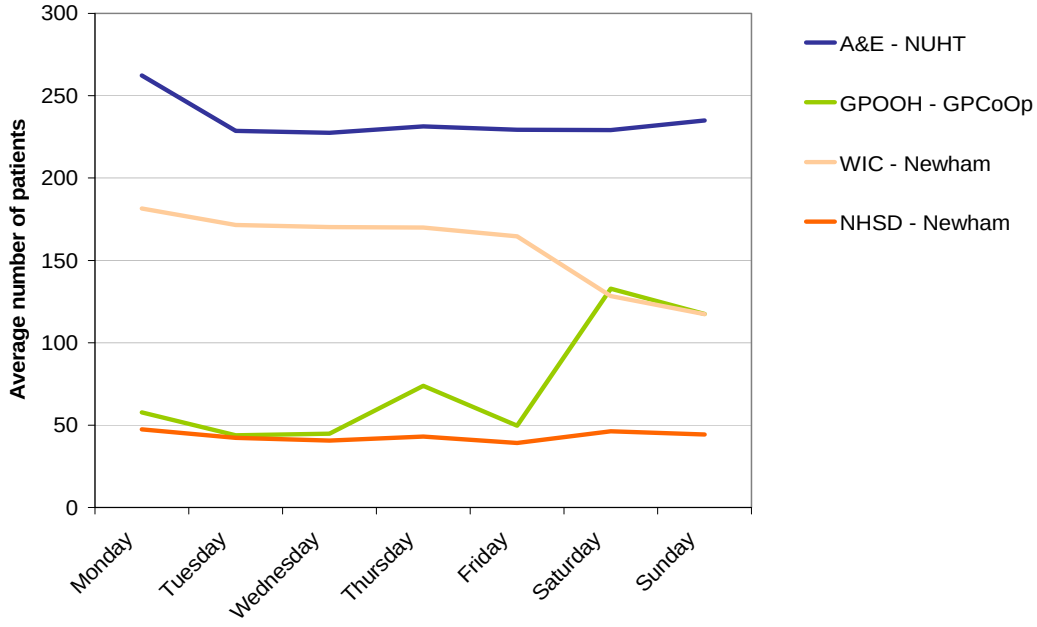
Figure 10: Chart showing the proportion of patients seen in A&E hours broken down by age group



5.3.2 Unscheduled care services are available at different times of the week, and over weekends

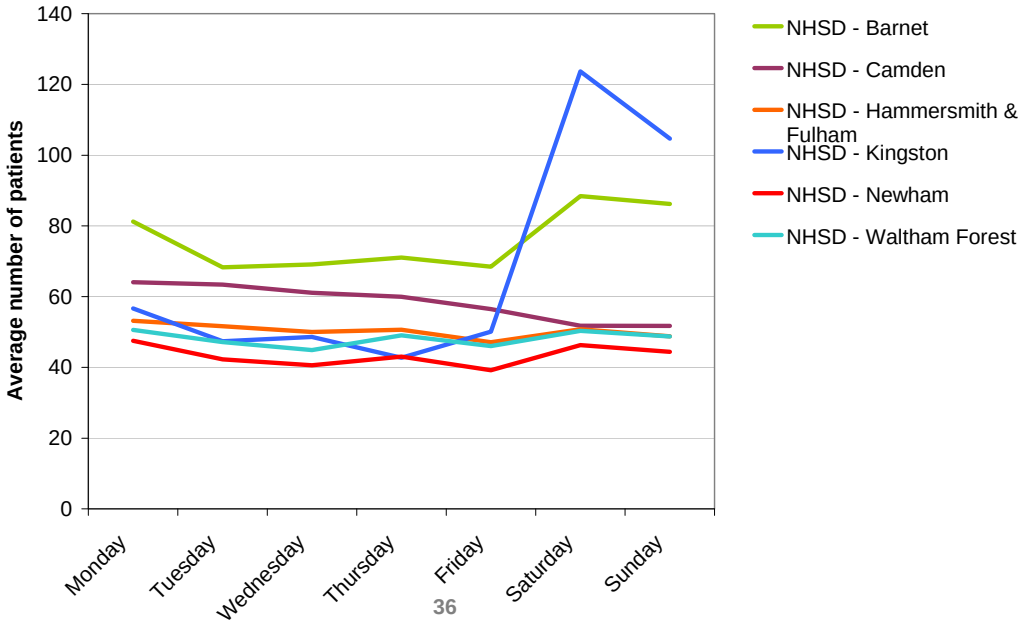
Where GPs are closed for certain periods of the week, for example Thursday afternoons and weekends in Newham, the demand for unscheduled care still exists. This is shown by the increase in calls to GP OOH services.

Figure 11: Peaks in demand for unscheduled care across A&E, GP OOH, WIC and NHSD during an average week



A&E departments see higher activity on a Monday potentially perhaps due to unscheduled care needs "building up" over a weekend and this calls into question whether these patients genuinely require same day care. NHSD calls tend to increase at weekends, and this effect is particularly marked in PCTs where there are limited providers (for example, in Kingston there is no WIC) of unscheduled care at the weekend.

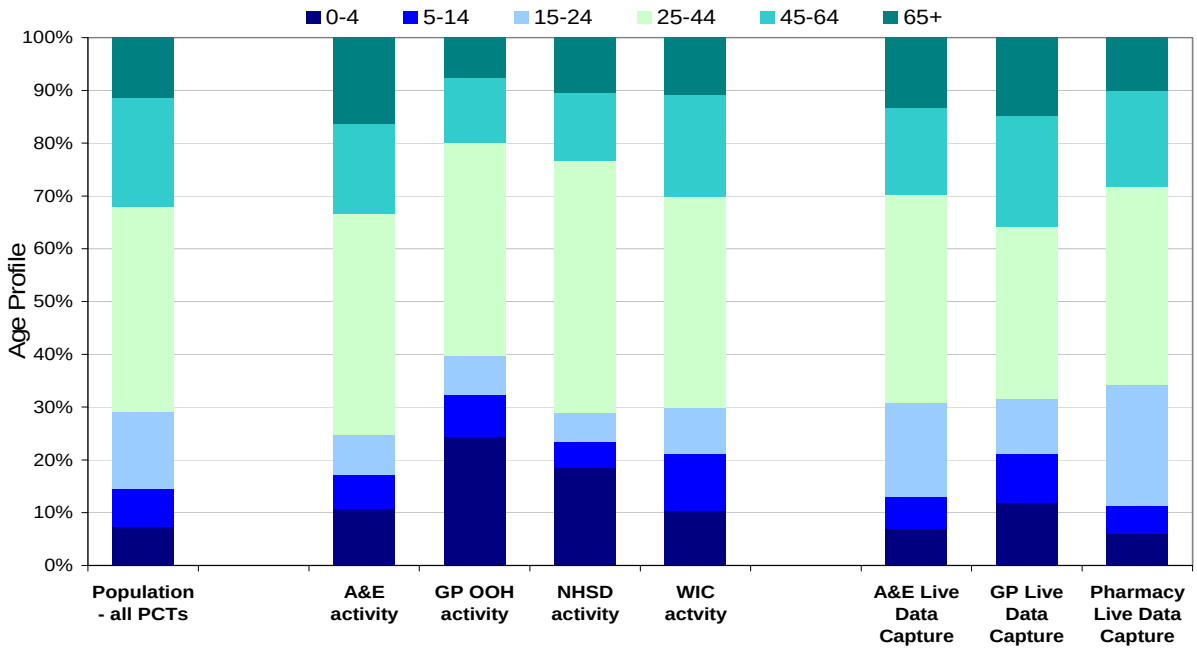
Figure 12: Peaks in NHS Direct demand over an average week by PCT



5.4 The socio-demographic make-up of a population will impact how unscheduled care is accessed

5.4.1 There appears to be a propensity for older people to use A&E and parents of the very young to use both A&E and telephone access points

Figure 13: The age breakdown across access points for all PCTs involved in the study

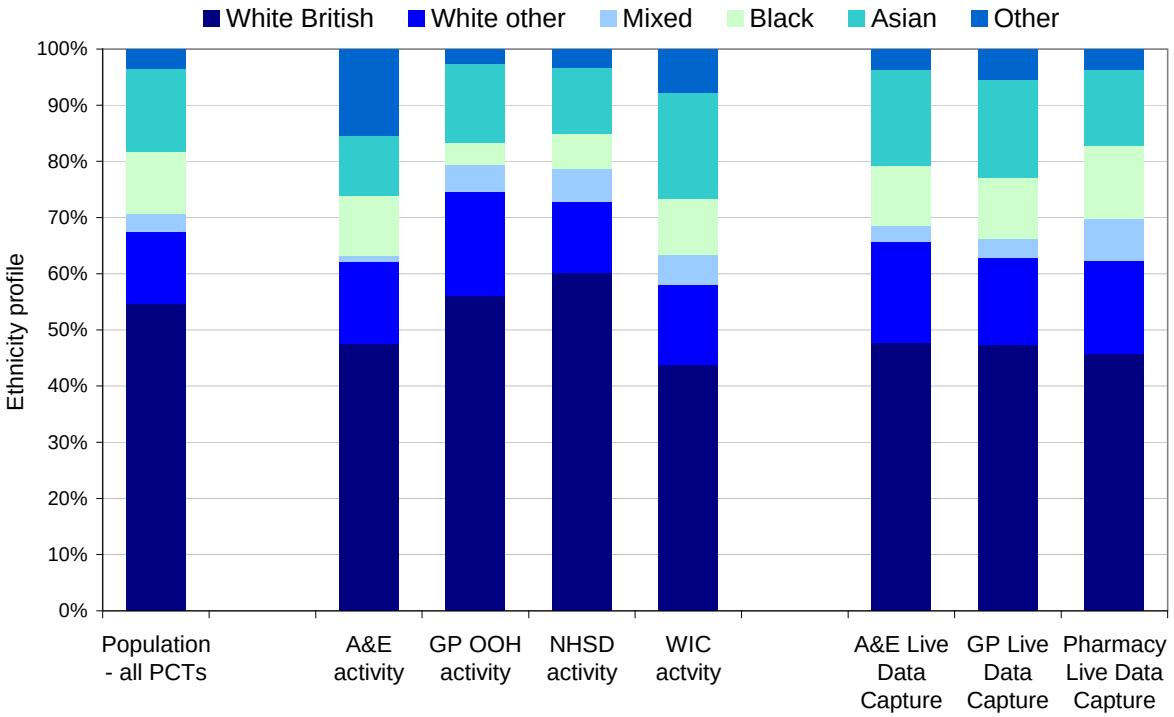


The age profile of patients accessing unscheduled care shows some variation across access points:

- Parents of young children appear more likely to use telephone access (GP out of hours and NHS Direct) possibly as a first point of contact before accessing other services like A&E. Telephone services may also provide immediate 'reassurance' for worried parents
- Older people appear to access A&E and GP services for their unscheduled care needs, with a lower propensity to use telephone access. This may be due to lack of knowledge of these services or relationship with these access points
- NHSD seems to be a more popular access point for those of a working age (25-44) and this may reflect convenience of access
- Pharmacies are less popular for those with children or babies and analysis show that these patients are risk-averse and will to seek treatment from the most experienced professional.

5.4.2 There is an indication that BME groups have greater propensity to access unscheduled care at their GP or A&E compared to White British patients

Figure 14: The age breakdown across access points for all PCTs involved in the study



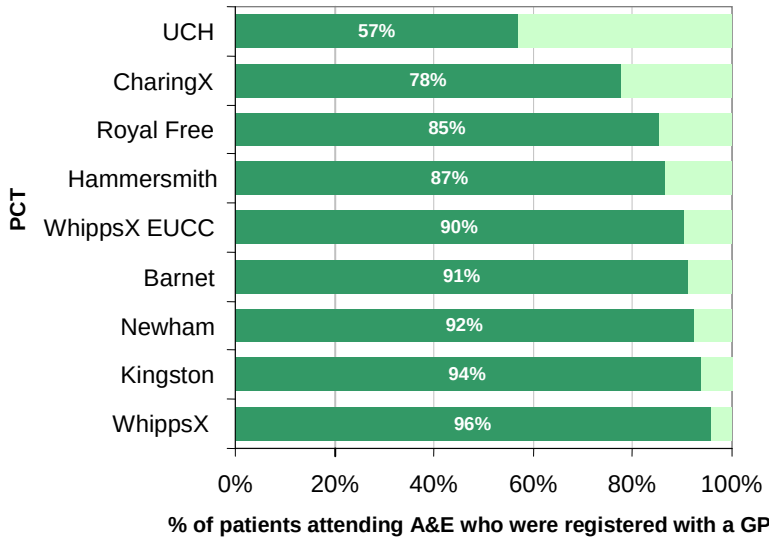
Overall there appears to be a greater tendency for BME patients to access unscheduled care as opposed to white British patients. Further analysis indicates that some ethnic groups are more likely to access unscheduled care through specific access points:

- In particular white non-British and Asian communities are more likely to access GP and GP OOH services.
- BME and White other patients are also more likely to access unscheduled care at A&E departments.
- White British patients are more likely to use telephone services to access unscheduled care, with Black and Asian patients being much less likely to use these services.

5.5 Patients who are registered at GPs tend to present at A&E departments less frequently and with more urgent needs

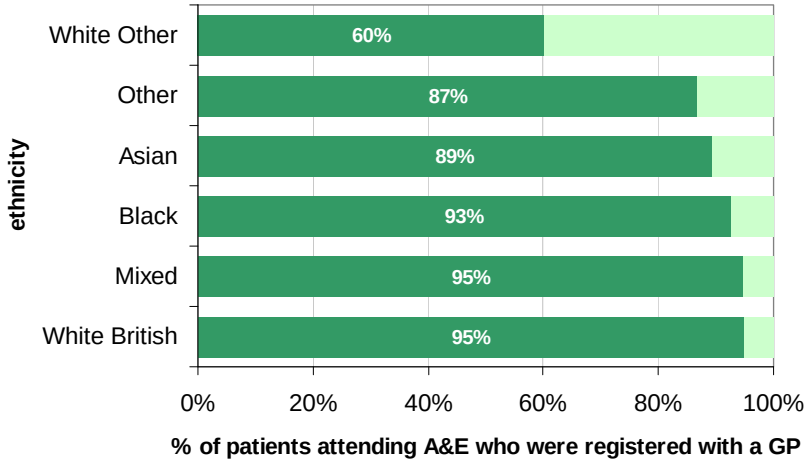
Approximately 13% of patients assessed at A&E were unregistered with a GP. Analysis shows that A&E departments in central London locations with large local BME communities record greater numbers of patients attending A&E who are not registered with a GP.

Figure 15: The proportion of GP-registered patients attending A&E broken down by A&E department



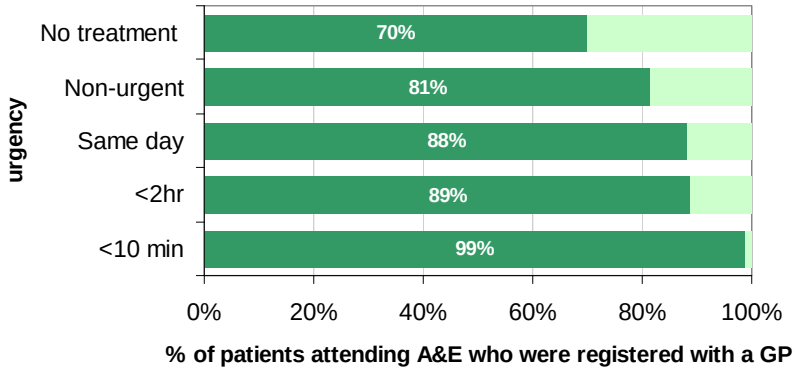
White other patients are much more likely to attend A&E without being registered with a GP compared to all other ethnic groups. 40% of White other patients attend A&E and are not registered with a GP and this may represent new immigrant populations many of whom are yet to or are unable to register with a GP. Asian and Black patients are slightly less likely than White British patients to attend A&E and not be registered with a GP.

Figure 16: The proportion of GP-registered patients attending A&E broken down by ethnicity



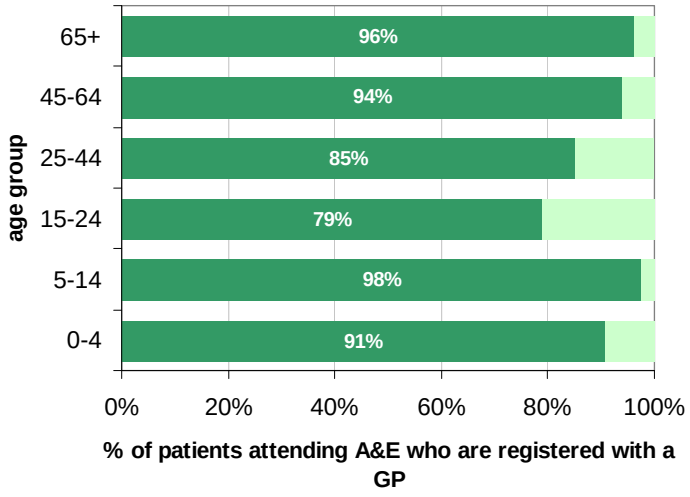
Walk-in patients requiring urgent attention at A&E were very likely to be registered with a GP. Patient presenting with non-urgent conditions and patients who do not require treatment are more likely to not be registered with a GP compared to urgent patients. This suggests that if patient registration can be increased a reduction in the number of patients attending A&E who do not require same day treatment could be achieved.

Figure 17: The proportion of GP-registered patients attending A&E broken down by urgency



Young adults and middle aged people presenting at A&E were less likely to be registered with GPs.

Figure 18: The proportion of GP-registered patients attending A&E broken down by age



This finding combined with the ethnicity breakdown suggest that transient working populations could be a major patient group who access A&E, as opposed to more appropriate access points, for their unscheduled care needs.

5.6 Hospital admissions are more likely for older patients, and those referred from a GP.

19% of A&E attendances result in the patient being admitted to a hospital bed. The level of admissions per attendance varies significantly between the resident populations in each PCT with Waltham Forest residents having the highest level of admissions per attendance at 22%. For Newham residents in contrast, only 13% admissions per attendance.

The chart shows, by PCT of residence, the percentage of attendances leading to admission to a hospital bed. Over all in the study, 19% of attendances lead to admissions.

Local data from the A&E departments show that the rate of admissions per A&E attendance is the highest for Barnet Hospital with 33% admissions. This is around 10% more than the average level of admissions for residents across the 6 PCTs.

Figure 19: Proportion of A&E attendances leading to admission by PCT

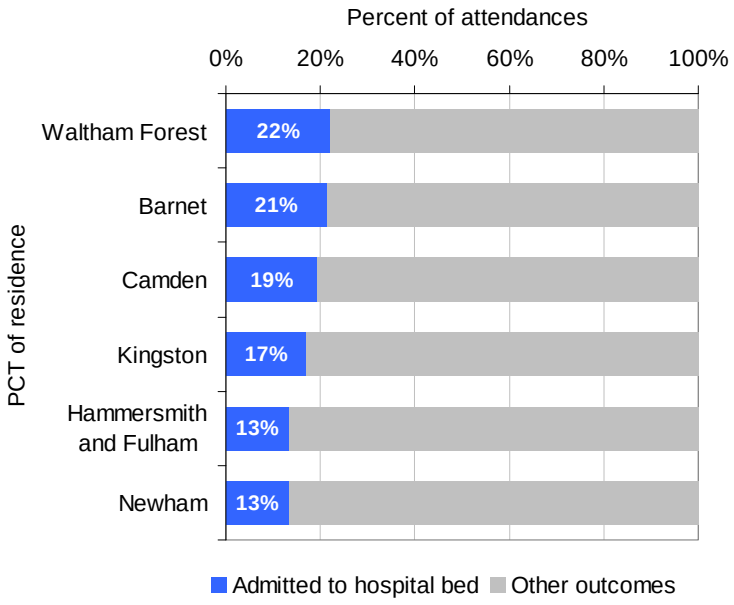
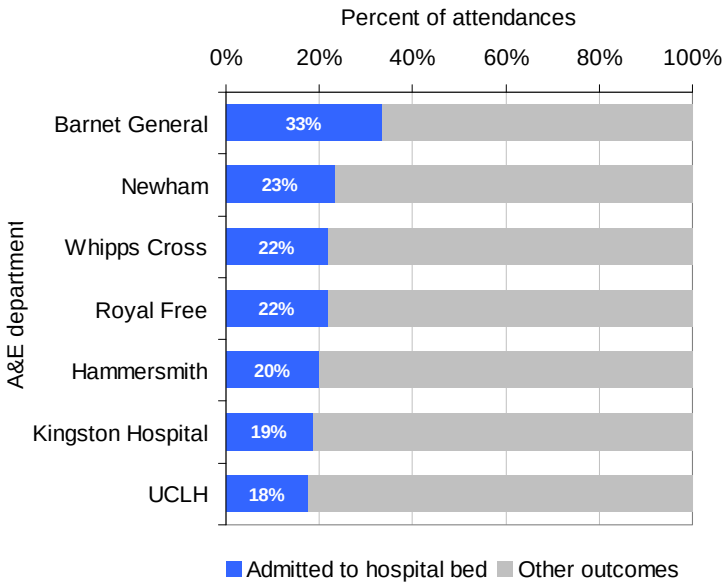


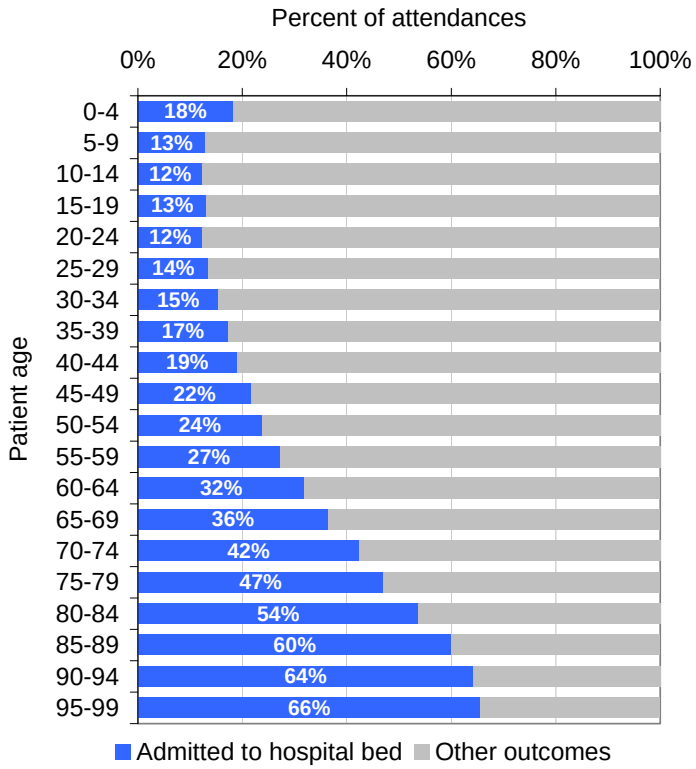
Figure 20: Proportion of A&E attendances leading to admission by A&E department



Elderly patients are, on average, much more likely to become admitted following an A&E attendance than patients in other age groups. This would explain the high levels of admissions in Barnet General, since Barnet PCT has an older population than the other six PCTs.

Patients over 75 years old are admitted in more than 47% of the cases. In comparison, admission rates for patients between 5 and 35 are between 12 to 17%.

Figure 21: Proportion of A&E attendances leading to admission across age bands

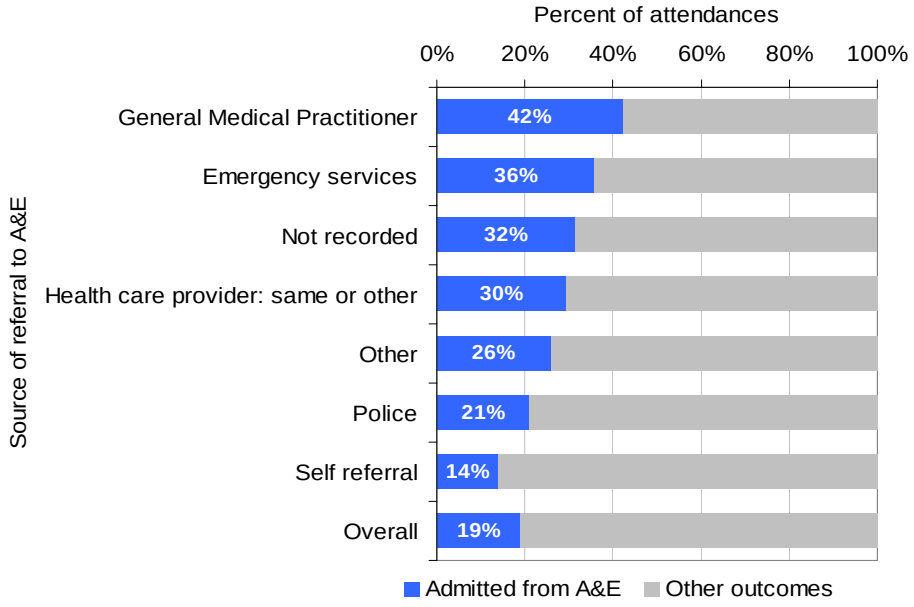


This signifies that younger age groups are more likely to use A&E services for relatively less serious conditions, whereas elderly patients present with conditions which are more likely to need further care. Elderly patients may also be admitted if they have nobody to care for them when they return home, these types of admissions would be less for younger age groups who are possibly more likely to have parents or family to care for them at home.

This implies that when considering alternative options for providing unscheduled care, a larger proportion of those in the younger age groups could potentially be seen in non-hospital or care centre settings, than for more elderly. Also, when considering what alternatives could provide care for elderly patients who attend A&E, the alternatives are more likely to involve other care institutions and nursing services offered as part of a long term care plan.

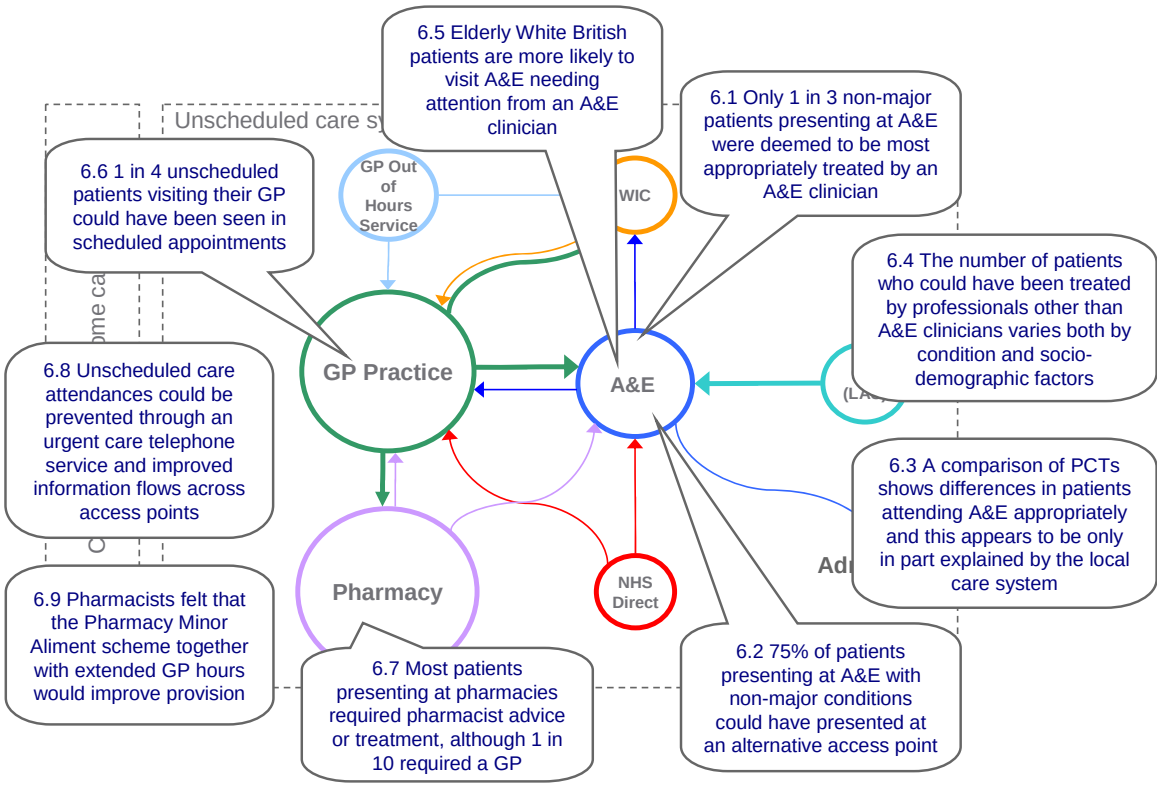
Patients who are referred to A&E departments from GPs are most likely to go on to be admitted -even more so than patients brought to A&E by emergency services. Interestingly those referred from other healthcare providers are relatively less likely to be admitted than those referred from GPs. Patients who self refer to A&E are least likely to be admitted.

Figure 22: Proportion of A&E attendances leading to admission broken down by referral source



6 Clinicians assessment of the unscheduled care system

This section reviews the information gathered during the live data capture exercise which assessed whether patients accessing unscheduled care could have accessed it in alternative settings. The live data capture exercise gathered a primary care view of over 5,000 individual patients across all three major access points. The diagram below summarises some of the key messages. In this section the terms 'appropriate' or 'more appropriately' are used frequently in describing whether patients could have been seen and treated in alternative settings - this does not mean that where they had actually presented was inappropriate or that they were treated inappropriately.

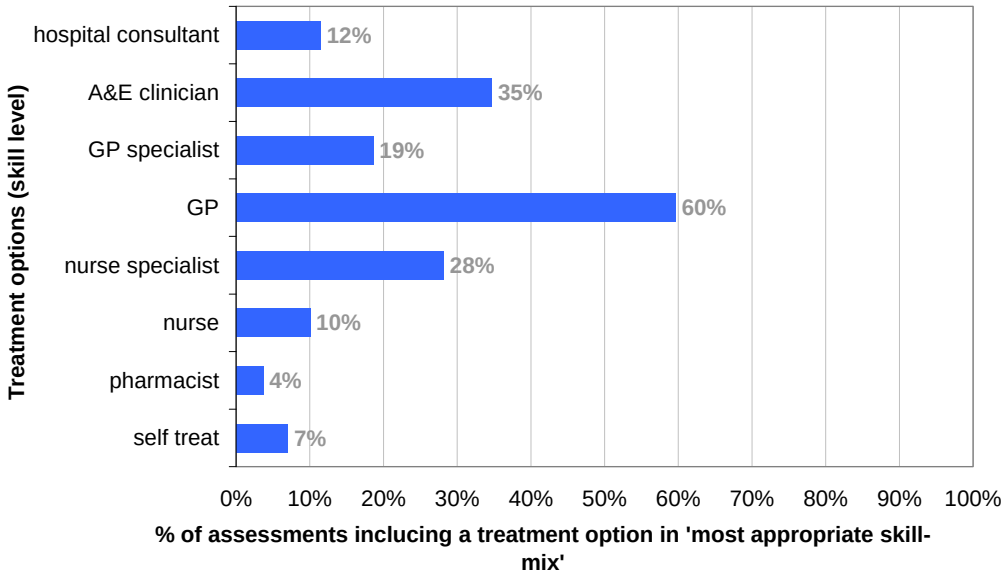


6.1 Only 1 in 3 non-major patients presenting at A&E were deemed to be most appropriately treated by an A&E clinician

GPs' assessment of patients at A&E suggests there may be considerable potential for treatment by other professionals. Of minor patients attending A&E departments for treatment, only 1 in 3 patients were assessed to require an A&E clinician in the appropriate skill mix to treat them. Although this study must acknowledge the primary care subjectivity, the data strongly indicates that other skill mixes are considered more appropriate than A&E clinicians for a substantial proportion of patients presenting at A&E. GPs and Nurse Specialists are frequently suggested as alternatives

It is important to note that approximately 50% of patients attending the A&E departments in the study were non-major. Detailed analysis of minors versus majors is show in appendix F1. Whist live assessment of some major patients was carried out, minors account for roughly half of all A&E activity and the study assessed sufficient numbers of minor patients to ensure the results are statistically valid. For many of the charts in this chapter, GP assessors were permitted to select more than one option and as such some percentages will, by design, not add up to 100%

Figure 23: Percentage of minor patients attending A&E broken down by the appropriate skill mix to treat them (multiple selections)

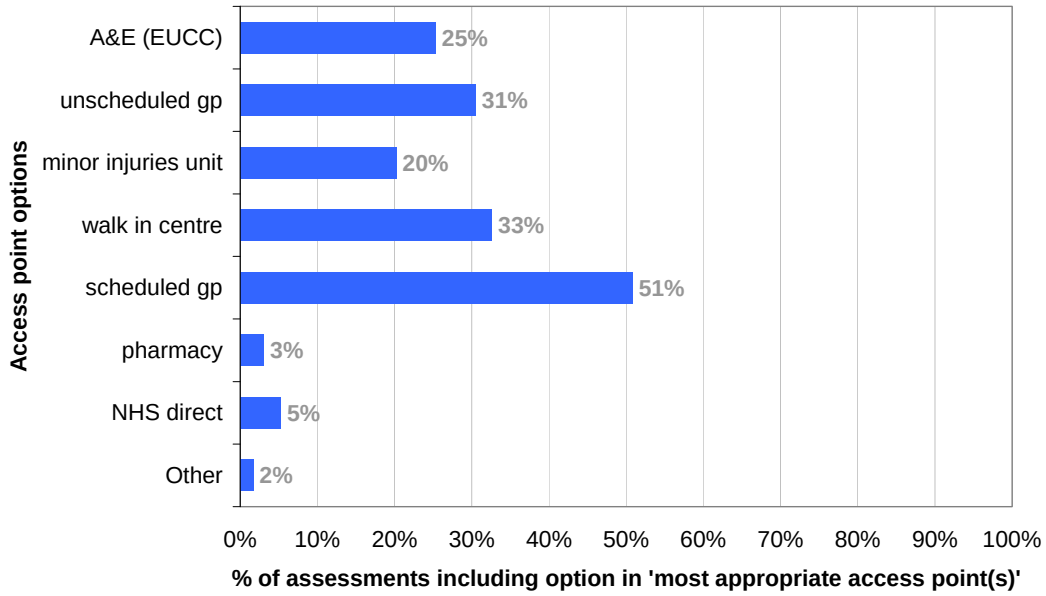


6.2 75% of patients presenting at A&E with non-major conditions could have presented at an alternative access point

GPs' assessment of patients at A&E also found that many could have been treated at other appropriate access points. It was assessed that around 75% of patients presenting at A&E departments could have presented at an alternative access point. This aligns with the assessment of appropriate skill-mix assessment in the previous section.

The assessment found that just over half of minor A&E attendances could potentially have been treated outside the unscheduled care system in scheduled GP appointments. The other potential options which patients could present to were WICs, minor injuries units, and unscheduled GP appointments (some of these options were felt equally appropriate and therefore selected as multiple options).

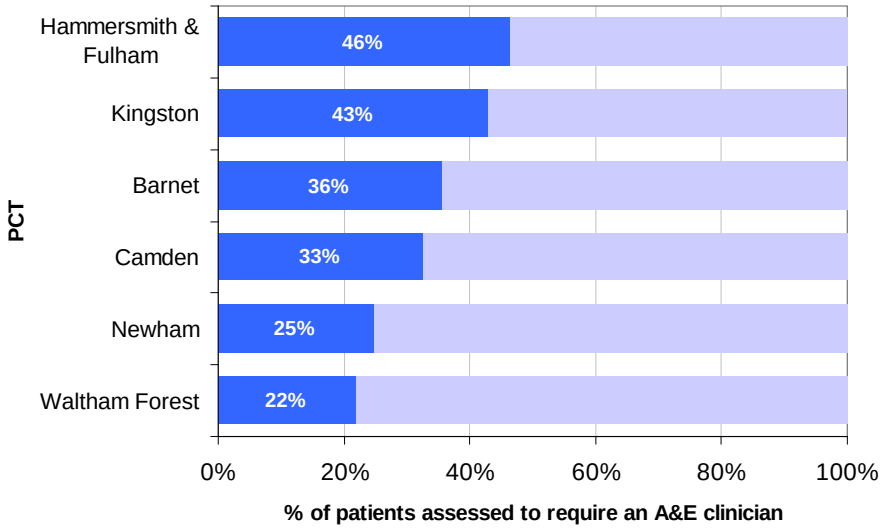
Figure 24: Alternative access points it was felt that patients attending A&E could have presented to (multiple selections)



6.3 A comparison of PCTs shows differences in patients attending A&E appropriately and this appears to be explained, only in part, by the local care system

The proportion of patients assessed as requiring attention from an A&E clinician varies across A&E departments from a high of 48% at Hammersmith & Fulham PCT to a low of just over 20% at Waltham Forest PCT. Hammersmith & Fulham has good WIC provision and this may explain the high proportion of patients assessed that attend A&E appropriately. However Kingston has no WIC or UCC provision yet still see a high proportion of appropriate attendees to A&E. The low figure for Waltham Forest may reflect the case mix of minor treatments provided at Whipps Cross EUCC and triage of urgent patients into Whipps Cross A&E department.

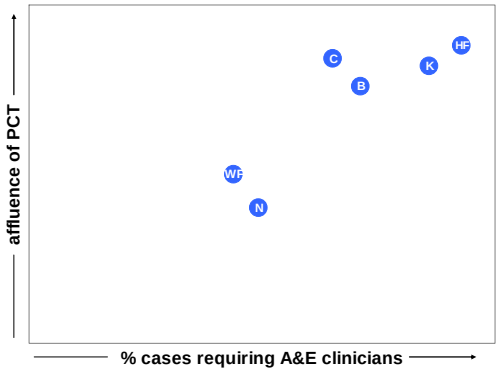
Figure 25: Proportion of patients attending A&E departments by PCT that were most appropriately seen by an A&E clinician against those patients that could have been treated by other professionals.



Where variation is not fully explained by the model of local provision it may be influenced by other factors, for instance, the distinctive socio-demographic characteristics across PCTs. Using the percentage of the workforce employed in managerial or professional occupations as a proxy for affluence we can compare the appropriateness of attendances at A&E departments compared to the affluence of the PCT. The scatter plot (Figure 26) may provide some evidence that the more affluent the PCT population the more likely local patients attending A&E will present with conditions that should be treated by an A&E clinician.

Figure 26: PCT Affluence vs. A&E appropriateness

PCT	A&E req.	Affluence
Barnet	36%	38%
Camden	33%	42%
Hammersmith & Fulham	46%	44%
Kingston	43%	41%
Newham	25%	20%
Waltham Forest	22%	25%



6.4 The number of patients who could have been treated by professionals other than A&E clinicians varies both by condition and socio-demographic factors

Patients presenting with closed fractures, cardiac conditions, joint injuries, lacerations and other head injuries were the most likely to require an A&E clinician to treat their condition. Live assessment of patients found that A&E clinicians were one of the most appropriate skill groups to treat over 50% of patients with these conditions.

Conversely, patients presenting with upper respiratory tract infections, dermatological conditions, ENT conditions, gastrointestinal conditions (including diarrhoea and vomiting) and soft tissue inflammation were assessed the least likely to require an A&E clinician to treat their condition. A&E clinicians were considered appropriate to treat only 25% or fewer patients with these conditions. Whilst these condition categories are relatively broad they provide an initial indication of the kinds of conditions that could be treated by alternative skill groups.

Presenting conditions at A&E broken down by age, ethnicity and urgency

The charts below show the top presenting conditions at A&E departments broken down by age, ethnicity and urgency. The analysis uses data collected during live assessment of patients at each A&E department. An analysis of condition from local data sources was carried out (this information is contained in PCT reports) and checked against live assessment data to ensure the analysis was representative. The most common conditions identified during live assessment are similar to the common conditions recorded in A&E databases. However, it is difficult to draw a direct comparison as local condition data is not always captured consistently or accurately and in some cases it is not recorded.

Figure 27: Top 10 conditions presenting at A&E broken down by age group

It is worth noting that for figures 27, 28 and 29 the top 10 conditions covered 44% of all minor conditions presenting at A&E.

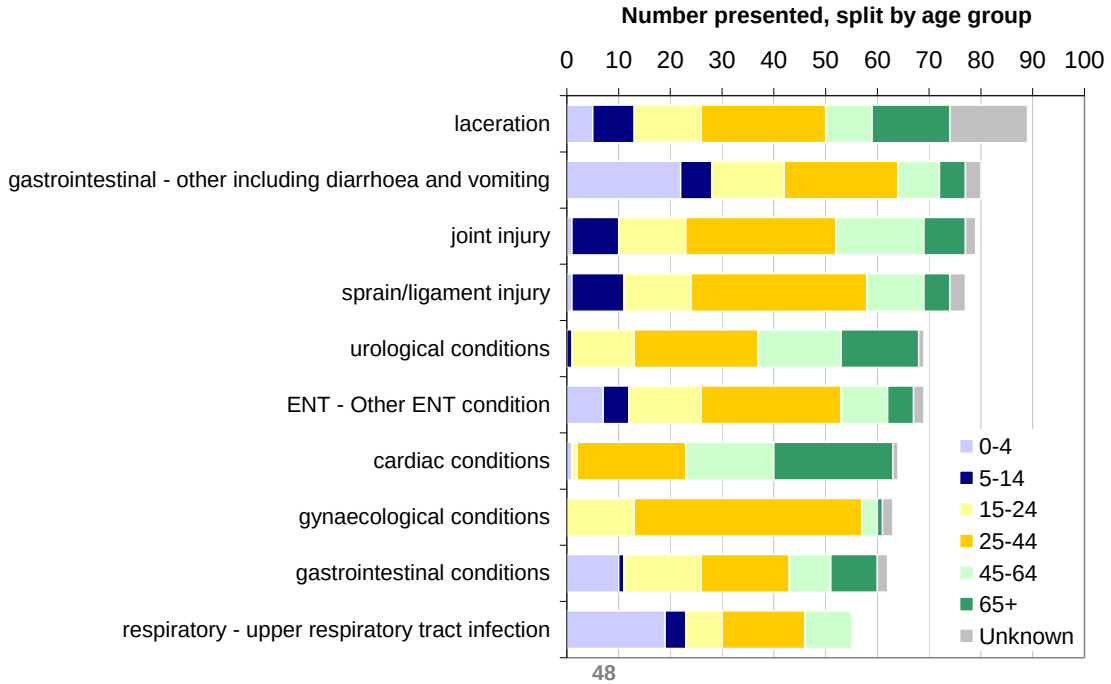
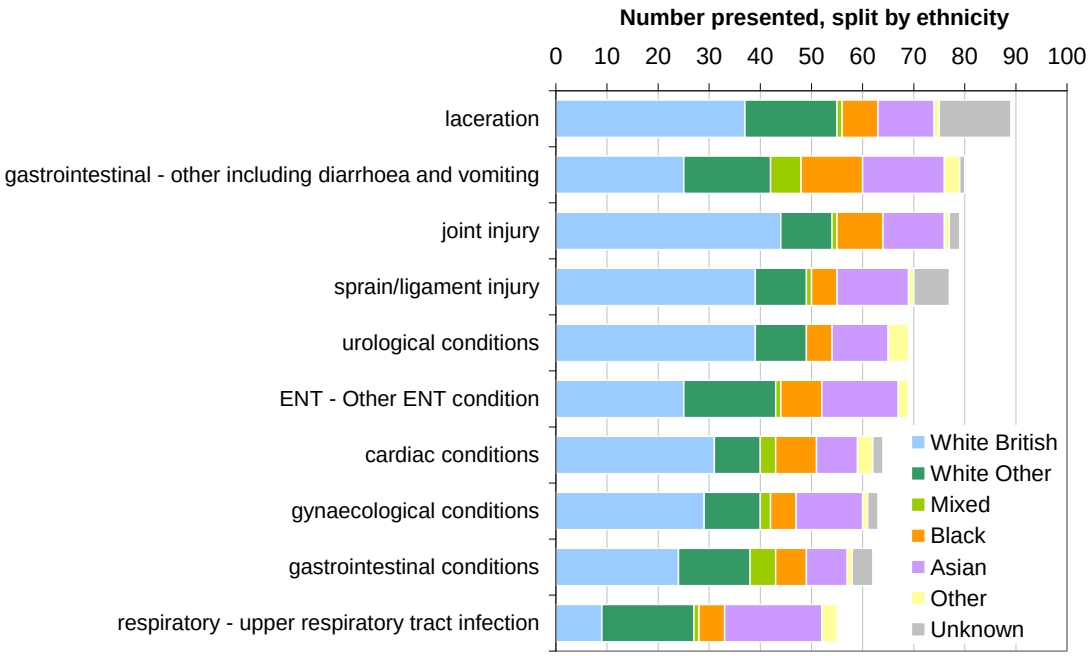


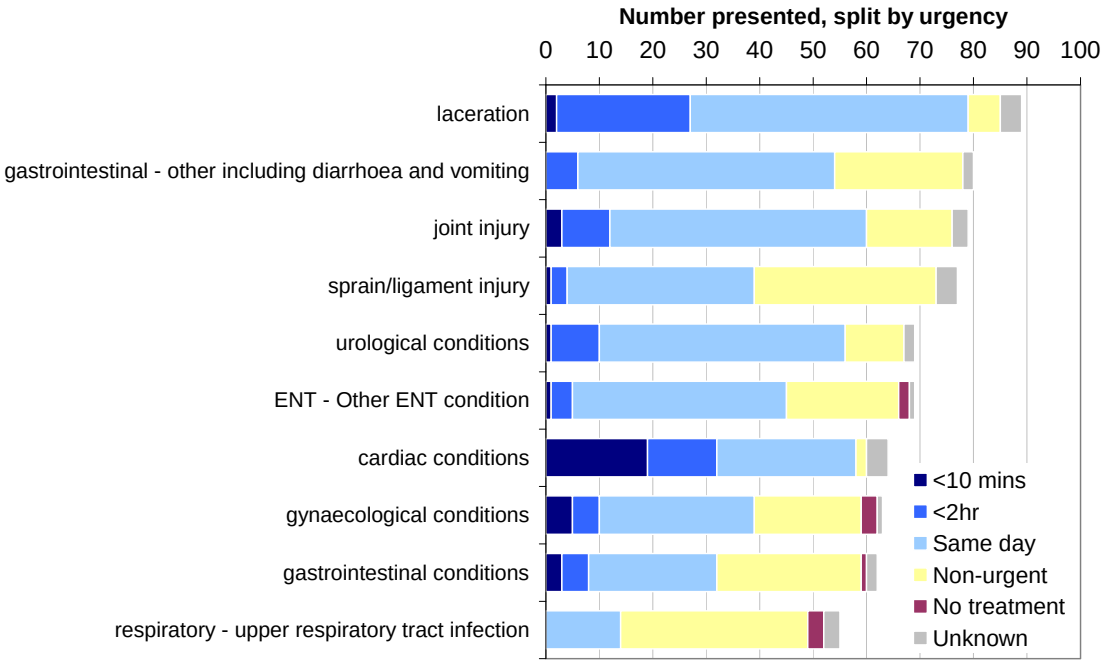
Figure 27 shows large proportions of 0-4 year olds presenting with gastrointestinal and respiratory conditions, while large proportions of elderly patients present with lacerations, urological and cardiac conditions. Further work should investigate the extent to which these presentations could have been prevented by, for example, improved elderly community care provision.

Figure 28: Top 10 conditions presenting at A&E broken down by ethnicity



The profile of ethnicity is relatively consistent across the top condition types, although the data indicates that patients presenting with gastrointestinal and ENT conditions are more likely to be from a BME community compared to patients with other condition types.

Figure 29: Top 10 conditions presenting at A&E broken down by urgency



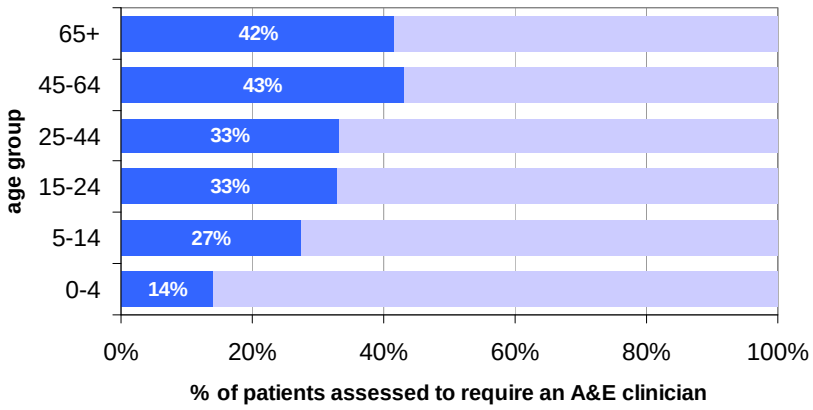
GP assessment in A&E found that the majority of the patients required same day attention (55%) and approximately 30% of patients were assessed to be non-urgent. Gastrointestinal conditions and sprain/ligament injuries have high proportions of patients requiring non-urgent treatment. Patients presenting with cardiac conditions and lacerations are more likely to require treatment in less than 2 hours compared to patients presenting with other condition types.

6.5 Elderly white British patients are more likely to visit A&E and require attention from an A&E clinician

Age of patients

Older patients attending A&E are more likely to require an A&E clinician to treat their condition. More than 40% of patients over 45 were assessed to need an A&E clinician as one of the most appropriate skill groups to provide treatments while only 15% of the 0-4 age group required an A&E clinician.

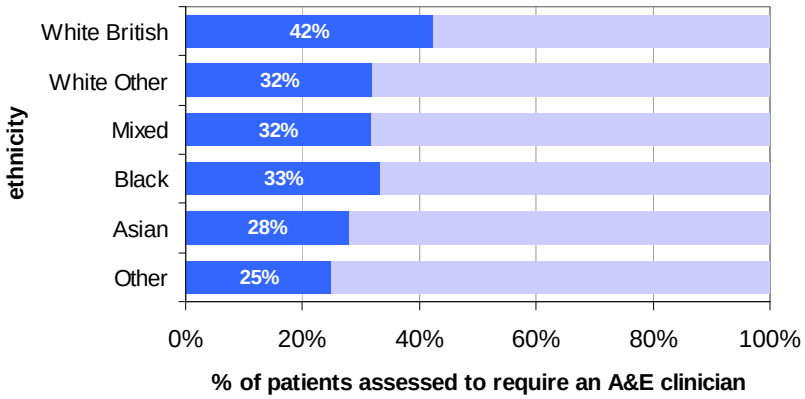
Figure 30: Percentage of patients whose appropriate treatment required an A&E clinician broken down by age group



Ethnicity of patients

BME groups appear to present at A&E with conditions less likely to require treatment from an A&E clinician compared to White British patients. The chart below shows how the percentage of patients whose treatment required an A&E clinician varies across ethnic groups. Approximately 40% of White British patients were assessed to require an A&E clinician as one of the most appropriate skill groups to provide treatment compared to only 30% (approx) of BME patients. This may support the hypothesis that BME patients attend A&E due to a culture of seeking hospital treatment or a lack of knowledge regarding alternative access points.

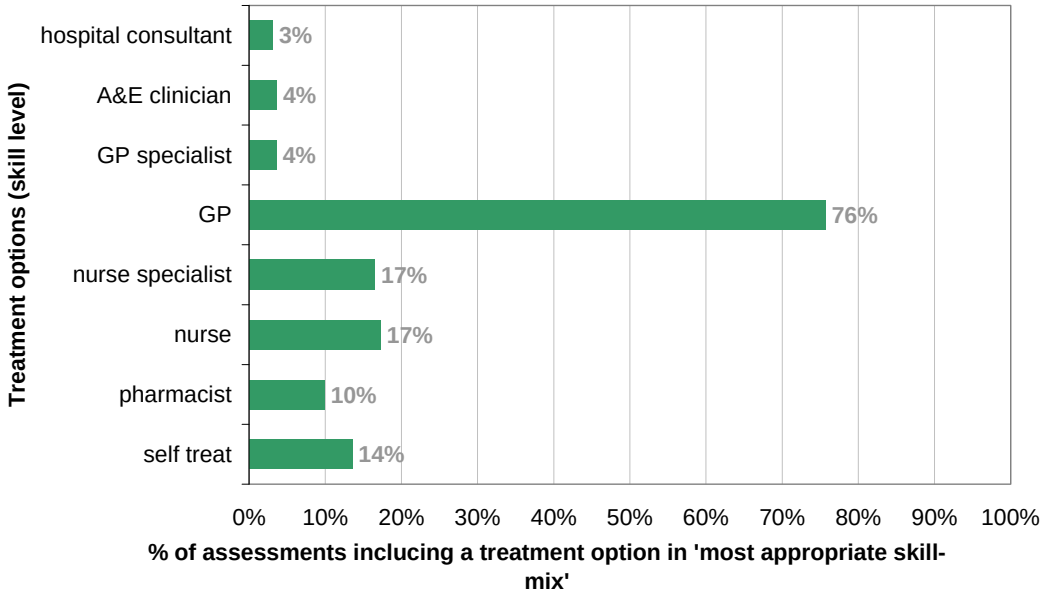
Figure 31: Percentage of patients whose appropriate treatment required an A&E clinician broken down by ethnic group



6.6 1 in 4 unscheduled patients visiting their GP could have been seen in scheduled appointments

Live assessment of patients accessing unscheduled care at GP practices shows that GPs consider themselves to be the most appropriate access point for the majority of patients. Across all PCTs in the study, GPs considered that 4% of patients should have presented at A&E, about 14% could have self-treated and 15% could have been seen by a nurse or nurse specialist.

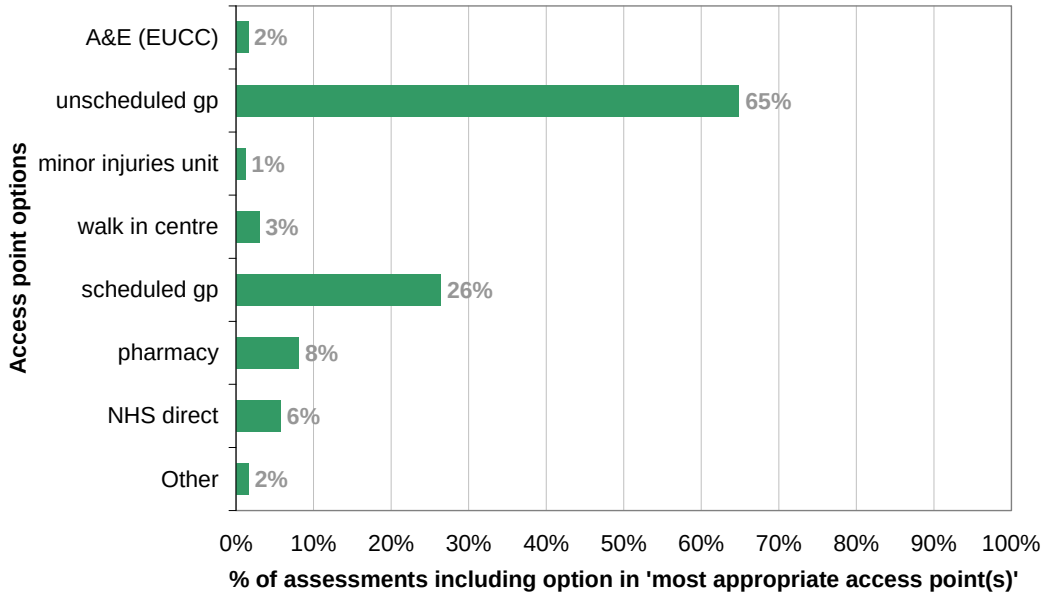
Figure 32: Percentage of unscheduled GP attendances (walk-ins and same day appointments) that could have been appropriately treated by other professionals (multiple selections)



In the view of GPs, patients presenting at GP practices are generally presenting in the correct place. The proportion of patients at GP practices who could viably be seen by a nurse, nurse specialist or pharmacist, or could have self treated appears small (between 10-14%). Because a large volume of unscheduled care occurs in a GP setting, even a small proportion of patients moving to a more appropriate setting can have a large beneficial impact on the system.

GPs assessment of unscheduled care patients found that at least 25% of patients could have been seen in a scheduled appointment slot. Since some GP practices participating in the study offered only unscheduled appointment slots, the option to recommend a scheduled appointment slot may not have been considered, therefore the 25% figure is likely to be a lower estimate.

Figure 33: Percentage of unscheduled GP attendances (walk-ins and same day appointments) that could have visited a more appropriate access point

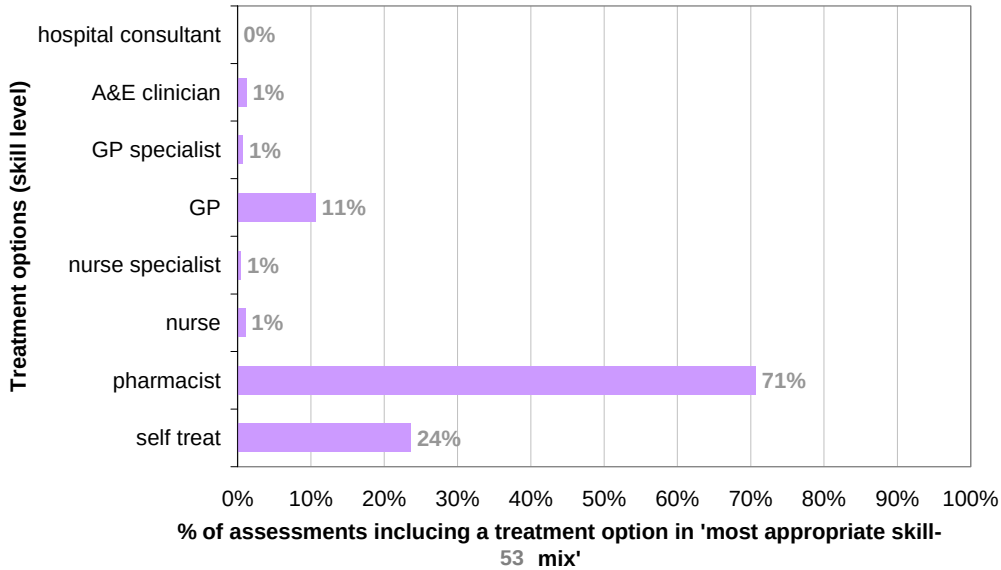


It is not clear from this assessment whether patients are requesting an unscheduled slot because of their perceived urgency, for their convenience or as a consequence of a GP practice only offering same day appointments.

6.7 Most patients presenting at pharmacies required pharmacist advice or treatment, although 1 in 10 required a GP

For the majority of patients presenting at pharmacies, pharmaceutical advice and/or self treatment was considered the most appropriate skill mix. It was felt that around 1 in 10 people presenting required a GP as the most appropriate skill mix to deal with their condition.

Figure 34: Percentage of patients visiting pharmacies that could have been appropriately treated by other professionals (multiple selections)

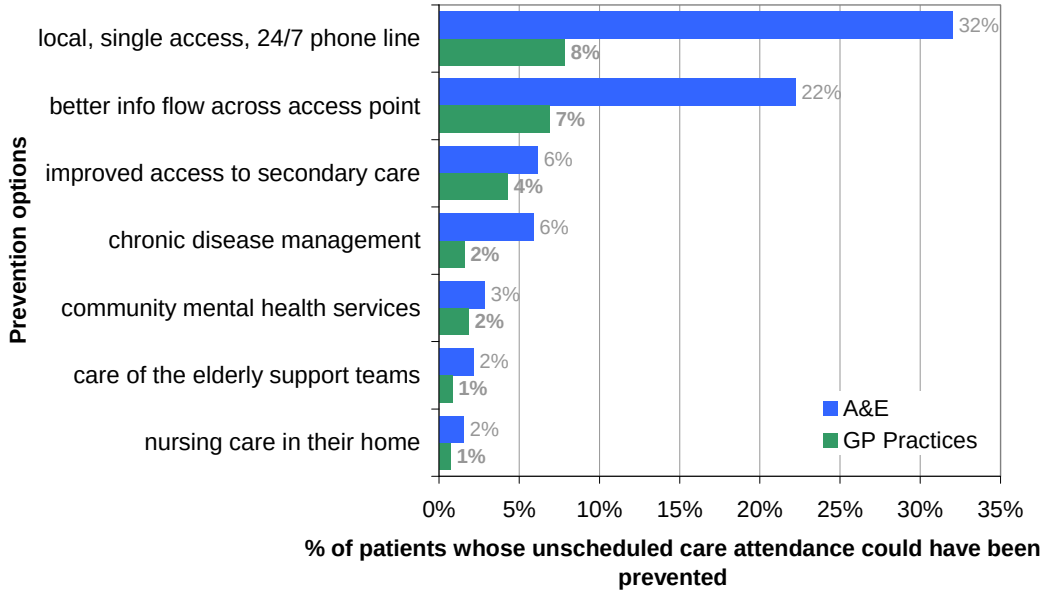


6.8 Unscheduled care attendances could be prevented through an urgent care telephone service and improved information flows across access points

For the assessments carried out in A&E and across GP surgeries the clinicians were asked how the unscheduled care need could have been prevented by a number of different services.

The GPs reviewing patients going to A&E felt that more of these attendances could have been prevented compared to those patients seeking unscheduled care from a GP. It is interesting to note that the ranking of the options is the same for each access point, with the single access phone line, and better information flow being by far the most popular prevention option.

Figure 35: The proportion of patients whose unscheduled visit to A&E or a GP practice could have been prevented by the options show



This assessment was made for each patient presenting at A&E departments and GP practices participating in the live assessment study. Improved access to secondary care and improved chronic disease management were also popular options and they may help to reduce the number of patients with long term conditions attending A&E (the live assessment study found 15% of A&E patients to have long term conditions). There may also be potential to prevent these attendances though improved care plans, better access to long term condition (LTC) care teams and other community based teams.

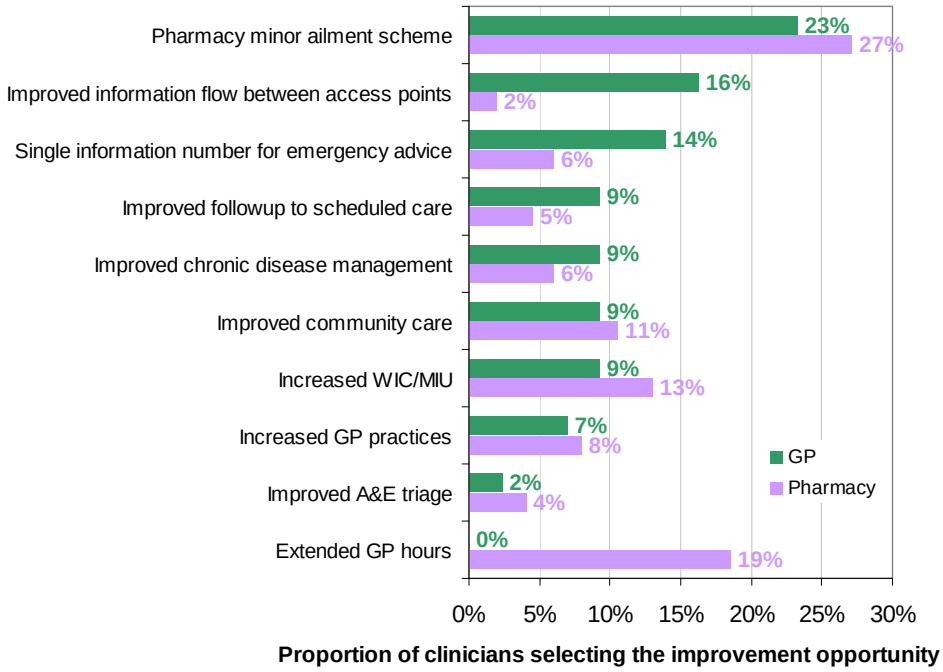
6.9 Pharmacists felt that the Pharmacy Minor Ailment scheme together with extended GP hours would improve provision

In the service surveys, which were distributed to all GPs and pharmacies across the 6 PCTs, GPs and pharmacists were asked their opinion regarding the ways unscheduled care provision could be improved. Over 100 responses were received from GPs and Pharmacists - with approximately 20 responses from GPs and 80 from pharmacists. GP sample size is small but nonetheless provides useful comparative information when combined with the findings from other data sources.

For both pharmacists and GPs the top improvement was the pharmacy Minor Ailments Scheme. GPs considered improved information flow and a single access phone line as the next best ways to improve unscheduled care. Pharmacists felt that extended GP hours and increased WICs and minor injury units were the next best ways to improve unscheduled care.

Figure 36 shows the breakdown of the opinions of GPs and pharmacists combined across all 6 PCTs as to the best ways to improve unscheduled care (People completing the form were asked to select their top 3 ways of improving unscheduled care).

Figure 36: GP and pharmacist opinion regarding the ways in which unscheduled care could be improved

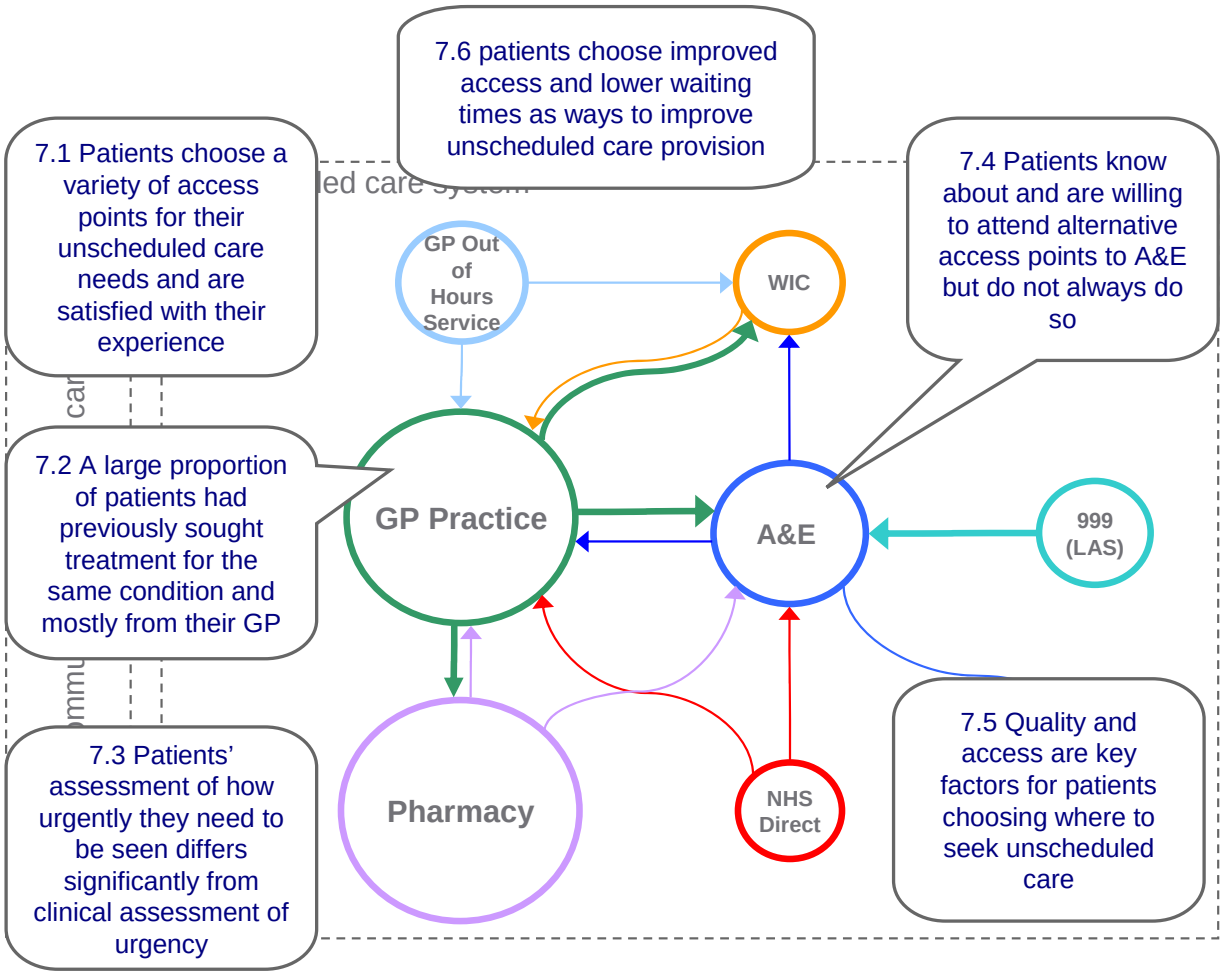


7 Patient behaviours and views about unscheduled care

This section sets out the findings from the patients surveyed at unscheduled care access points across the six PCTs. Approximately 650 in-depth patient surveys were carried out by Ipsos MORI at GP practices, A&E departments, WICs and pharmacies, each lasting roughly 20 minutes. These surveys provided information to help better understand patient behaviours and views about unscheduled care.

In collecting and analysing patient and public survey data sufficient sample sizes were collected to draw reliable conclusions and to ensure that they were representative of the socio-demographic profile of the patients across the PCT and of patients using each access point. To ensure that results were truly comparable the survey information was triangulated with other sources.

The key messages are summarised on the system diagram below:



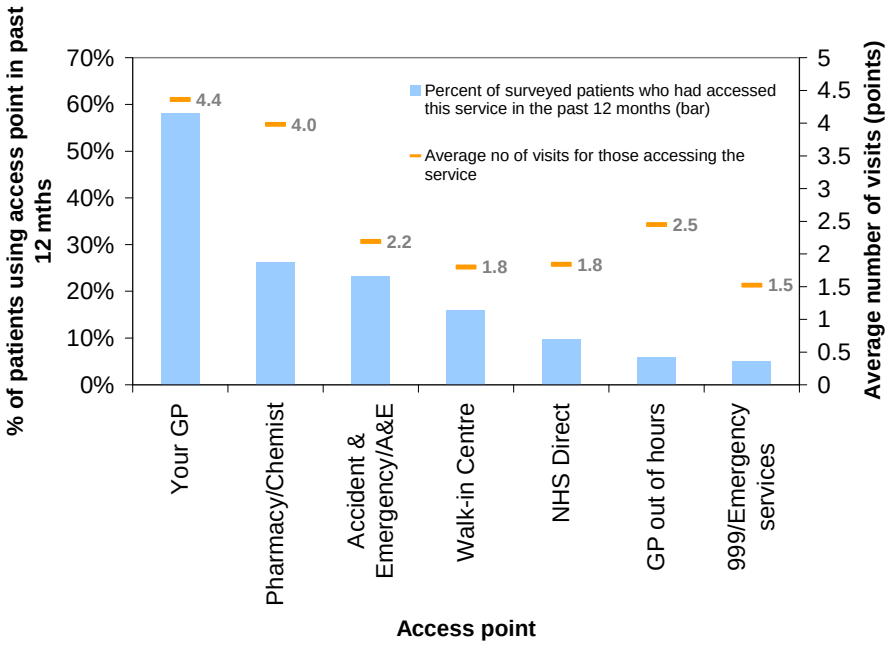
Patients choose a variety of access points for their unscheduled care needs and are satisfied with their experience

Patient choice of access point

The chart below shows the proportion of patients interviewed who had visited each access point over the last 12 months. The orange bars show the average number of visits per patient for those patients attending the access point. So, for instance, approximately 23% of all patients interviewed had previously visited an A&E department in the last 12 months and each of these patients who had been to A&E had visited approximately twice a year.

Of all patients interviewed, most patients had accessed their GP in the past year and patients who visited their GP went on average 4.4 times a year. Far fewer patients (approx 26%) visited their pharmacy for care over the last year, however those that had, used the service frequently (on average 4 times a year). GP out of hours services show a similar profile, only 6% of patients had used the service in the last year but they had used the service quite regularly, and perhaps more regularly than should be expected, given the nature of the service.

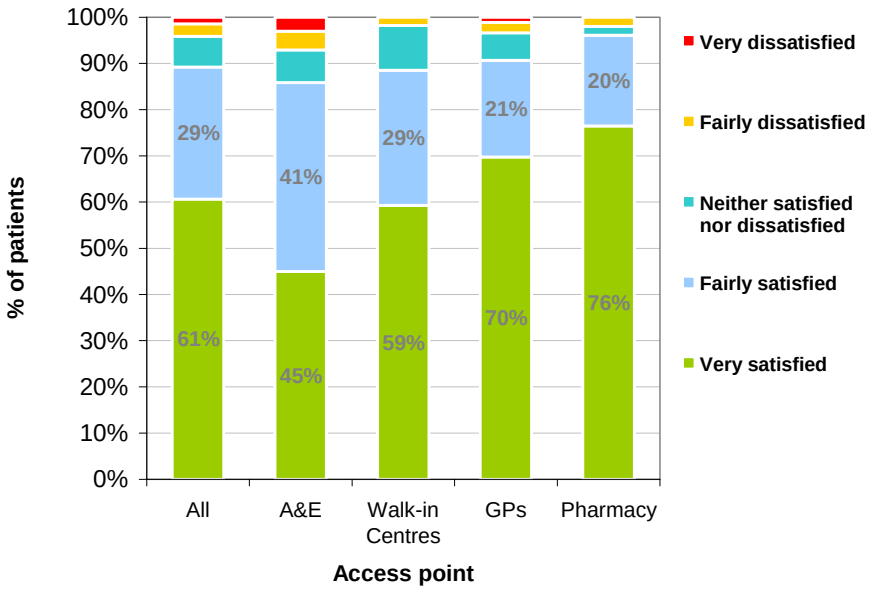
Figure 37: Where patients went for treatment in the last 12 months and the average number of times they visited



Patient satisfaction

A majority of patients are satisfied with the treatment they receive at access points for unscheduled care. The chart below shows 86% of patients interviewed were satisfied and 6% were dissatisfied with the treatment they received at A&E. An even greater proportion of patients were satisfied with their treatment at GP practices (91%), pharmacies (96%) and walk-in (88%) centres. These slight differences in views may be influenced by patients' conditions, their reasons for seeking care or their expectations of each service.

Figure 38: Patient satisfaction at access points

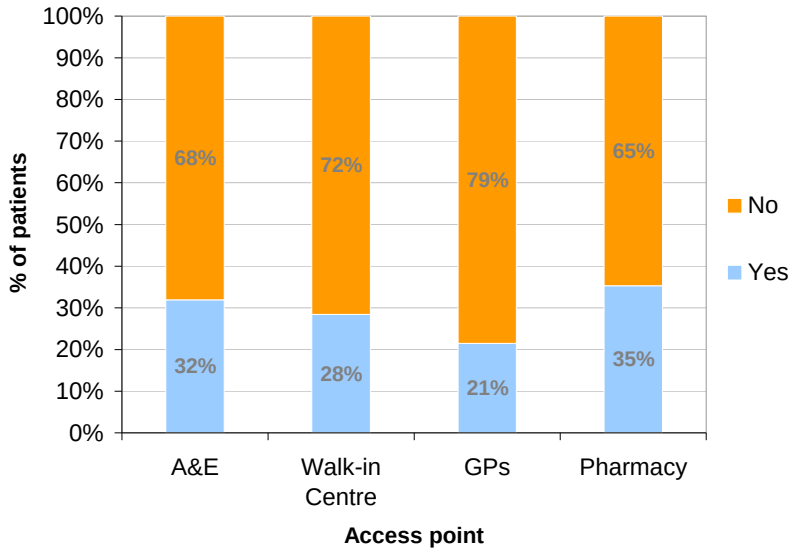


7.1 A large proportion of patients had previously sought treatment for the same condition and mostly from their GP

Prior attendance to an access point

Of patients interviewed, approximately 1/3 had previously sought treatment for their condition in the past 7 days. This suggests a significant number of repeat visits and/or flow of patients between health care providers within a relatively short time span. However, the majority of patients sought advice for their current condition for the first time during the seven days. Figure 39 shows the proportion of patients who have previously sought advice in the last seven days for each access point.

Figure 39: Whether patients had previously sought treatment for their condition over the last 7 days



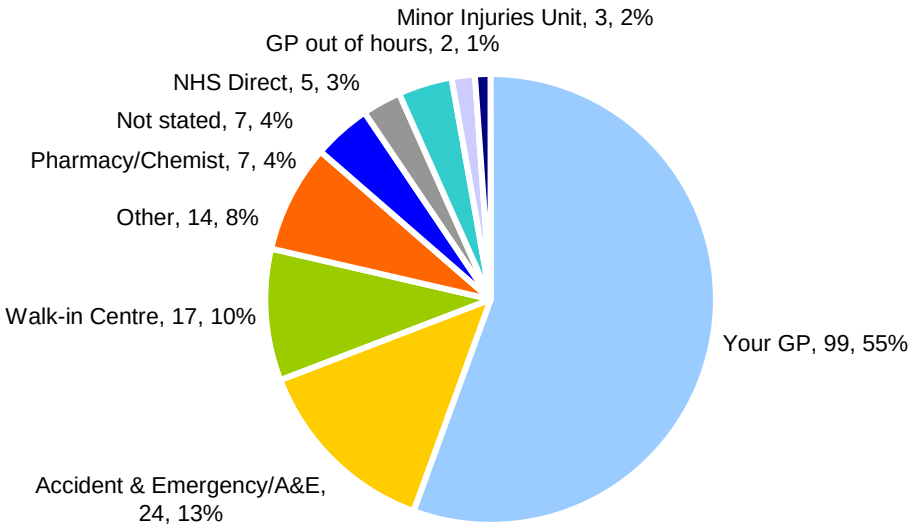
Where patients previously sought treatment

Of patients interviewed who had sought medical advice during the past seven days (shown in the previous chart), 55% had sought advice or care from their GP before attending the access point at which they were interviewed. A proportion of these patients are likely to have been referred to an alternative access point by their GP.

Few patients had called NHS Direct or accessed GP out of hours services for advice or care before attending the access point. Just fewer than 1 in 3 patients had accessed a WIC or an A&E department before attending A&E. Figure 40 shows the access points patients went to in the previous seven days before attending the access point at which they were interviewed.

Figure 40: Where patients first went for medical advice or care for their condition in the past seven days (both the total number of patients and percentage of those attending are shown on the chart)

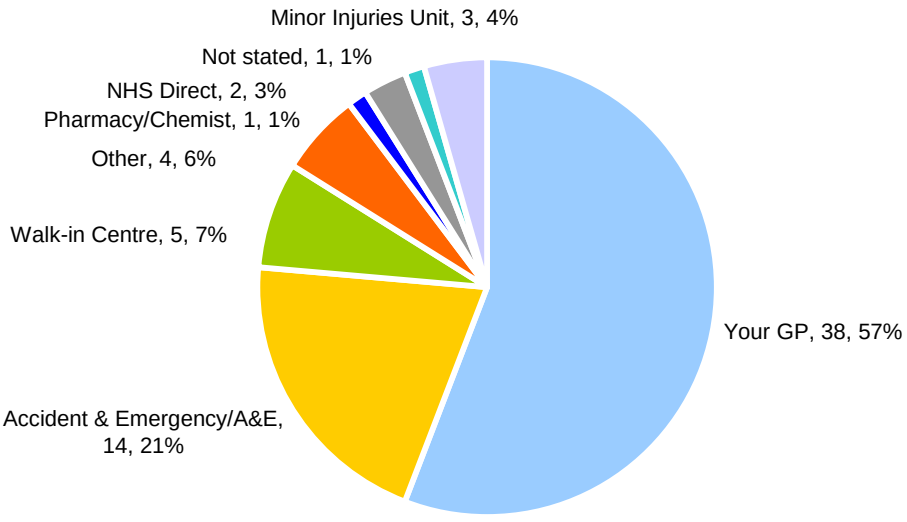
For example, in the chart below the total number of patients who first visited their GP was 99, this equates to 55%.



Where A&E patients previously sought treatment

Over 1 in 5 patients had accessed an A&E department over the past seven days before attending an A&E department again. Figure 41 shows the access points patients attended in the previous seven days before visiting an A&E department.

Figure 41: Where patients presenting at A&E first went for medical advice or care for their condition in the past seven days (both the total number of patients and percentage of those attending are shown on the chart)



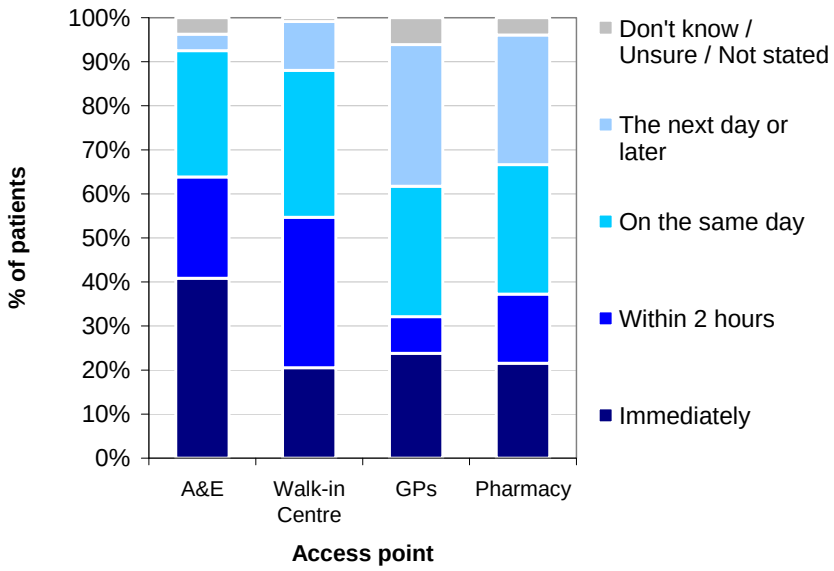
7.2 Patients' assessment of how urgently they need to be seen differs significantly from clinical assessment of urgency

Patients' assessment of their urgency

Patients' assessment of how urgently they needed to be seen shows that the assessment of urgency is greatest for patients attending A&E and WICs. At these access points, more than 50% of patients said they needed to be seen within 2 hours, and around 90% on the same day.

This shows that a majority of patients who currently access unscheduled care services at A&E departments and WICs would not be prepared to wait, even for one day, to be seen. At GP practices and Pharmacies, a larger proportion of patients assess their condition as less urgent. Figure 42 shows how urgently patients felt they needed to be treated for each access point.

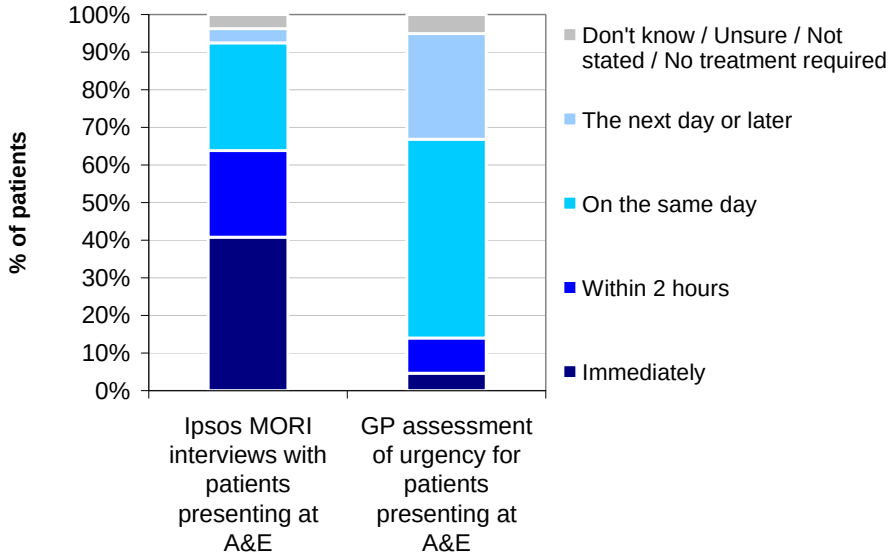
Figure 42: Patients' perception of how urgently they needed to be treated



GPs assessment of patient urgency

Patients' assessment of how urgently they need to be seen differs significantly from GPs assessment of urgency. The chart below compares the perceived urgency of patients interviewed at A&E departments (left bar) with GPs assessment of the urgency for patients presenting at A&E departments from the live assessment study (right bar). This shows that while 60% of patients feel they need to be seen within 2 hours, GPs assess that only about 15% need to be seen within 2 hours. This gap in patient perception and clinical assessment of urgency may partly explain why patients choose to go to A&E rather than to their GP.

Figure 43: Comparison of patient perception of urgency against GP assessment of patient urgency

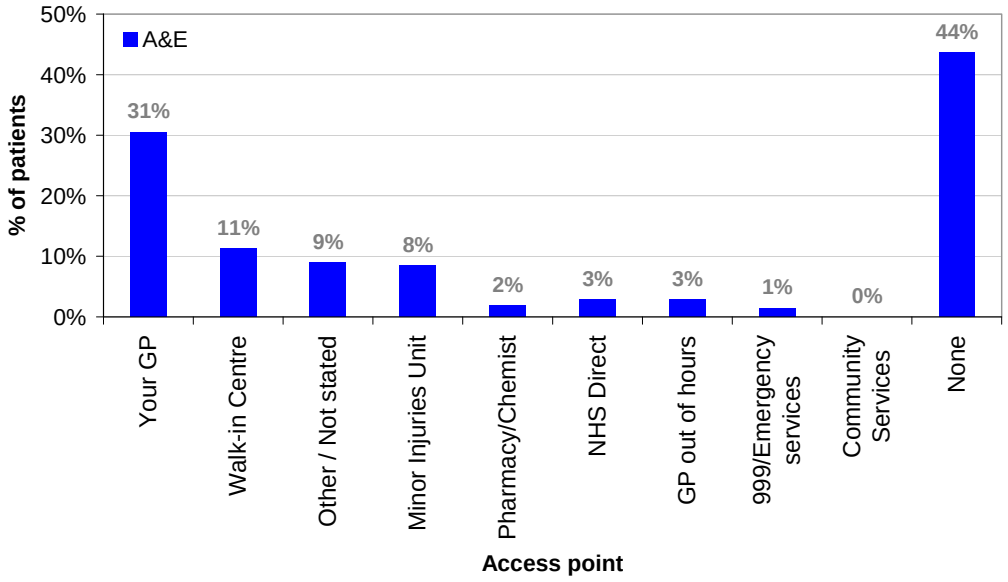


7.3 Patients know about and are willing to attend alternative access points to A&E but do not always do so

The alternative access points A&E patients considered using

Only 43% of patients said that A&E was the only appropriate place for them to seek care, whereas about a third said they could have been treated by their GP. Smaller, but nonetheless significant, proportions of patients knew about local WICs (11%) and minor injuries units (8%) and would have been willing to go to these access points as an alternative to A&E. The chart below shows the proportion of patients who felt other health services could have provided them with treatment.

Figure 44: Other than A&E, which other health services did patients feel could have provided them with treatment

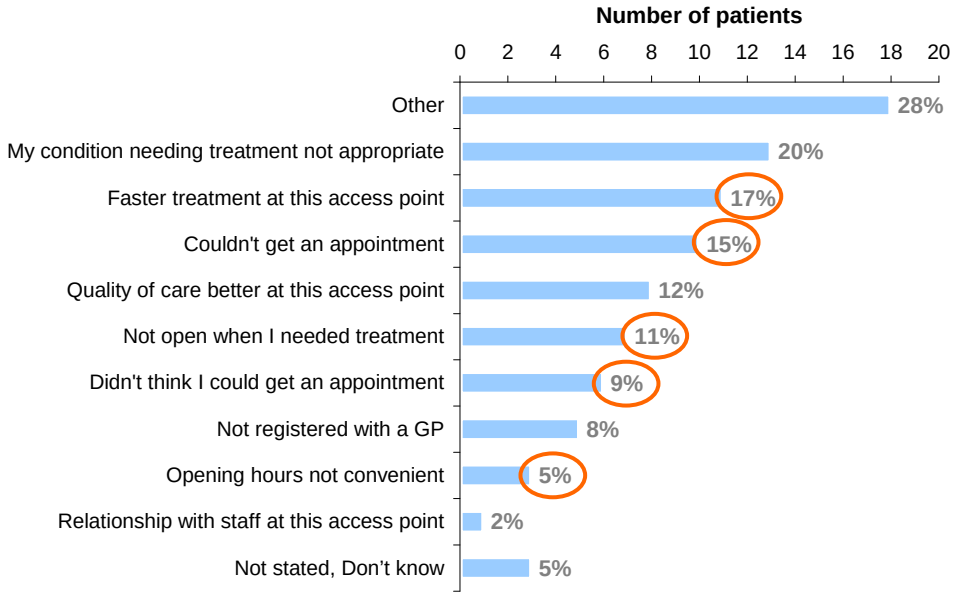


Why did patients who considered visiting their GP go to A&E instead?

For the third of patients interviewed who could have visited their GP instead of A&E many felt that GP access was a blockage. Key issues highlighted by patients were around GP access, in terms of the ability to get appointments with GPs and the belief that treatment at A&E would be faster than at a GP practice.

Figure 45 shows the reasons patients provided for not going to a GP. The factors which relate to GP access are circled and at least one of these factors was chosen by over 50% of patients. Better quality of care was chosen by only 12% of patients indicating that patients do not perceive a significant quality gap between the care provided by GPs and the care provided by A&E clinicians. However 20% of patients felt that their condition could only be treated appropriately in an A&E setting.

Figure 45: Reasons cited by those patients who attended A&E even though they felt their condition could have been treated by their GP



The alternative access points GP and pharmacy patients considered using

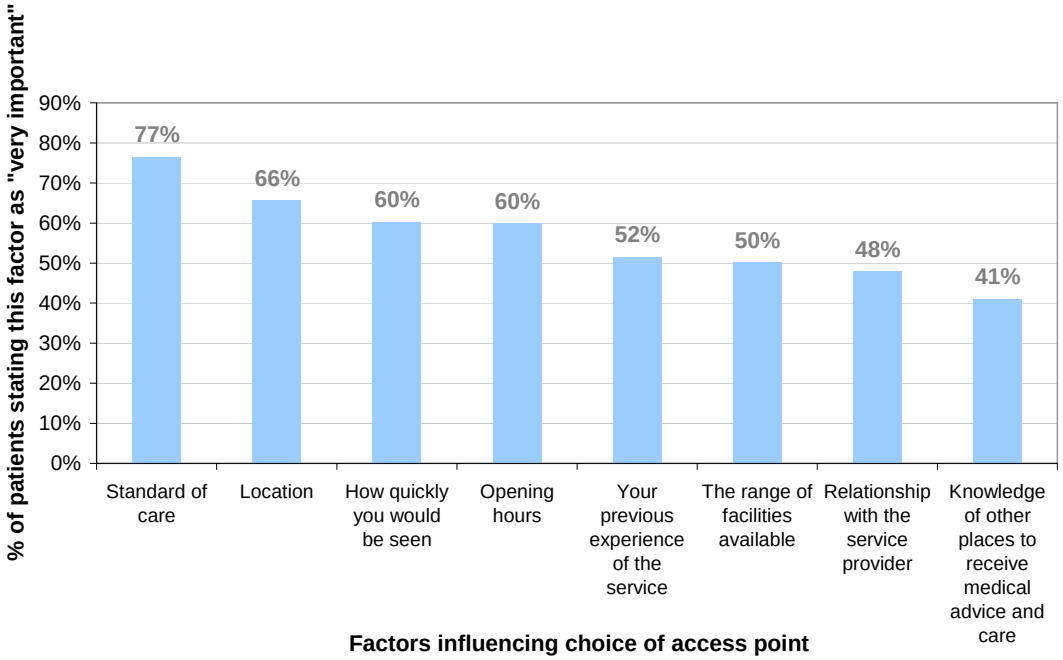
Patients in WICs and GP practices were also asked whether they could have sought treatment elsewhere. Only 21% of patients interviewed in WICs said it was the only appropriate place for them to seek care; GPs (43%) and A&E (42%) were the most common alternatives selected by patients. Conversely, 60% of patients interviewed at GP surgeries said it was the only appropriate place for them to seek care, with WICs (16%) as the most popular alternative.

7.4 Quality and access are key factors for patients choosing where to seek unscheduled care

The factors patients consider when choosing an access point

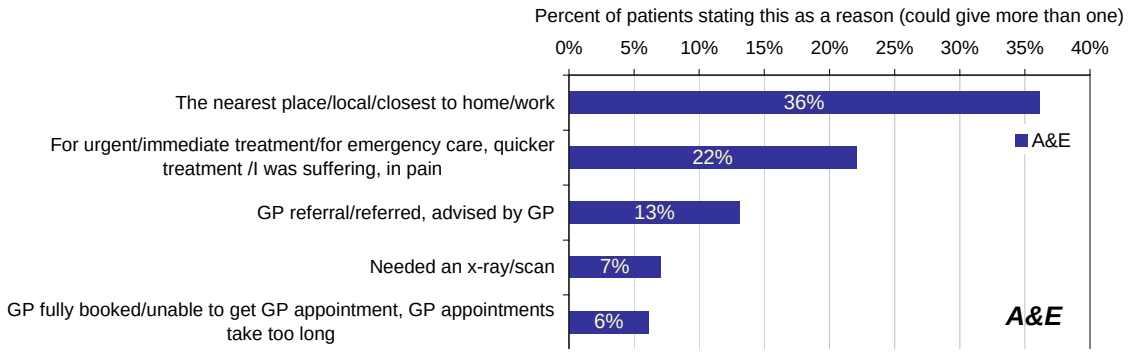
Patients were asked to rate, in order of importance, a number of predefined factors that may influence their selection of access point (multiple selections were allowed). 77% of patients rated standard of care as 'very important', this was followed by location (66%), speed of diagnosis/treatment (60%) and opening hours (60%) as other key factors. Figure 46 shows the characteristics of unscheduled care access points that are most important to patients.

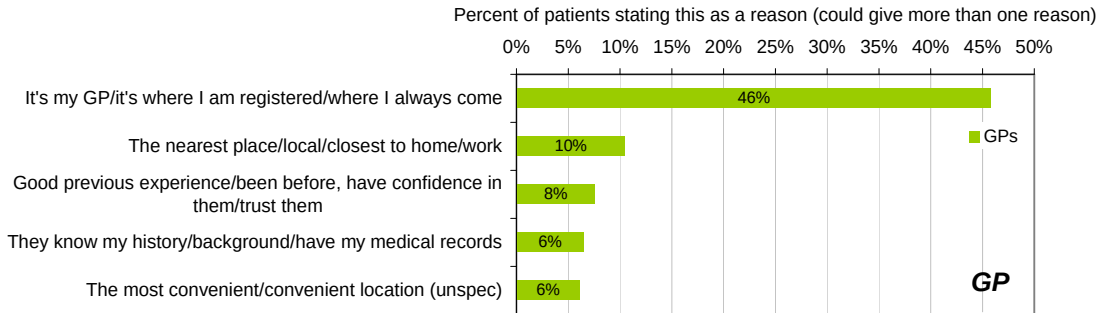
Figure 46: The factors patients rate as 'very important' when choosing an unscheduled care access point

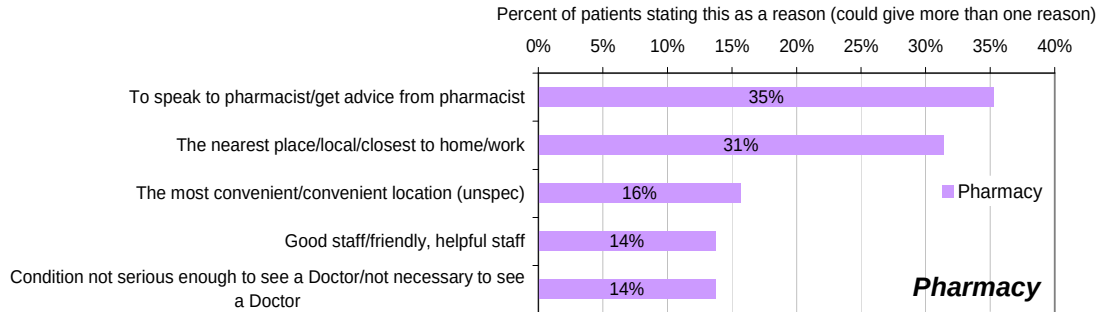


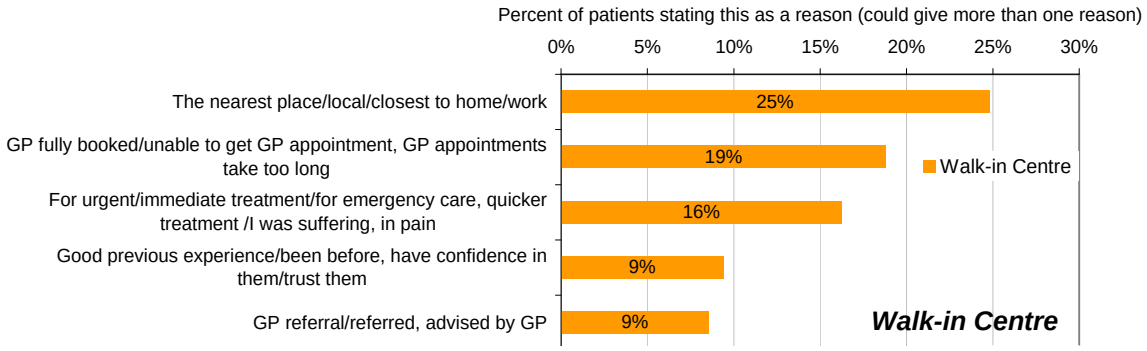
The detailed reasons for choosing a particular access point

Figure 47: Series of four charts showing the top 5 reasons patients gave for choosing the access point they attended (questions were free form and unprompted)









A large proportion of patients who attended A&E stated proximity as a key reason when choosing where to go for care. Other reasons put forward by patients were the need for rapid treatment, having been referred by GPs and limited GP access.

Aside from patients stating that the GP they visited was their registered GP; patients described proximity/convenience and trust/previous relationship as the most common reasons for selection.

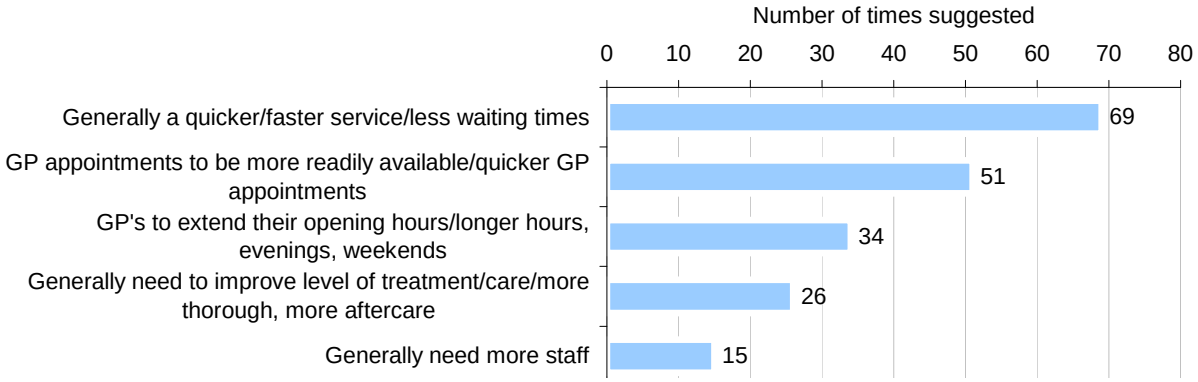
Proximity to home/work and good and helpful staff were the most common reasons stated by patients for selecting pharmacists.

Again, patients chose proximity as the most important factor for them choosing to go to a WIC. The second most common reason is related to limited access to GPs. This suggests that WICs may be doing some activity that was previously carried out by GPs, however previous analysis showed that patients rated both A&Es and GPs as popular alternatives to a WIC.

7.5 Patients choose improved access and lower waiting times as ways to improve unscheduled care provision

When asked how they would like their unscheduled care need to be met in the future, patients highlighted a requirement for quicker services with less waiting times. Patients commented on both the need for GP appointments to be more readily available, and the need for GPs to extend their opening hours. Patients also asked for improvements in the quality of treatment with more aftercare.

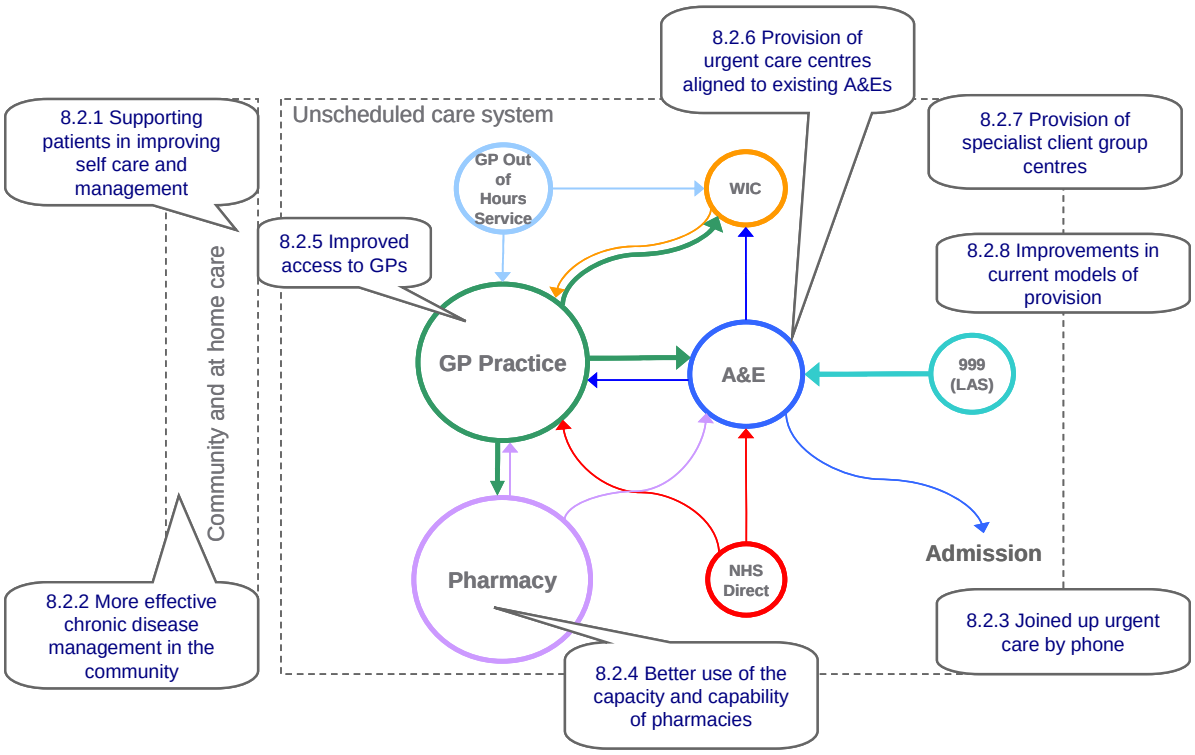
Figure 48: Patient views regarding how unscheduled care could be improved in the future (questions were free form and unprompted)



8 Improvement opportunities for unscheduled care system

This section sets out the overall improvement goals and opportunities that should drive the development of future models of unscheduled care in London. Where possible the opportunities are illustrated with examples, highlighting where they exist across each of the six PCTs included in this study.

The improvement options described in 8.2 are summarised on the system model below:



8.1 Overview of improvement opportunities

This study has examined the variety of access points and systems for unscheduled care across six PCTs. It has examined how they work, why people use services in the way they do and considered the views of professionals providing these services against the backdrop of Healthcare for London. So what does this mean when considered together?

8.1.1 The findings from this study support the concerns raised in 'A Framework for Action' about unscheduled care

The findings from this study support the concerns raised in 'A Framework for Action' about unscheduled care, in particular:

- **'London has a higher rate of access to A&E than the rest of the country and a poor range of alternative access points' -** this study shows that whilst there is a good range of alternatives to A&E, patients experience difficulties in getting access at a time convenient to them. It also shows that there is indeed a high rate of use of A&E with 75% of minors assessed by the GP triage process suggesting they could have been treated elsewhere and even patients themselves saying they would be willing to use alternative access points. This point is exacerbated by the second area of concern raised in 'A framework for action"
- **'Londoners do not always know about the services nor which ones are best to attend'** - this is supported by the study but does also show that in the majority of cases patients are aware of the range of access points but are not sure of exactly what services are provided at each access point. They tend to default, therefore, to the access point where they know they will receive a comprehensive service - A&E. Interestingly, it was also clear from the stakeholder interviews that staff do not always understand the full range of services available at each access point and so are unable to support patients in navigating around the system
- **'Access to GP services in and out of hours is poor'** - what is certainly clear from this study is for patients who attend A&E who could have seen their GP and know they could have seen their GP, the major factor in not attending their GP is that they couldn't access either a scheduled or unscheduled appointment at a time, either in or out of hours, that was convenient to them
- **'There is duplication and poor utilisation of unscheduled care services'** - whilst this comment is certainly true for acute services such as trauma and emergency surgery, this study found that it is also true of the services for more minor unscheduled care episodes. Although it could be argued that this is about the provision of choice and wider access.

8.1.2 There are a number of improvement opportunities in the unscheduled care system highlighted by this study

In addition to reinforcing the messages from 'A Framework for Action' there are a number of other summary messages that stand out:

- **There is significant potential for preventing patients entering the unscheduled care system -** The study shows that around 1 in 4 of patients attending unscheduled slots at GP practices could have been seen in a scheduled slot. 13% of patients attending at A&E are not registered with a GP and so are tending to use this service as a default. Feedback from stakeholders suggest that more effective Long Term Conditions management and self care would have a significant impact on the number of patients entering the unscheduled care system
- **There is a significant potential for patients to be seen and treated in alternative settings -** 75% of minors patients presenting at A&E could potentially be seen in alternative settings at lower cost. Patients say they are willing to use alternative settings if access is convenient and they perceive the quality of care to be high
- **There is potential to reduce attendance at A&E by improving access to GP services (scheduled, unscheduled and OOH) -** Patient preference survey results show that patients know about and would visit other access points as an alternative to A&E. Access to GP appointments was identified as the major blockage to this occurring. The A&E live data collection shows that around 50% of minor patients could be treated in a scheduled GP setting
- **Given the significant differences in commissioning costs across the unscheduled care system, small changes in the model could have a significant impact on overall costs to PCT -** Around 75% of patients who enter the unscheduled care system use either their GP or pharmacy, 10% use A&E at ten times the total cost of patients seen by a GP. The average unit commissioning cost in a A&E is around £68, compared to a UCC at £49, GP £27, and NHS Direct £16
- **There is evidence that whilst UCCs at the front of A&E departments do deflect significant volumes away from A&E whilst other evidence suggests that they may increase overall demand for unscheduled care services -** Whilst the study was limited to two examples of how UCCs may impact the attendance at A&E, the evidence from Whipps Cross suggests that whilst the monthly attendance at A&E decreased by about 2,000 attendances a month once the EUCC opened, the numbers of those redirected from A&E was more than matched by the increase in monthly attendance at the new access point
- **There is some potential to reduce repeat attendances -** 7% of patients attending at A&E and WICs and 25% at GP surgeries had been to the same access point for the same condition within the previous three days. Whilst some of this repeat attendance may be appropriate, it looks significant enough to attract further analysis and improvement effort. In addition there are some significant flows through the unscheduled care system that show patients presenting at multiple access points for the same condition. In particular, 20% of those arriving at A&E had previously seen their GP and 13% at WICs had similarly been to see their GP, although it is worth noting that a proportion of these may have been referred
- **There is some potential in exploiting the capability and capacity of pharmacies -** there is some evidence that patients entering the unscheduled care system could receive treatment in a community pharmacy setting. There is strong stakeholder support for the Pharmacy Minor Aliment Scheme amongst both GPs and Pharmacists. GP assessment of patients presenting at A&E suggested that 3% of patients could have sought care at a pharmacy. In addition, a key message from stakeholders' workshops suggests that better hospital pharmacy care could potentially be used as an explicit part of the unscheduled care system, together with OOHs services

- **There is potential for reducing the proportion of the elderly and the very young attending A&E -** there is a propensity for the elderly to use A&E and parents of the very young to use both A&E and telephone access points. This might suggest that these and perhaps some disease related groups could be better catered for through tailored services in a community setting that could combine both scheduled and unscheduled care
- **There is significant potential to improve access through a more joined up and strategic view of opening times for services at a local level -** stakeholders identified a key challenge to overcome for the delivery of unscheduled care services is the current misalignment between extended opening hours and the lack of access to support services such diagnostics, pathology (for bloods etc) during these extended hours. It was noted that if the patient perceives that their GP or WIC has no rapid access to tests they believe they need, they will elect to go straight to A&E to access these services
- **There is support for the concept of streamlining the telephone access to health care across London** - however there were mixed views from stakeholders about what the model could look like but universal agreement that it would require a significant improvement in knowledge management and supporting infrastructure.

8.2 Unscheduled care system improvement options identified by this study

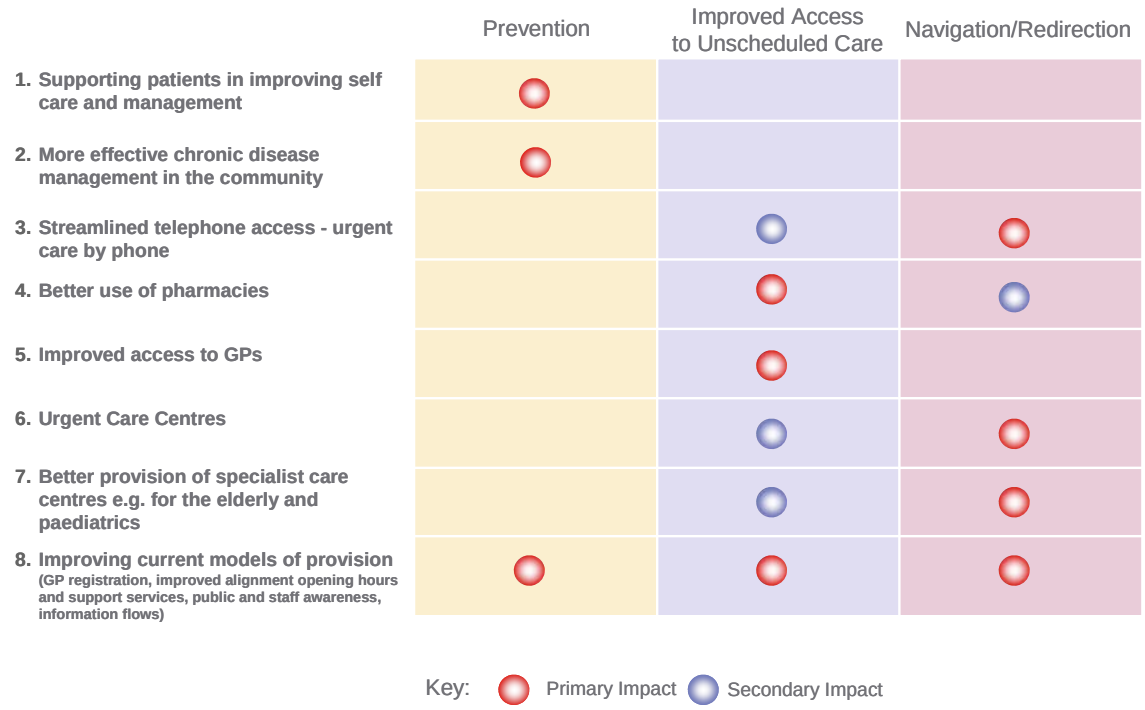
In exploring the opportunities for improvement outlined above with stakeholders, three overriding goals consistently emerged. They are:

- **Prevention:** concerned with supporting patients in avoiding the need to enter the unscheduled care system through wellbeing or better self management interventions
- **Improving access:** concerned with ensuring that when patients do need unscheduled care they are able to access it at the most appropriate setting and at a time and location that is convenient
- **Improved system navigation:** concerned with supporting patients in finding access to unscheduled care at the most appropriate setting, active management of access to A&E departments and redirection of unscheduled care patients to both more appropriate unscheduled and scheduled care settings, where appropriate

Any future models of unscheduled care across London will have to address the challenge to strike the right balance between prevention, improved access and critically improved system navigation/redirection.

The remainder of this section sets out eight options for exploiting the delivery of unscheduled care services highlighted by the study. Each of the improvement opportunities have been categorised by the impact they would have on the three goals. A summary of this is shown in the table below:

Table 4: Unscheduled care system improvement opportunities



These eight improvement opportunities are supportive of the proposals made by 'A framework for action', in particular those concerning: urgent care centres; specialist paediatric centres; single telephone number; and increasing patient awareness of the options available.

The eight improvement opportunities are now described in more detail in the following sections

8.2.1 Supporting patients in improving self care and management

Description

If patients with long term or chronic conditions (such as diabetes, renal, skin or respiratory problems), were better supported in managing their own conditions or supported in looking after themselves more effectively, they would be less likely to need access to unscheduled care.

In effect, this is Level 1 of the three tiered Long Term Conditions pyramid model promoted by the Department of Health which reflects the learning from US models such as Kaiser Permanente and Evercare. This Level is concerned with collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively. The group that could benefit from this improvement opportunity typically makes up 70-80% of the population with chronic conditions[6]

[6] Chronic Disease Management: A compendium of Information. Department of Health, May 2004

This is not a new improvement opportunity and several examples exist across the NHS that have shown the benefits that can be accrued as a result of more effective support to patients for self care management, including reductions in GP and A&E attendances and admissions and reductions in days off work.

Commissioning enablers and challenges

Providing patients and their carers with greater confidence and skills to manage their own care more effectively may require commissioners and providers to ensure:

- A greater level of information is available to support patients
- That new IT to support self care (such as ways of monitoring conditions in the home remotely) are invested in
- Programmes are established to skill up patients and their carers and to increase their desire, confidence and competence to self manage
- An increased focus on managing long term conditions more effectively across London could be considered at Practice Based Commissioning (PBC) consortium, PCT or pan London levels.

8.2.2 More effective chronic disease management in the community

Description

The underlying argument here is that for a minority of patients with more severe long term or chronic conditions, they will benefit from specialist planned input to their care at home or in the community, that will help prevent avoidable attendances at GP surgeries or A&E departments and reduce hospital admissions. In effect this is Level 2 Disease Management and Level 3 Case Management of the three tiered Level Long Term Conditions pyramid model promoted by the Department of Health. The group that could benefit from this improvement opportunity typically makes up 20-30%of the population with chronic conditions[7].

Evidence from stakeholder interviews across the six PCTs involved in the study suggest that community matrons, district nursing teams and other allied health and social services teams do help ensure that patients are managed in a scheduled way in their home and so do not need to access unscheduled care services as frequently. The community psychiatric nurse scheme has been highlighted as a successful way of delivering specialised clinical care in the community, and preventing the unnecessary use of unscheduled care or in-patient resources.

Many further examples exist across the study area including: the single access point for community nursing at night in Hammersmith & Fulham; the community matrons scheme focusing on frequent users of care and unscheduled care in Kingston; and the care provided at weekends in the WIC in Hammersmith and Fulham.

On the whole the GPs surveyed were supportive of the principle of better chronic disease management as a way of improving unscheduled care system.

[7] Chronic Disease Management: A compendium of Information. Department of Health, May 2004

Case Study - Community Matrons

A patient has been regularly using unscheduled care services, both A&E and their GP, during the previous year. Their GP refers their case to the local community matron service, pointing out, as part of the referral, the frequency of the patient's unscheduled care use. The community matron then meets with the patient, their family, carers and health care professionals to develop a personal care and escalation plan. The patient is given the mobile phone number of the community matron, who becomes their first point of contact in the health care system. The patient has not accessed the unscheduled care system now for six months.

Commissioning enablers and challenges

The commissioning enablers and challenges for this improvement opportunity are well documented and understood and include:

- The need for PCTs to work in partnership with social care, NHS providers and London Ambulance Service to develop new models of care
- Developing the local skills and systems to support patients in reminding them about following their care plans, case management and periodic review
- Enabling IT systems that link up and share information across access points and professionals and supports more effective care planning

8.2.3 Streamlined telephone access

Description

'A Framework for Action' sets out the idea of a single telephone number across the capital which could help co-ordinate, from a patient perspective, the services of the London Ambulance Service, NHS Direct and local GP OOHs providers. Call handlers would need access to high quality real-time information and advice tailored to the location of the caller. So a Londoner calling this service would have their needs assessed and either be put through to emergency services, directed to a local urgent care access point (e.g. GP OOHs or WIC) or provided with advice and guidance.

There is a lack of clarity amongst stakeholders about how the single telephone number model would actually work and also a degree of scepticism about whether it would deliver the benefits claimed. An alternative model proposed is to ensure that the existing services are more effectively and seamlessly joined up through the use of technology. So, for instance, NHS Direct could transfer details of a patient's telephone triage process directly to the London Ambulance Service, GP OOHs, GP, or an UCC.

Whatever model is taken forward, all stakeholders were concerned that it would need to be underpinned by a robust telephone triage system operated by skilled clinicians. The current triaging system that is used by GP OOHs was mentioned as a model that could be expanded upon.

Case Study - Streamlined Telephone Access

A patient calls the new single access telephone line and is asked for further details about their condition by the trained operator. The operator effectively triages the patient over the telephone. The patient discussed their symptoms and their condition with the operator, who decides that the patient's condition is not serious enough to

Case Study - Streamlined Telephone Access

warrant an ambulance, ECP or to advise them to attend A&E. Instead, the operator transfers the patient to her GP, who provides advice to the patient over the telephone. The patient is reassured by the provision of advice and also attends a local pharmacist the following morning to discuss self treatment options with a pharmacist.

Commissioning enablers and challenges

GPs in their assessment of patients accessing unscheduled care services through the study, selected the single telephone number improvement option more than any other when considering how to prevent patients from entering the system. However, providing a single urgent care telephone number would require a number of issues to be addressed on a pan London basis including:

- Designing the appropriate strategic and operational model that will deliver value for money, act as an incentive for driving up quality and co-ordinate seamlessly with current providers (i.e. London Ambulance Service and NHS Direct)
- Selecting the appropriate call routing technology, including data and voice transfer
- Health care record availability to all access points along urgent care pathways and an underpinning knowledge management system
- A significant public and clinician awareness campaign on the role and services for the single number is likely to be required
- In addition the solution may also require access to GP advice and/or the ability to book GP appointments or at least to transfer people to their GP
- Stakeholders are concerned that this model should only be commissioned if it can provide contextual advice about the patient's locality. Telephone triage is viewed as inherently less safe and therefore more risk averse when the clinician does not know the patient and has only audio clues to guide them.

8.2.4 Better use of pharmacies

Description

Exploiting the capability and capacity of pharmacists/pharmacies to play an increasing role in the delivery of unscheduled care services, not only in the dispensing of drugs, but also in the provision of advice and guidance, which could help alleviate the pressure on other access points as part of a wider strategy for improving unscheduled care across the capital.

The Minor Ailment Scheme is popular with pharmacies and has been hailed as a success. However, the scheme has not been universally rolled out across London. This scheme could be a natural candidate for enhancing pharmacy services in the capital.

Case Study - Minor Ailments Scheme

A patient is suffering from a chesty cough but realises that, given their local pharmacy offers the 'minor ailments scheme', there is no need for them to visit their GP. Instead, they visit their local pharmacist, who provides them with a full consultation about their medical condition. As the patient is eligible for free prescriptions, the pharmacist is able to provide the patient with expert advice about their condition and a free prescription of drugs to treat the condition.

Commissioning enablers and challenges

Increasing the active role of pharmacies in the delivery of unscheduled care across London would require a number of issues to be addressed including:

- Public and clinician awareness campaign on the services and role of pharmacies in delivering unscheduled care
- Physical layout of pharmacies would need to include appropriate space to allow private consultations to take place
- Reflect additional services in the enhanced services part of the contract, which may require commissioners to shift resource to pharmacies

8.2.5 Improved access to GPs

Description

This improvement opportunity is concerned with shaping GP services to be more readily available to patients with unscheduled care conditions. This might mean more convenient opening hours, more GP OOHs services, improved booking processes, or greater use of telephone consultations. There is the potential in doing this to develop the role of nurses/nurse specialists to enable an increase in in-hours GP capacity. The outcome would be more patients who require an appointment at short notice for minor unscheduled care conditions are able to get one at a time that is convenient for them. It will be critical to take a community wide view of the opening times for the full range of services to ensure that these reflect the peaks and troughs in demand.

Commissioning enablers and challenges

This improvement opportunity will require the following issues to be addressed by commissioners:

- Funding to support/incentivise improved access e.g. OOH provision
- Co-ordinating opening times for related/supporting services e.g. Pharmacies
- GP registration schemes at A&E
- GP surgeries having a consistent tailored response to telephone calls dependent on condition and urgency and communicating to patients in a way that reflects the urgency

There is evidence across the PCTs of GPs successfully increasing access for patients. Examples include:

- Some GPs have broadened their opening hours and introduced innovative ways by which patients can book appointments. For example in Kingston one GP service allows patients to book online.
- Newham PCT funds GP appointments to treat patients with non-emergency care needs at certain times of day and in the evening
- In Kingston some GP surgeries are issuing pamphlets to patients to explaining access options and discouraging A&E attendance
- GPs have one hour slots each morning when they answer the telephone in Newham focused on unscheduled care patients

8.2.6 Urgent Care Centres

Description

This improvement opportunity concerns the increased provision of generalist UCCs aligned to A&E departments. The A&E department then becomes more akin to the US model of an 'emergency room'.

There could though be room for two models in London: one on the front of each acute hospital where the next step would be Emergency Medicine (A&E), Acute Medicine or Surgery; the other might be free standing, perhaps co-located with a local (community) hospital and/or part of a 'polyclinic'.

These models reflect the proposals for UCCs described in 'A Framework for Action'.

This recognises that a significant proportion of patients prefer to access A&E services because they see it as a means of accessing comprehensive care quickly. One of the challenges with the WIC model is that when newly opened they take a while to ramp up utilisation as it requires patients to change behaviour. One key benefit of the UCC model is that it does not require a change in patient behaviour.

Commissioning enablers and challenges

Delivering this improvement opportunity successfully would require a number of challenges to be addressed by commissioners:

- Raising public and clinician awareness on the role and services of UCCs
- Developing the right model for triage at the UCC i.e. it should be carried out by appropriate primary care professionals (GP or emergency care nurse practitioners). This may require the development of the GP with Specialist Interest role and/or emergency care practitioner role for employment in the UCC to ensure effective triage and treatment
- Developing and agreeing appropriate transition arrangements to incentivise A&E providers to accept reduction in revenues as activity is diverted to alternative settings. This is complicated however by the lack of suitable tariff for community based services

Examples found across the six PCTs include:

- The WIC and UCC in Charing Cross Hospital A&E ensures that many unscheduled care patients are dealt with quickly. This UCC has GP sessions, hosted by the PCT and Imperial College Trust demonstrating excellent integration of nurse and GP services
- The Royal Free Hospital is currently piloting a primary care front end at their A&E
- However from the analysis of the impact of the introduction of the Whipps Cross model, there is some evidence to suggest that whilst the UCC deflects demand from A&E, overall activity across both access points has increased significantly

Case Study - Waltham Forest Urgent Care Centre

A patient in Waltham Forest attends Whipps Cross Hospital thinking that their condition is serious enough to use A&E. They find that they are only able to access the Emergency Urgent Care Centre (EUCC). Staff at the EUCC consider the patient's condition. They decide that the patient's condition is not serious enough to merit use of

Case Study - Waltham Forest Urgent Care Centre

A&E so, instead, treatment is provided by primary care professionals in the EUCC. The patient leaves the EUCC satisfied with the care provided and happy that reasons that they were not transferred to A&E were clearly explained to them.

8.2.7 Better provision of specialist client group services e.g. for the elderly and paediatrics

Description

Establishing specialist client group care services to focus on particular needy patient groups. Again these could be positioned at the front end of A&E, targeting those who attend inappropriately, or with existing services or standalone or within a polyclinic.

Commissioning enablers and challenges

Delivering this improvement opportunity successfully would require a number of challenges to be addressed by commissioners:

- Raising public and clinician awareness on the role and services for UCCs
- Developing the right model for triage at the UCC - should be carried out by appropriate primary care professionals (GP or emergency care nurse practitioners)
- Developing the GP with Specialist Interest role and/or emergency care practitioner role for employment in the UCC to ensure effective triage and treatment
- Developing and agreeing appropriate transition arrangements to incentivise A&E providers to accept reduction in revenues as activity is diverted to alternative settings.

8.2.8 Improving current models of provision

Description

Rather than setting out a new model of service provision for unscheduled care this scenario is concerned with improving the benefit that existing models provide. Stakeholders offered several ways in which this could be achieved including:

- **Ensuring that supporting services e.g. diagnostics (pathology, x-ray), pharmacy are available to the access point** and that the operating hours for these supporting services are aligned with those of the access point. More generally, it was noted that improved access to diagnostic tests and their results would improve the service that GPs could provide to patients and should result in a decrease in GP referrals to A&E.
- **Stakeholders highlighted that a change in behaviour of healthcare professionals would be a key way of initiating change across the services**. In particular the idea of a coordinated 'health care community' working together, rather than primary or secondary care, was put forward by a number of stakeholder groups. It was felt that the primary and secondary care terms are becoming increasingly unhelpful and stakeholders recognise the need to work together to find solutions in a more holistic and proactive way.

- **Effective communication between the various access points was recognised as being a key requirement for good continuity of care.** There is a lack of communication between and transfer of patient information across access points. There is a lack of confidence in the quality of patient details being captured and transferred at various access points. Stakeholders felt this is particularly true for the interface between primary care GPs and A&E clinicians. Currently there are pockets of good practice that exist, for example, GP OOH services email or fax GPs if they see a patient on their rounds during the night so they are aware and can act. There is a strong desire to join up access points more effectively with IT solutions to ensure that patients receive seamless care.
- **The deployment of emergency healthcare practitioners around the community to prevent unnecessary attendance at A&E.** The role of the Emergency Care Practitioner (ECP) was identified as a success in Barnet PCT. These practitioners are deployed by car to the site of a reported emergency medical incident and where possible, treat the patient locally, thus preventing their attendance in A&E. When utilised correctly it has been found that Barnet ECPs can prevent 40% of patient attendances in A&E.
- **Well-trained reception staff – the first point of contact for many unscheduled care patients – can steer the patient onto the optimum pathway**. Conversely, poorly functioning reception staff can overload their GPs with unscheduled patients who in fact could have been dealt with differently and leads to patients feeling frustrated.
- **Driving down the rates of unregistered patients**. One of the reasons why non-acute patients present at A&E is that they are either not registered with a GP in London, or their GP is elsewhere (transient or commuter population). Initiatives developed by various PCTs to get patients registered with GPs have been identified as successes. Newham University Hospital A&E has a system where unregistered patients can be registered when they are attending A&E. In Hammersmith and Fulham, Charing Cross Hospital A&E department have Primary Care Advisors who register non-registered patients and advise on where they could access care for their current condition instead of staying in A&E. According to stakeholders in the PCT this has decreased the numbers of non registered patients presenting in the A&E from over 20% to below 10% each day.

Case Study - Primary Care Advisors at Charing Cross

A patient attends Charing Cross Hospital A&E Department suffering from a migraine. The Primary Care Advisor (PCA) at the hospital asks the patient whether they are registered with a GP. On finding that the patient is not registered with a GP, the PCA registers the patient with their local GP, advises the patient that they should purchase some migraine relief tablets from a nearby 24 hour pharmacy and should book an appointment with their GP over the next few days to discuss the causes of the migraine.

- **Driving up public awareness of how and when to use these access points**. Barnet General Hospital A&E department has found their information system to work well. This system, available in the A&E waiting room, informs patients where they can access the local WIC, pharmacies and local GP out-of-hours services rather than staying in the A&E department and waiting for care. Kingston PCT has practices who have taken the initiative to educate patients about unscheduled care. They call patients who have attended A&E recently to see if they need follow-up, and to make them aware that they can attend the practice for care instead. Other practices are developing leaflets and information for patients informing them what unscheduled and scheduled care services are available to them locally and how and when to access them.

Case Study - Kingston GP Surgery

A patient attends Kingston Hospital complaining of stomach ache. Once the patient leaves A&E, staff at the hospital share the details of the patient's treatment with their GP. Admin staff in the GP's surgery call the patient to discuss the reasons for them choosing to attend A&E rather than using their GP. The practice staff will then

Case Study - Kingston GP Surgery

explain what A&E should and should not be used for and trying to persuade the patient to use their GP for similar unscheduled care issues in future. The practice then follow the call up by posting an information leaflet to the patient explaining services offered by various access points. The practice has found that this highly personalised approach has reduced the number of their patients using A&E when they could be using their GP.

8.3 Providing unscheduled care in alternative settings can potentially offer cost savings to PCTs

This section explores how different scenarios for seeing unscheduled care patients in alternative settings may impact on commissioning costs. A key barrier to reforming the unscheduled care system highlighted by stakeholders concerns tariff. A widely accepted fact is that the tariff does not adequately compensate providers for majors and over compensates for minors. Likewise the fact that unscheduled care in a primary care setting is funded by a capitation formula and in secondary by a tariff means that the incentives between the two systems contradict i.e. the incentive is to treat less patients in a primary care setting and more in an acute setting. Shifting more minors out of A&E will have significant consequences for the income streams for provider trusts. Healthcare for London has the opportunity to use the evidence of this study to work with the Department of Health to influence future tariff adjustments but will also need to work with commissioners across London to agree transition arrangements that will 'soften' the impact on providers as some of the proposed changes take effect.

The scenarios in this section consider how proportions of those patients presenting for minor conditions at A&Es can alternatively be seen at GP surgeries and WICs. In addition, the effect of reducing re-attendance to A&E for the same condition is also explored.

A note of caution must be made that this analysis explores the effect on current commissioning costs i.e. price, rather than the underlying provider costs as this was readily available during the study. The analysis uses the cost data provided in section 4 i.e. PCT data submitted to the Healthcare Commission. It would be worthwhile conducting further work to repeat the exercise using underlying costs of service provision but this would require significant further analysis.

The table below describes a range of scenarios for how unscheduled care patients, who currently attend A&E as minors might move to alternative care settings.

Table 5 Outline of scenarios for how unscheduled care patients, currently attending A&E as minors, may move to alternative care settings

Scenarios for shifting care to alternative settings		A&E	WICs	GP surgeries	Attendance avoidance
		Percent of attendances to alternative access points			
A. Baseline scenario - 100% A&E	A	100%			
B. More use of GPs	B1	80%		20%	
	B2	60%		40%	
	B3	40%		60%	
C. More use of GPs and WICs	C1	80%	10%	10%	
	C2	60%	20%	20%	
	C3	40%	30%	30%	
D. Reduction in re-attendances	D	95%	0%	0%	5%
E. Combination scenario	E	55%	20%	20%	5%

The baseline scenario (A) describes the current situation where patients are attending A&E for unscheduled care. Scenarios B1, B2, and B3 describes the effects when respectively, 20%, 40% or 60% of patients attending A&E as minors, seek treatment with their GP instead. Scenarios C1, C2, C3 investigate the effects of shifting care to a combination of GP surgeries and Walk-In-Centres. Next, scenario D looks at the effect of reducing re-attendances to A&E for the same condition by 5%. Finally, Scenario E, considers the combined effects reducing re-attendances, and moving some care to GPs and WICs.

The table below shows how a shift in care setting may impact on the costs of commissioning unscheduled care services. The example outlines the cost impact of shifting care settings of those currently attending A&Es for the six PCTs involved in this study.

It is estimated that the 1.3M PCT residents in the 6 PCTs, will have about 520,000 attendances to A&Es during a year in total. From local A&E data, it is known that the patients attending A&Es as minors, constitute between 40 and 60% of all attendances. Thus, the PCT residents will have approximately 250,000 minor attendances during the year. If we assume an average A&E minors tariff of £56, the total commissioning cost of these A&E attendances is about £14M, and this constitutes our baseline scenario.

Table 6 Estimated commissioning cost for 250,000 patients across the six PCTs

			A&E	GP surgeries	WICs	Total commissioning cost
Average cost per attendance		[£]	£56	£27	£25	
A. Baseline scenario	A	[£000]	£14,000	-	-	£14,000
B. More use of GPs	B1	[£000]	£11,200	£1,325	-	£12,525
	B2	[£000]	£8,400	£2,650	-	£11,050
	B3	[£000]	£5,600	£3,975	-	£ 9,575
C. More use of GPs and WICs	C1	[£000]	£11,200	£663	£625	£12,488
	C2	[£000]	£8,400	£1,325	£1,250	£10,975
	C3	[£000]	£5,600	£1,988	£1,875	£ 9,463
D. Reduction in re-attendances	D	[£000]	£13,300	-	-	£13,300
E. Combination scenario	E	[£000]	£7,700	£1,325	£1,250	£ 10,275

Data sources: NAO: NHS Pay Modernisation: New Contracts for General Practice Services in England, 28th Feb 2008 (GP cost per consultation approximated from: Total cost of GP services in 2006/07 : 7.7 billion / No of consultations: 290 million = £27 per consultation)

The table below shows the resulting average costs per attendance and change in costs compared with the baseline scenario.

Table 7 Summary of how commissioning costs are impacted by seeing patients presenting for unscheduled care in alternative settings

		Average cost per attendance	Estimated net saving compared with scenario A [£'000]	Percent saving compared with scenario A
A. Baseline scenario	A	£56	-	0%
B. More use of GPs	B1	£50	£1,475	11%
	B2	£44	£2,950	21%
	B3	£38	£4,425	32%
C. More use of GPs and WICs	C1	£49	£1,512	11%
	C2	£43	£3,025	22%
	C3	£37	£4,537	32%

		Average cost per attendance	Estimated net saving compared with scenario A [£'000]	Percent saving compared with scenario A
D. Reduction in re attendances	D	£53	£ 700	5%
E. Combination scenario	E	£41	£3,725	27%

This shows that commissioners might save up to 32% per minor patient who currently attend A&E, if patients seek care in alternative settings. The estimated potential net savings across the 6 PCTs range from £700 to £4.4M by scenario.

9 Proposed next steps

This section sets out proposed next steps for the Healthcare for London Unscheduled Care Project to consider as it shapes this agenda moving forward. The proposals have been organised into areas that require further investigation and analysis, as well as improvement actions that, if taken, would have more of an immediate impact on the quality of services across London.

9.1 Suggestions for further investigation and action

The Unscheduled Care Project should consider the following in respect to developing models of unscheduled care:

- Conduct a **joint commissioner and provider feasibility study into the development of UCCs** at the front end of all A&E departments across the capital, to reduce the number of patients attending A&E that could be effectively treated in an alternative setting. This will need to explore the implications for costs, workforce and impact on A&E departments and provider revenue and set these in context of the overall benefits. However, the wider potential for this model to increase overall demand on the system as has been suggested by the example at Whipps Cross, should be further investigated as part of this work.
- Conduct a **joint commissioner and provider feasibility study into the development of care centres targeting specific client or disease groups** e.g. paediatrics, elderly, mental health or musculo-skeletal services, to provide a tailored and more effective range of care and reduce propensity for these groups to attend at A&E. Again, the implications for costs, workforce and impact on provider revenue would need to be examined and set within the context of the overall benefits.
- Further **definition work is required to set out exactly how a single telephone number for London would work in practice and deliver real benefit for patients**. This would need to consider the various options that current and future technology will allow, joining up with the National Programme for IT agenda. It would also need to consider the implications of the introduction of a national single three digit telephone number and there may be a timely opportunity here to join up with the Department of Health as they are planning to commission such a study in May 2008.
- **Reduce the number of patients with long term conditions from entering the unscheduled care system** by ensuring that the best practice models within and outside of London are shared, developed and properly implemented. It is clear that differing models have been adopted across the PCTs in this study with different degrees of emphasis. Therefore, this will afford some opportunity to share learning across PCTs and a real opportunity to share best practice and implement an end to end model.
- **Exploit the capability and capacity of pharmacies to play an increasing role** in the delivery of unscheduled care services. In particular this work should consider whether the extension of the popular minor ailments schemes would deliver real benefits for patients and value for commissioners.

The Unscheduled Care Project should consider the following in respect to future commissioning processes:

- **PCTs should review the opening hours of unscheduled care access points across their own patches and ensure that there is effective coverage through peak periods.** This should include ensuring that there is access to support services for them e.g. diagnostics and pharmacy. This is likely to involve encouraging PBC consortia to examine how GP scheduled and unscheduled care access is supported and the effectiveness of the coverage of OOHs provision.
- **Identify the key information flows across the unscheduled care system that will facilitate the management of care pathways, increase patient safety and provide management information to support commissioners and providers in improving services**. This study has provided a rich source of information to support commissioning decisions for the future, however, much of the information would be valuable on an ongoing basis both for commissioners and providers to improve services for patients. This will mean ensuring that the future technology requirements to support a more joined up unscheduled care service are developed closely with the National Programme for IT.
- **Develop commissioning transition arrangements to avoid destabilising A&E providers.** A key barrier to reforming this system is the widely accepted fact that the tariff does not adequately compensate providers for majors and over compensates for minors. Shifting more minors out of A&E will have significant consequences for the income streams for provider trusts. NHS London has the opportunity to use the evidence of this study to work with the Department of Health to influence future tariff adjustments but will also need to work with commissioners across London to agree transition arrangements that will 'soften' the impact on providers as some of these changes take effect
- **Develop pan London mechanisms for sharing good practice.** Stakeholders commented through this study process that one of the benefits had been the opportunity to come together and share good practice. This could be more formalised as the Unscheduled Care Project agenda develops and grows to stimulate the right environment for innovation and change.
- **Develop a public and clinician awareness and information campaign** to develop understanding the unscheduled care system and how to access it appropriately and effectively
- **Develop a set of commissioning principles and guidance that underpins the results of this and future work to support PCTs in developing models of unscheduled care.** In developing local strategies and models for unscheduled care PCTs should be looking to take a whole systems approach bearing in mind some of the patient and system behaviours highlighted by this study. In particular they should be seeking to strike the right balance between prevention, access and navigation (and redirection). This guidance should also afford the opportunity to determine what should be pan London and what should be locally driven. There is appetite amongst stakeholders and patients to see an emphasis on a pan London approach.

Appendix A: Outline of care provision

A.1 Accident and Emergency

Every PCT has at least one A&E department serving the local population. The size of the departments differs between PCTs. The table below gives an estimation of size through annual activity and number of Consultant posts. The way patients access and flow through A&E differs between hospitals. The major differences are explained in the table below.

PCT	Barnet PCT	Camden PCT	Hammersmith and Fulham PCT	Kingston PCT	Newham PCT	Waltham Forest PCT
Activity Volumes	Barnet General 76,000 patients	UCLH 92,000 patients Royal Free Hampstead 76,000 patients	Charing Cross 70,000 patients Hammersmith 30,000 patients	Kingston Hospital 98,000 patients	Newham University Hospital 87,000 patients	
Number of consultants	3	7 (UCLH) 6 (RFH)	5.4 (CXH) X (Hamm.)	4	6	
Comment and comparison	Charing Cross Hospital has a nurse led UCC style service (locally termed WIC) co-located with A&E department. This allows some transfer of activity in both directions Kingston Hospital has high activity volumes given the size of the population. Admission ratios are also high. Kingston is the only A & E without an observation unit, meaning that the Medical Assessment Unit can, at times, be stretched. UCLH in Camden is positioned in a more central London location resulting in more transient (e.g. commuters, students and tourists) user patterns Newham Hospital has a GP based in A&E . The GP self selects the patients appropriate to be seen. Transport links to the hospital are very strong, particularly compared to more community based services Whipps Cross has an urgent care centre which acts as the gatekeeper to emergency care services. Patients are triaged and appropriately streamed by primary care clinicians. The urgent care centre has led to some change in the access of unscheduled care. Since primary care physicians act as gatekeepers, this has the effect of limiting emergency care to when it is absolutely necessary. Hammersmith Hospital A&E is a smaller department with no trauma access. Services are scaled down outside of the core 0800-2200 hours					

A.2 Urgent Care Centres (primary care front end to A&E)

The models of triage and streaming in A&E vary considerably between hospitals. One of the fundamental differences is the way in which primary care attempts to ensure the acute services available at A&E are used most appropriately. One solution has been to develop some kind of primary care 'front end' to the service, often termed 'Urgent Care Centres'. Again there are different ways in which this is achieved as documented by the table below.

PCT	Barnet PCT	Camden PCT	Hammersmith and Fulham PCT	Kingston PCT	Newham PCT	Waltham Forest PCT
Structure	None	Pilot completed in Royal Free	Nurse led WIC style service	None	GP based in A&E part time	Full urgent care centre operational in Whipps Cross
Comment and Comparison	The results of the RFH pilot have not yet been published. The pilot developed a GP led urgent care stream for patients presenting with conditions within the fixed clinical protocols In Newham the GP self selects patients according to clinical appropriateness and capacity. The GP is only present for fixed hours every day. No patients are formally triaged to been seen exclusively by the GP The Charing Cross example, developed from a walk-in centre model, receives self referrals as well as patients who have been triaged by A&E. A minimal GP and ECP service is available. As well as receiving treatment, un-registered patients are given the opportunity of registering with a GP and booking an initial appointment Whipps Cross has the most developed urgent care centre of all the PCTs in the study. There has been a move away from the typical A&E model to an Emergency Care Centre and Urgent Care Centre (UCC) . Access to the 'Emergency Care Centre' (most acute setting) is only via the UCC or via ambulance. Patients are triaged and streamed depending on clinical urgency. GPs and nurses are a key element of the UCC staffing. Physically the two units are very close. The UCC has become the 'gatekeeper' to the hospital emergency services. All PCTs are considering a primary care led 'front end' to A&E in some way. These plans are at various stages of development ranging from tending the service (Newham) to feasibility and design discussions (Camden - in relation to UCLH)					

A.3 General Practice

Making comparisons of General Practice between PCTs is challenging because of the considerable variation between individual GP practices. The variations are unlikely to be based on PCT boundaries. Practices will differ in many ways, including list size, number of GPs, populations served, services offered and links to community providers, making generalities very difficult to draw,

The table below outlines the number of practices in each PCT and some of the good practice or innovations demonstrated by some of the practices in the PCTs.

PCT	Barnet PCT	Camden PCT	Hammersmith and Fulham PCT	Kingston PCT	Newham PCT	Waltham Forest PCT
Number of GP practices	74	42	32	29	69	50
Comment and comparison	Opening hours vary significantly. PCT trends are unlikely. In each PCT there are examples of where GPs have tried to extend or vary opening hours to better accommodate for population needs such as opening outside of usual working hours. In Camden and Newham some of the larger practices have developed comprehensive telephone consultation capability. This has made access to GP advice much faster and easier. It has allowed a larger number of patients to be reviewed and 'treated'. Often this may only be through advice although prescription and referral mechanisms have also been developed In Barnet some GPs have begun to pilot the idea of email consultation and advice. This is early in the development process, particularly given concerns regarding identity, security and robust clinical governances Some GPs in Kingston have started to offer online booking of appointments to improve availability. Where possible some GPs attempt to follow-up patients who have attended A&E to understand why the GP was not used instead. A small number of Camden practices are investigating the potential of open appointments for A&E dept to book into. This will allow a more robust handover of the patient hopefully preventing repeat attendances The flow of patient level information is very variable. With some PCTs doing some intensive work on ensuring the discharge summaries from A&E really provide the necessary information for GPs					

A.4 Pharmacy provision

Similar to general practice, the provision of pharmacy services is largely variable between individual providers. Although the direction of pharmacy provision can be influenced by the PCT, the majority of the providers are private companies and develop their own individual future plans.

Pharmacies are required to operate minimum staffing levels based on numbers of prescriptions but the overall service offering will vary depending on location and demographics of users, size, number of qualified staff and aspirations of the owner / manager. These differences are not PCT specific. The table below draws comparisons between number of pharmacies and some good or innovative practices found in some of the PCTs.

PCT	Barnet PCT	Camden PCT	Hammersmith and Fulham PCT	Kingston PCT	Newham PCT	Waltham Forest PCT
Number of pharmacies	78	63	41	30	63	59
Comment and comparison	Minor Ailments scheme operates in Camden, Kingston and Newham. It has been piloted in Hammersmith and Fulham but not yet rolled out. The scheme allows users access to a limited number of medicines directly through the pharmacist rather than the GP. Private testing is being taken up by pharmacies in most PCTs. These are simple diagnostic tests for conditions such as high cholesterol, diabetes and some STDs Medicines review scheme has been praised as particularly successful in Hammersmith and Fulham PCT Each PCT pharmacy provision includes some of the larger providers as part of national chains. In many cases it is these that provide the longer opening hours. This has been particularly noted in Waltham Forest PCT An increasing number of pharmacies have taken on education roles in their communities offering seminars and training sessions on health promotion and the management of specific conditions Every PCT has examples of the increasing consultative role pharmacists are taking in the management of conditions. The development and use of a consulting room allows for the obtaining of a more complete history and understanding of condition before treatment.					

A.5 Walk-in centres

The nature of a walk-in centre, given the common skill mix and establishments, often results in the service offerings being quite similar. The biggest differentiators will be size, location and local population demographics. The table below explains how the WICs located in the six participating PCTs differed

PCT	Barnet PCT	Camden PCT	Hammersmith and Fulham PCT	Kingston PCT	Newham PCT	Waltham Forest PCT
Activity	Edgware: 40,000 patients Finchley: 40,000 patients	No WIC	Parson's Green 20,000 patients	No WIC	Newham University Hospital Trust (NUHT) site: 57,000 patients	No WIC
Comment and comparison	The location of the Newham WIC on the main hospital site allows for some flow and transfer of activity between the two sites. The central location, supported by strong transport links, makes the service very accessible The Parson's Green service is relatively small and services a largely residential population. The staff rotate between the Charing Cross 'walk-in centre' and this site resulting in a highly skilled workforce. The two Barnet facilities have very similar service offerings amended to reflect the different demographic user trends. Camden, Kingston and Waltham Forest do not have walk-in centres although they are being considered. Anecdotally the Soho walk-in centre (Westminster PCT) is used by patients of south Camden.					

A.6 Community services

Community services, including; community matrons, intermediate care teams and mental health services, play a role in unscheduled care in each of the PCTs. The part that community services play in unscheduled care differs between PCTs, but their primary focus is on prevention and early intervention (meaning that people do not need to have contact with unscheduled services) and post unscheduled care provision (providing care plans and sustained care in the community). This is the case across the PCTs.

The community based service that has the biggest impact on unscheduled care is mental health services, as patients attending with mental health issues have a considerable impact on A&E. All of the PCTs have mental health crisis and intervention teams, which work with A&E, as well as general community mental health services. Community services provided are generally similar across PCTs.

A.7 NHS Direct

NHS Direct provides a full service across the PCTs. It should be noted that NHS Direct operators also supply the telephone part of most of the Out of Hours services across the PCTs.

A.8 London Ambulance Service

The London Ambulance Service has an important role to play in the provision of unscheduled care across the capital. Ambulances generally take patients straight to A&E, with as many as a quarter of people arriving at A&E arriving by ambulance. The most noticeable difference across the PCTs is in Barnet, where Emergency Care Practitioners treat some of the lower priority 999 calls in the patient's home.

A.9 Information flows between access points

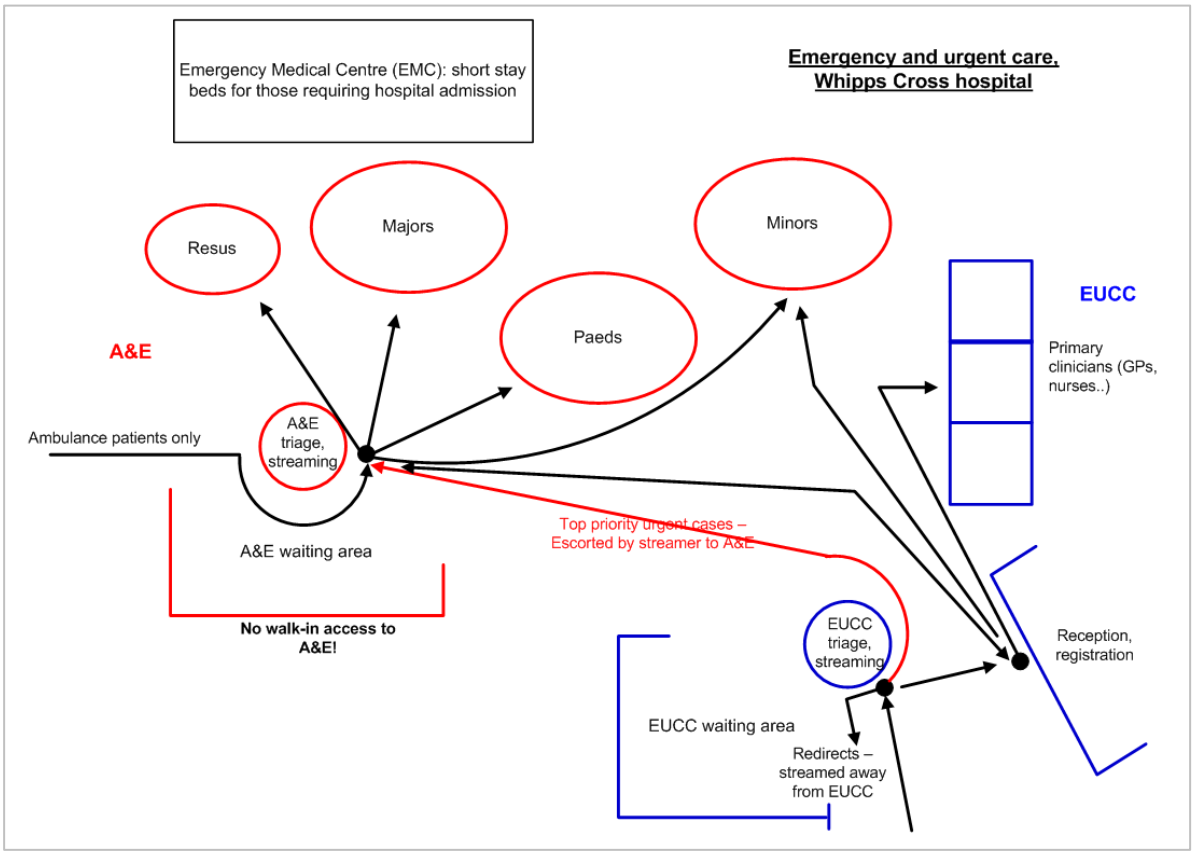
In all PCTs, the information flows and general communication between different access points was found to be limited. Although detailed information about the IT systems used in the flow of information was not collected in any detail as part of this study, it is clear that the IT systems used for referrals and other communications are not as joined up to allow the flow of information between access points.

A.10 Whipps Cross A&E and EUCC

All acute medical care in Waltham Forest is delivered in Whipps Cross University Hospital (WCUH). This care is delivered via two centres, A&E which houses Majors, Minors, Resuscitation, and emergency Paediatrics, and an urgent care centre, EUCC which is a primary care resource and to which all pedestrian patients are directed.

If staff there deem a patient's condition to be acute enough, they are then transferred to A&E (100m away). There is no pedestrian access to A&E, however ambulance-borne patients arrive there. If A&E staff deem a patient's condition to be urgent but not emergency, then the patient is transferred to the EUCC. The diagram below illustrates the patient pathway through Whipps Cross EUCC and A&E department.

Figure 49: Whipps Cross EUCC model



Appendix B: A&E attendance rates per PCT population

This section outlines our methodology for estimating the total number of A&E attendances for the resident population in the six PCTs. The estimated number is computed by combining data that is available from the Secondary Uses Service (SUS), local A&E data and information from the Hospital Episode Statistics.

The SUS A&E database should ideally record all A&E attendances for PCT residents at A&E departments both within and outside of PCT boundaries. However, this is limited because some A&E departments are currently not providing information to SUS. Therefore, for Hammersmith and Fulham PCT, where the A&E departments do not submit data to SUS, the SUS data has been complemented by local A&E data from Hammersmith and Charing Cross A&E department. In addition, a measure of the completeness of A&E data for each PCT has been approximated by comparing A&E attendance data with admitted patient data. Admissions data includes hospitals without A&E departments so the total would be lower than 100%, but for comparability it has been uplifted to 100% for all PCTs.

Table 50: Calculation of A&E attendances per 1000 population per year

	Barnet	Camden	H&F	Kingston	Newham	Waltham Forest
A. Total no of A&E attendances per population per year (1)	107,785	67,525	72,796	47,910	97,712	75,396
B Admitted patient episodes at hospitals where we have A&E data (2)	92%	92%	94%	78%	92%	95%
D. Estimated no of A&E attendances per population per year (uplifted) (3)	117,766	73,533	77,681	61,450	106,242	79,732
E. PCT population (in 1000)	314	220	166	150	242	242
F. Estimated no of A&E attendances per 1000 population per year	375	335	468	411	440	330

(1) Total attendances per year, estimated based on average no of attendances to A&E per month as provided in (SUS 01/04/07-31/12/07 and local A&E data for Hammersmith and Charing Cross A&E (incl. WIC at t. at CHX A&E) (01/04/07-01/01/08)

(2) Percent of admitted patient episodes that take place at hospitals that have submitted A&E data to SUS (HES 0506)

(3) Estimated number of total attendances per year uplifted to 100% by taking (A)/(B)

The estimate of data completeness (B) shows that the availability of A&E data is similar across PCTs, except for Kingston, where a significant number of the population attend A&E at St George's Healthcare NHS Trust which does not provide A&E data to SUS.

Appendix C: Unscheduled care activity

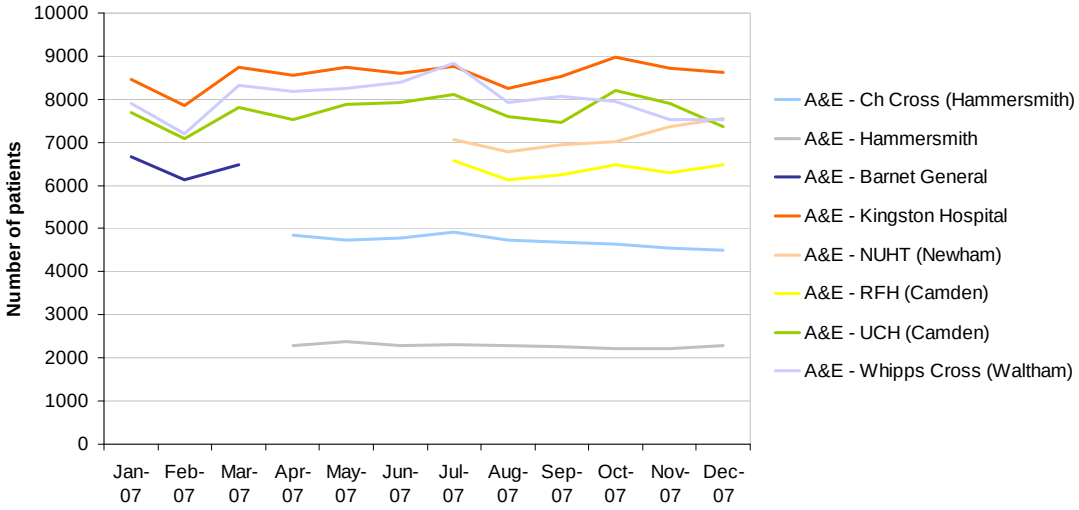
C.1 Unscheduled care services over a calendar year

Attendances to unscheduled care services are mostly stable over the year. However, there is a notable Christmas peak in activity for NHS Direct and some GP out of hours services (GPOOH)

A&E yearly activity volumes

The chart below shows monthly numbers of A&E attendances for each of the eight A&E departments who participated in the study.

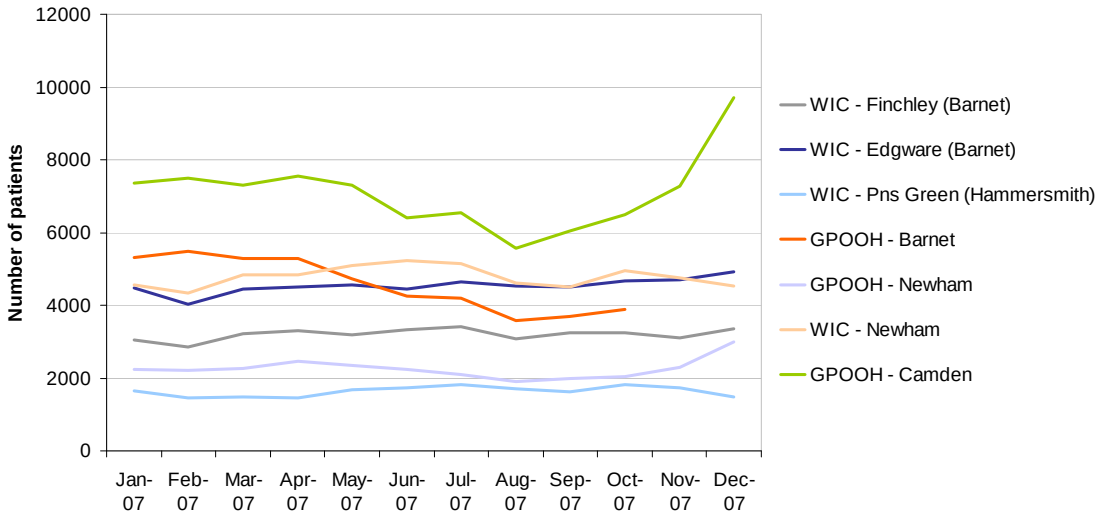
Figure 51: Monthly attendance volumes for A&E departments in 2007



WIC & GPOOH yearly activity volumes

The chart above shows monthly numbers of attendances to walk-in centres and the number of patients using GP out of hours services for each of the PCTs involved in the study. (Please note that the out of hours service for Camden also covers Islington, Haringey Teaching and City and Hackney Teaching PCTs)

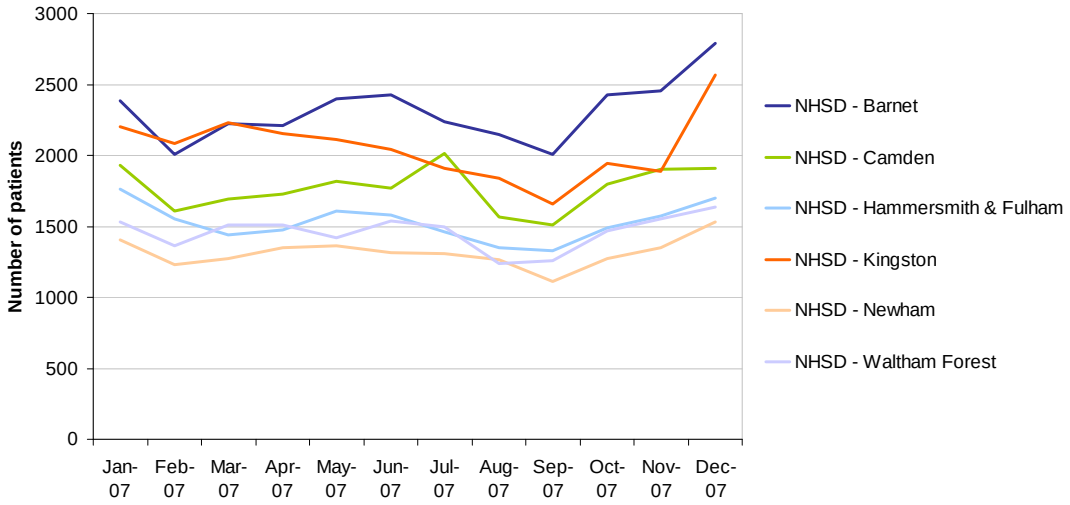
Figure 52: Monthly attendance volumes of activity for WIC and GPOOH services in 2007



NHSD yearly activity volumes

The chart shows monthly numbers of calls to NHS Direct for each PCT. The chart shows clear seasonality, with a marked dip in volumes across all PCTs during August-September and an increase in volumes up to December.

Figure 53: Monthly call volumes for NHSD in 2007



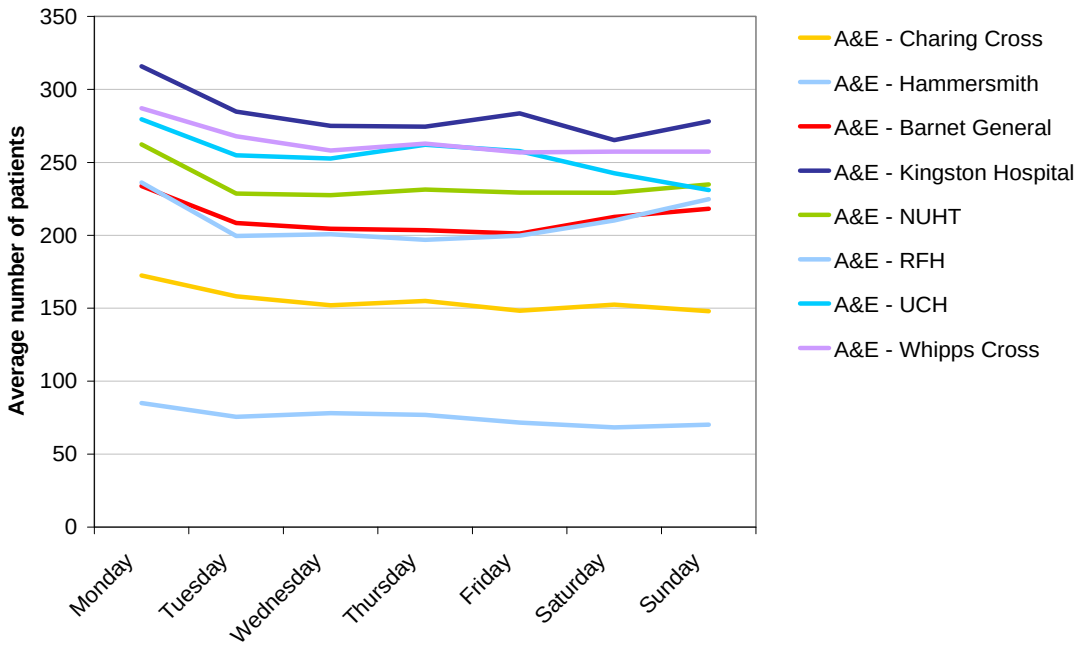
C.2 Unscheduled care activity over the week

Unscheduled care activity levels during the week are generally higher on Mondays than on all other weekdays.

A&E weekly activity volumes

For A&E departments, the daily volumes are fairly stable from Tuesdays through to Sundays.

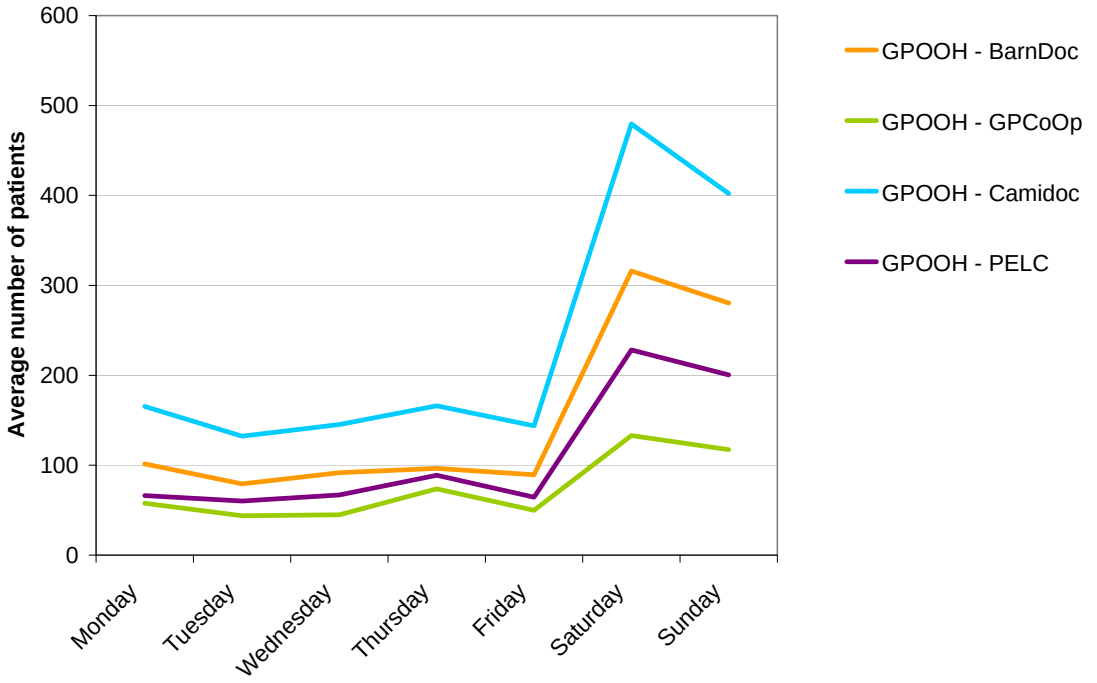
Figure 54: Daily attendance volumes to A&Es



GPOOH weekly activity volumes

GP out of hours call volumes appear to be greater over the weekend and GPOOH call volumes are greater on Thursdays when some GP practices are closed.

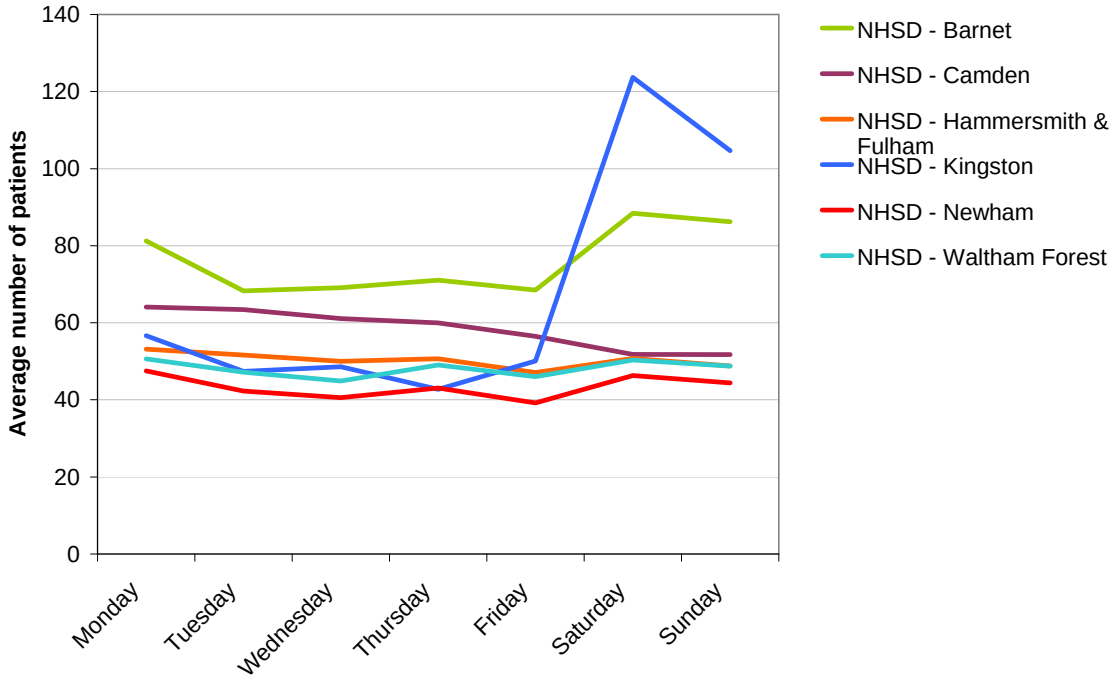
Figure 55: Daily attendance volumes over a year for GPOOH



NHSD weekly activity volumes

NHS Direct volumes are consistent throughout the week, with some PCTs peaking at weekends. The largest jump in weekend call volumes is seen in Kingston, where calls to the GP out of hours services are handled by NHS Direct call handlers, and patients requiring clinical advice are forwarded to GPs in Kingston Health on Call.

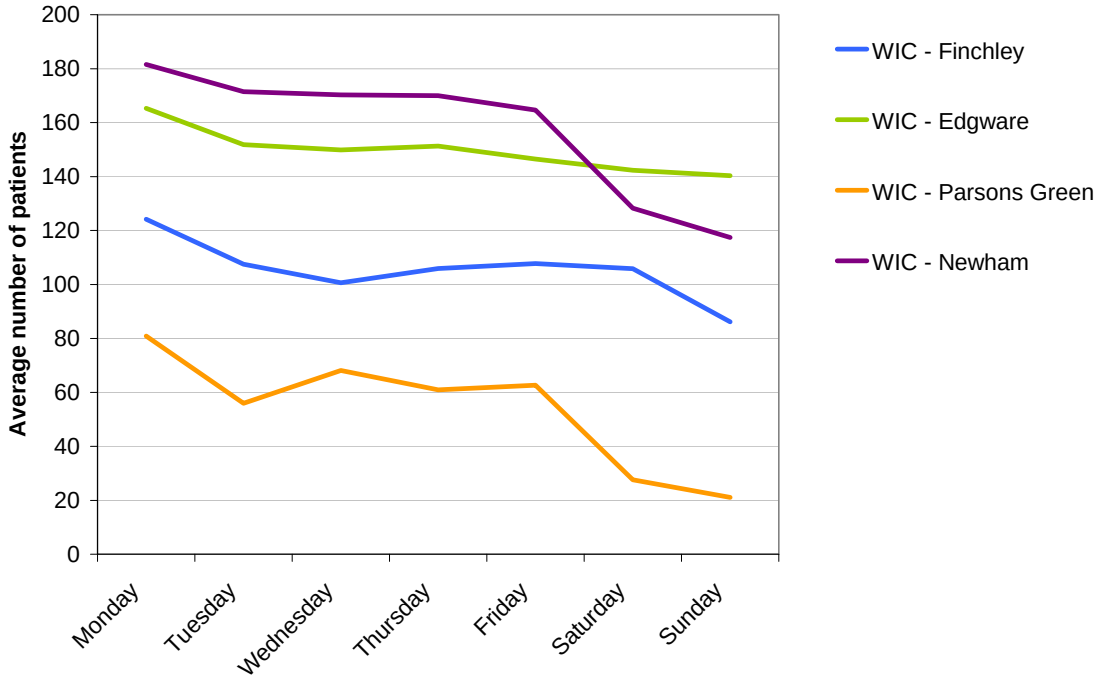
Figure 56: Daily attendance volumes over a week for GPOOH



WIC weekly activity volumes

Walk in centre attendances peak on a Monday similarly to A&E, but then appear to trail off slightly through out the week. There are lower attendances at weekends for most WICs.

Figure 57: Daily attendance volumes over a week for WICs



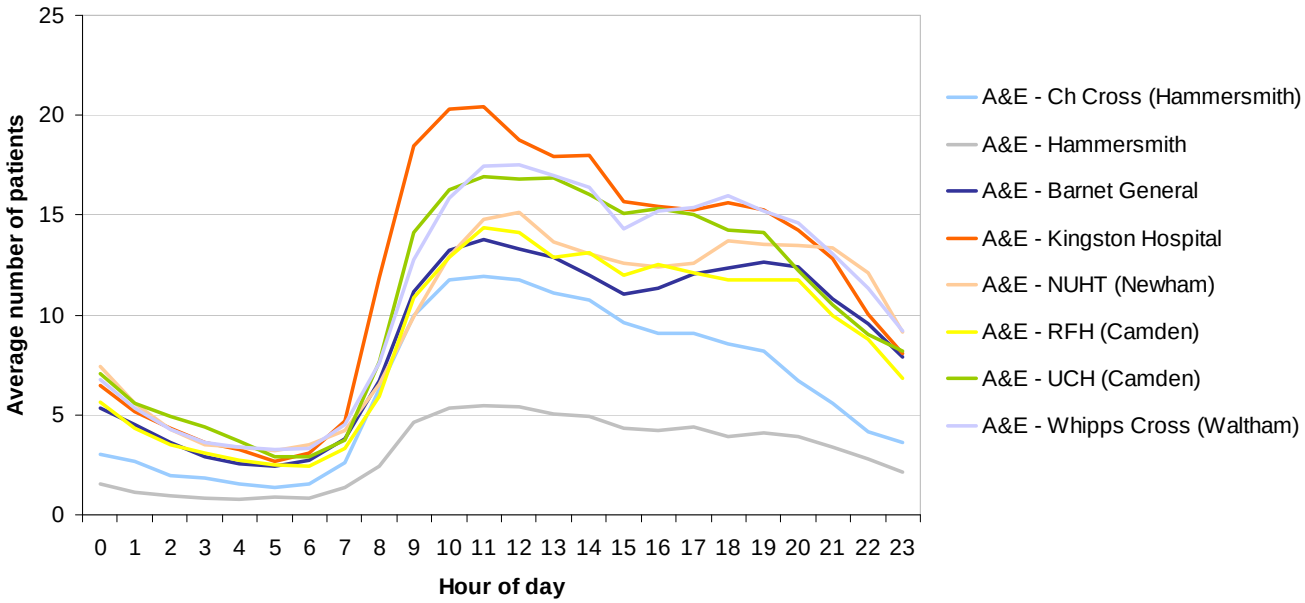
C.3 Unscheduled care activity over the 24hr day

This section examines how patients currently access unscheduled care services during the day. Whilst patient behaviour today is constrained by the services available to them at different times of the day, valuable insights can be gained by examining how patients behave within these constraints. This will be important in shaping future unscheduled care services.

A&E activity volumes over a 24hr day

The chart shows the total number of patients arriving during each hour of the day for an average month for A&E departments. Access patterns show that A&E departments are utilised to the greatest degree between the hours of 9am and 9pm. There is a particular peak between 11am and 1pm. Thus a potential shift of these patients from A&Es to alternative access points would probably require alternative services to be provided in this time window. This applies in particular to GP services which are a key alternative for patients accessing A&E services for minor conditions, and are mostly closed for lunch.

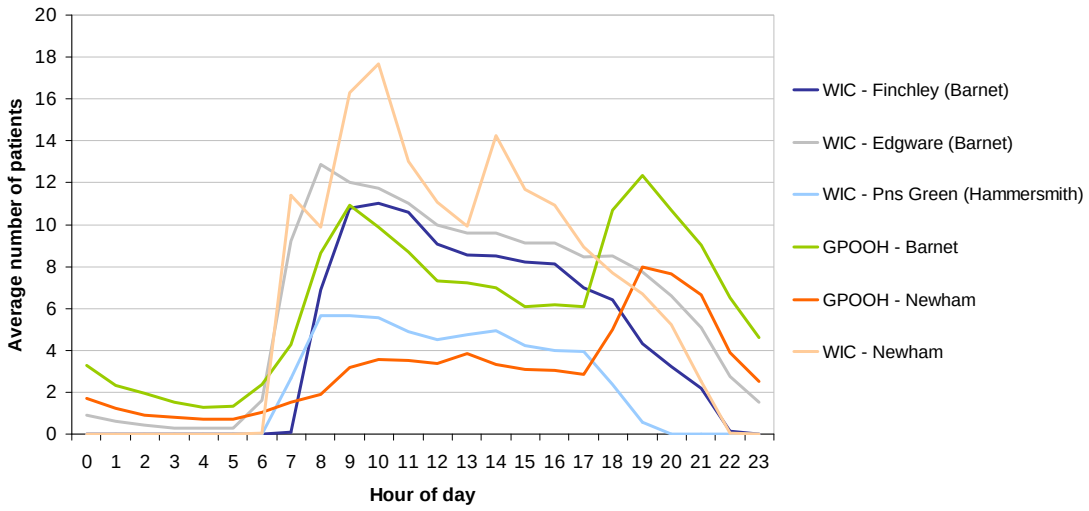
Figure 58: Hourly attendance volumes over 24 hrs for A&Es



WIC activity volumes over a 24hr day

The chart shows the average number of patients arriving/calling each hour of the day for GP out of hours services and walk-in centres. WICs vary in terms of their size and the services they provide. While these differences are reflected in the hourly activity profiles across each walk-in centre, they still broadly resemble the arrival distribution of A&E departments. Newham WIC has a second peak in activity at 2pm which may be explained by a greater propensity amongst the local population to use this service during working day lunch breaks. For out of hours services, evening calls peak between 7pm and 8 pm, and there are also calls during the day for weekends and bank holidays.

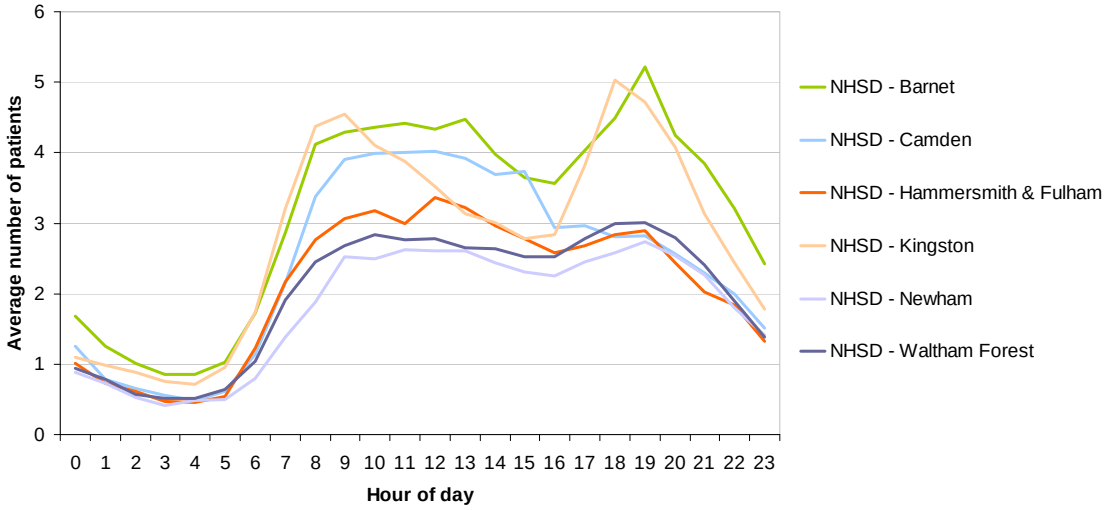
Figure 59: Hourly attendance volumes over 24 hrs for WICs



NHSD activity volumes over a 24hr day

The below shows the average number of calls to NHS Direct per hour of day. Most calls come in between 8 am to 7 pm, with a drop in activity around 4 pm.

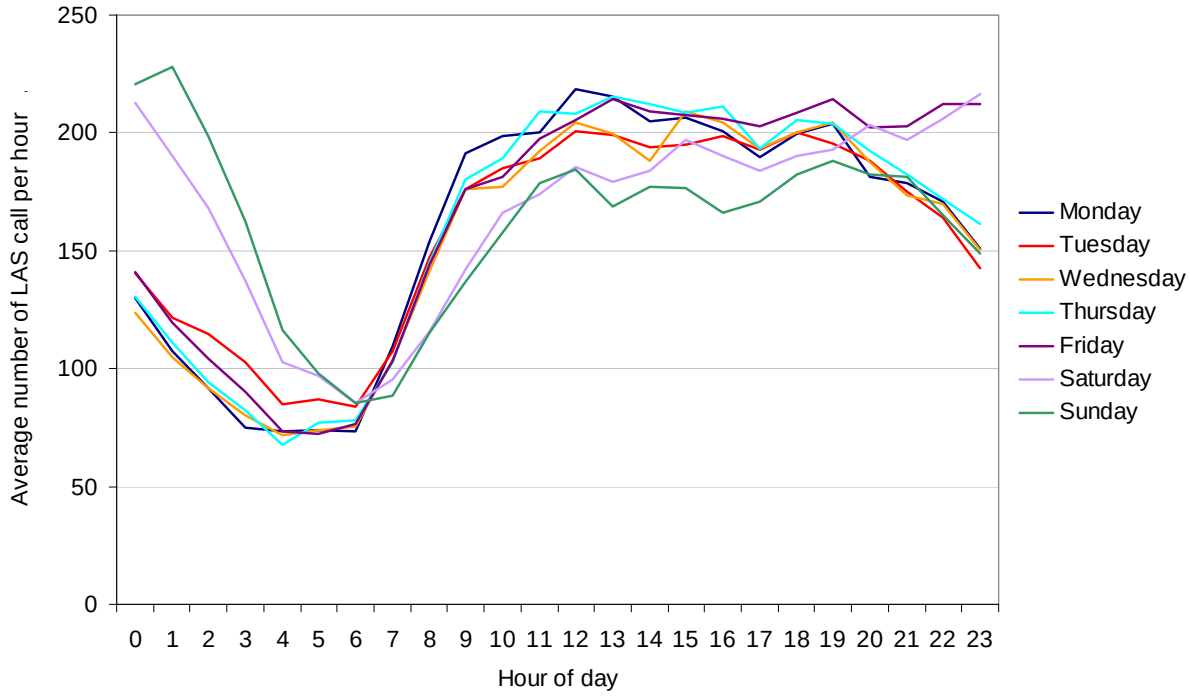
Figure 60: Hourly attendance volumes over 24 hrs for NHSD



LAS activity volumes over a 24hr day

For most days of the week, there are about 200 calls per hour to the London Ambulance Service. On Fridays and Saturdays, there are high numbers of calls until midnight. The lowest number of calls is between 2 am and 10 am.

Figure 61: Hourly call volumes over 24 hrs for LAS



C.4 Unscheduled care activity across all access points by PCT

This section examines the use of unscheduled care provided within each PCT.

Barnet PCT

Use of most unscheduled care services were relatively static for Barnet PCT during 2007. Of particular note is the sharp decrease in the GP out of hours activity in August. This appears to support the general trend nationwide for a downturn in out of hours requirements during the summer. The sharp upturn in both WICs at 7 am and 8am, respectively reflects the opening times for these access points. The 7 pm to 9 pm uplift in Barndoc volumes is shadowed by a similar uplift for NHSD possibly reflecting that patients are aware of both and self select whether they feel they need to talk to a GP rather than a nurse/call handler.

Figure 62: Monthly activity volumes over 2007 for access points in Barnet

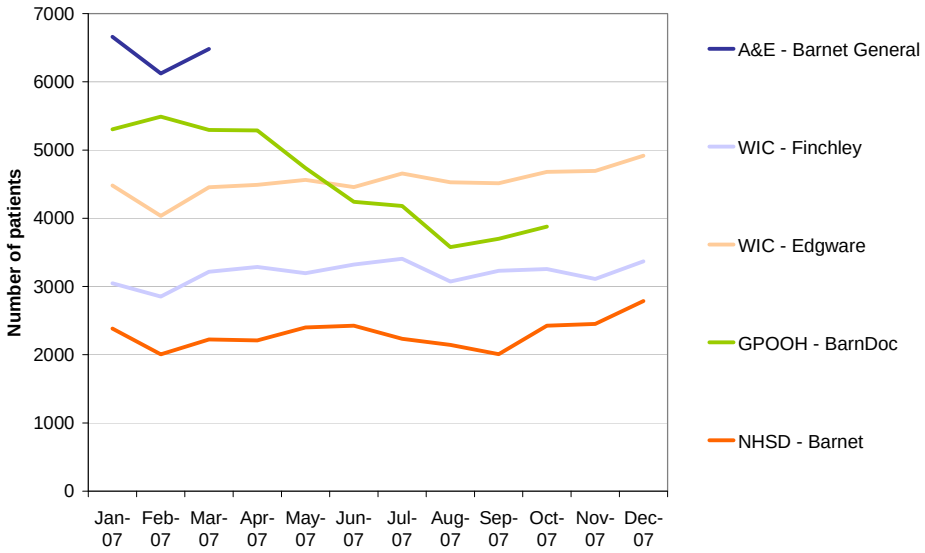
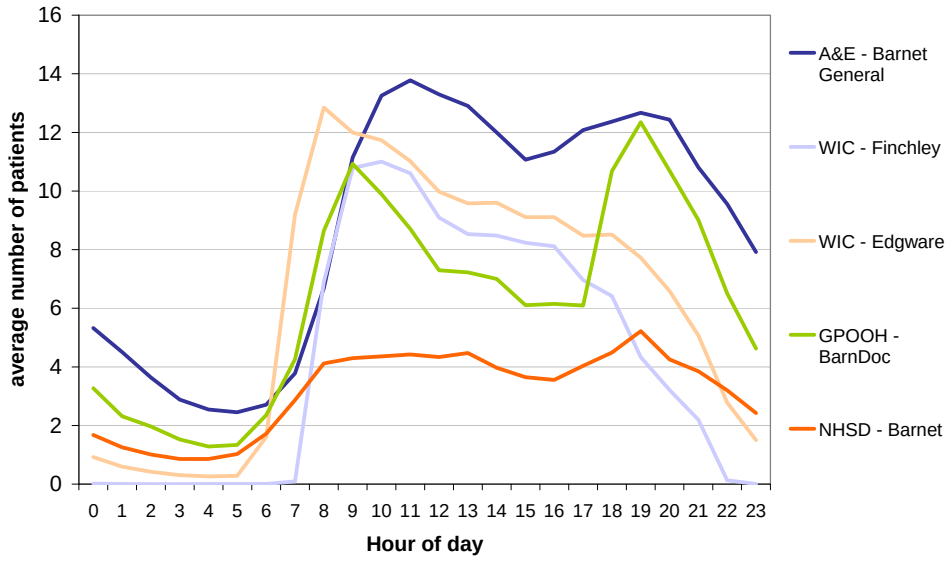


Figure 63: Hourly activity volumes over a day for access points in Barnet



Waltham Forest

The access patterns for Waltham Forest show a decrease in attendances to the EUCC during the summer, increasing again in November and December. The services are utilised to the greatest degree between 9 am and 9 pm. There is a particular peak between 11 am and 1 pm. Any potential shift of patients to alternative access points must take account of this daily activity profile.

Figure 64: Monthly activity volumes over 2007 for access points in Waltham Forest

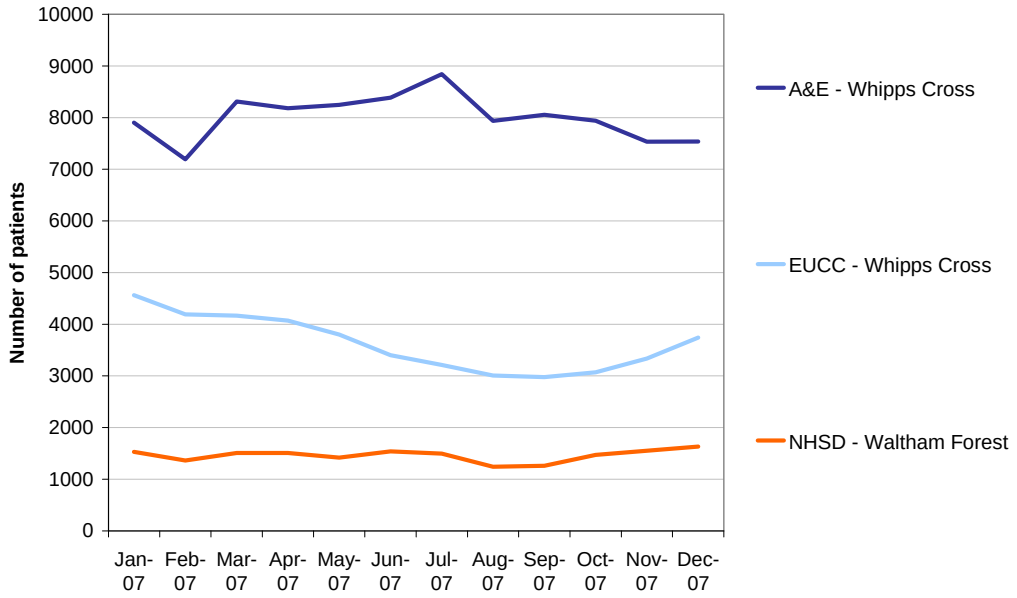
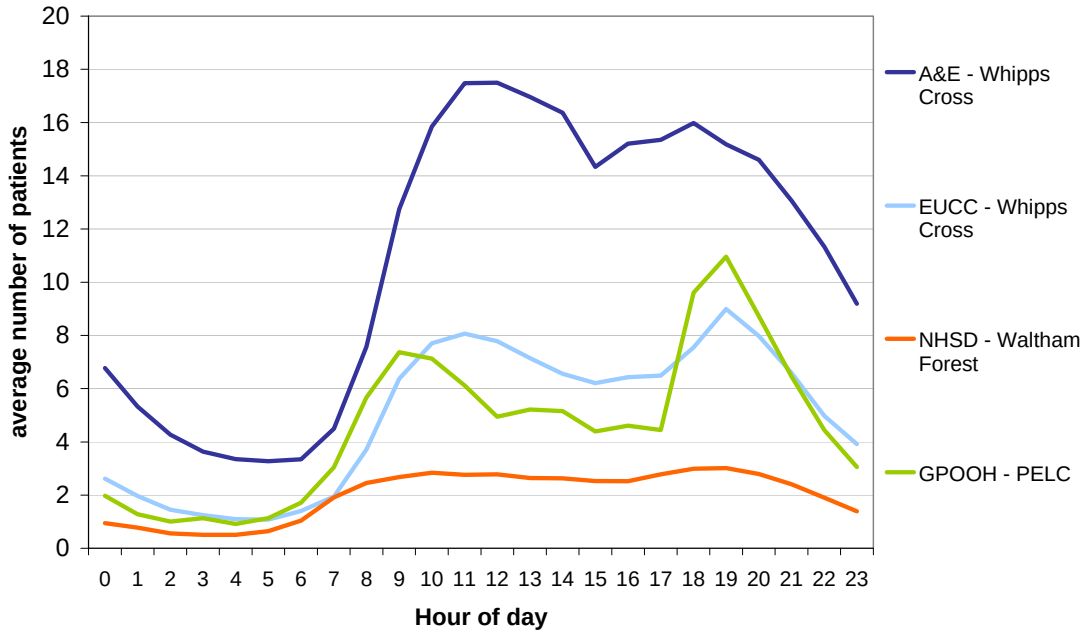


Figure 65: Hourly activity volumes over a day for access points in Waltham Forest



Newham

There is a peak in activity during the summer for Newham WIC and the expected dip in activity in August-September. In the early morning there are more attendances to Newham WIC than to the A&E department.

Figure 66: Monthly activity volumes over 2007 for access points in Newham

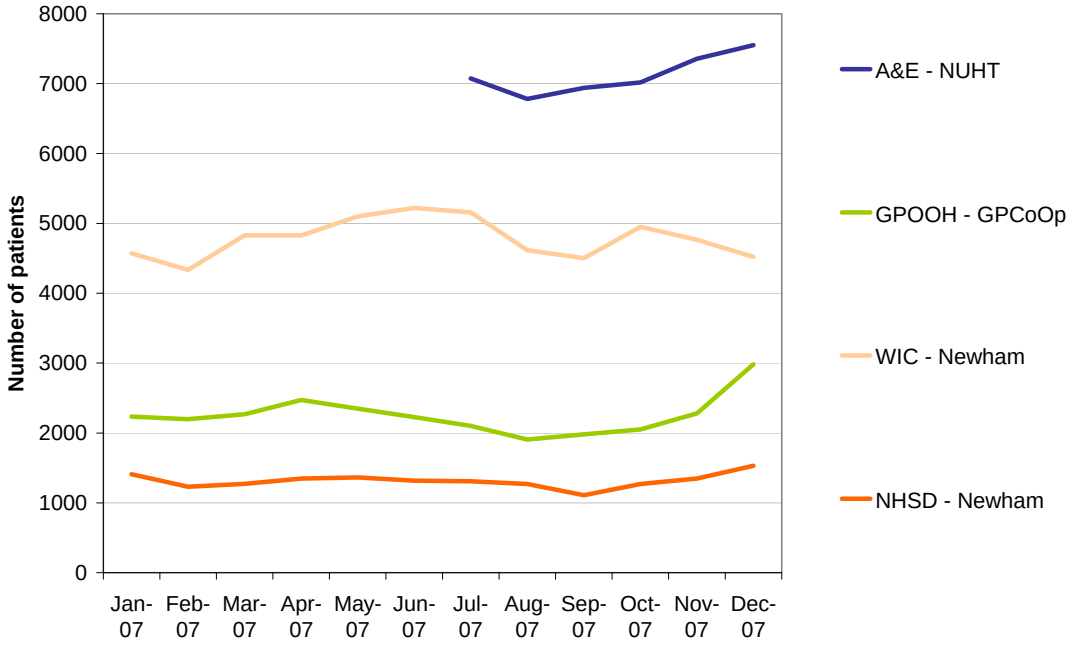
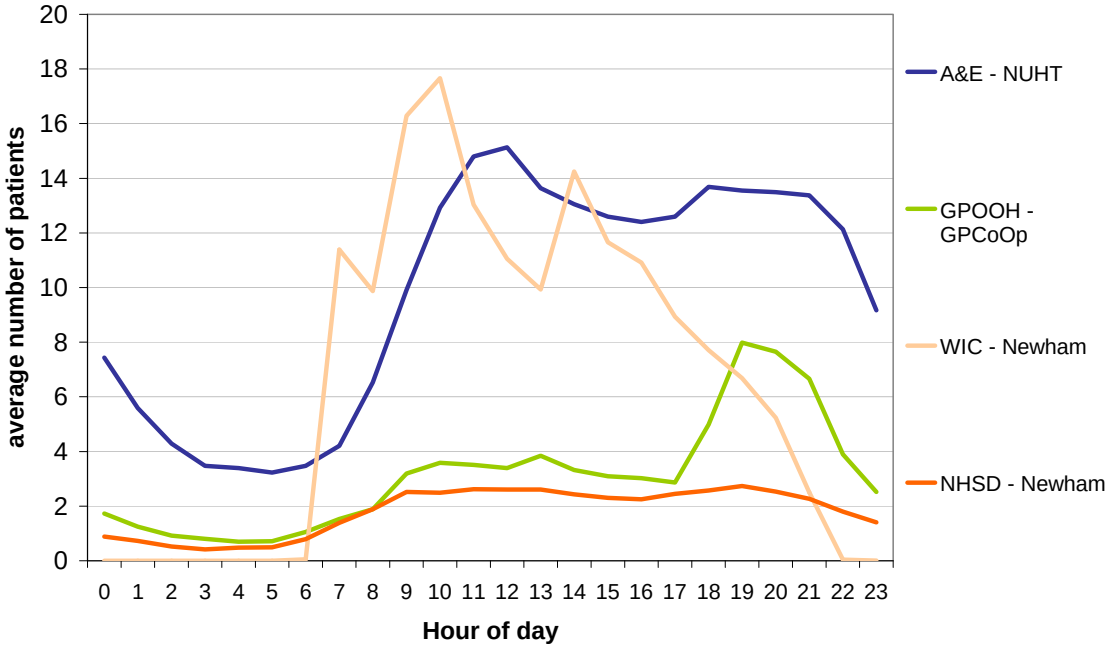


Figure 67: Hourly activity volumes over a day for access points in Newham



Kingston

Monthly attendance at A&E is relatively static across Kingston, other than minor dips in February and August. The chart also displays a substantial end of year peak for NHS Direct, with almost an extra 500 patients being advised by NHS Direct during the Christmas period. OOH also displays a noticeable peak during the festive season.

Figure 68: Monthly activity volumes over 2007 for access points in Kingston

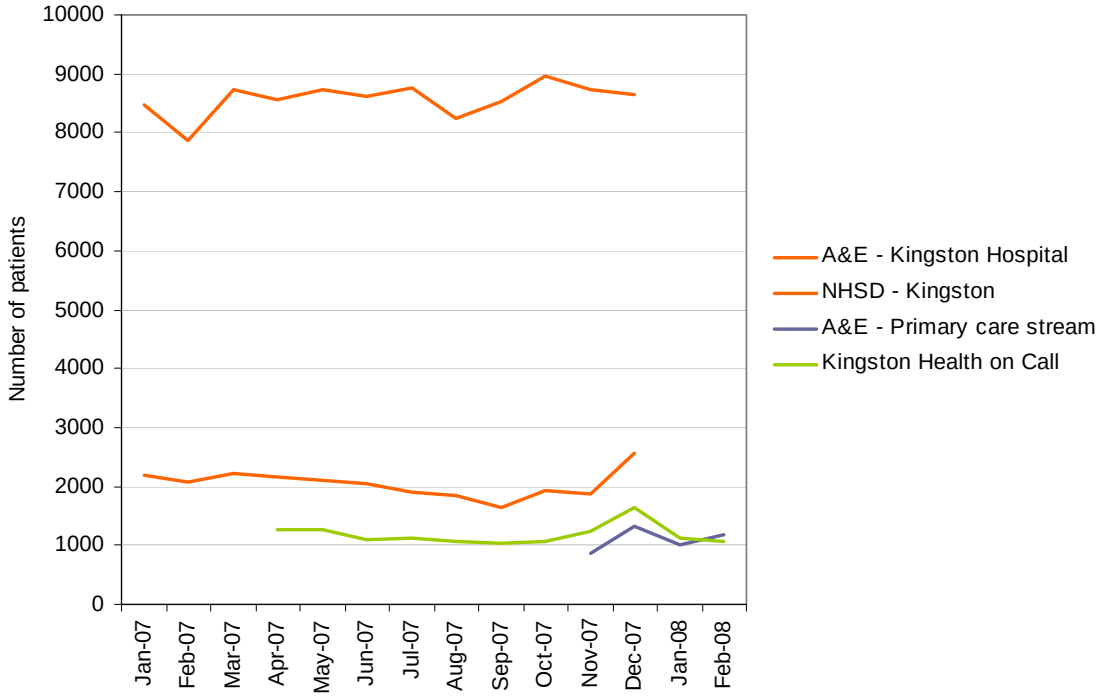
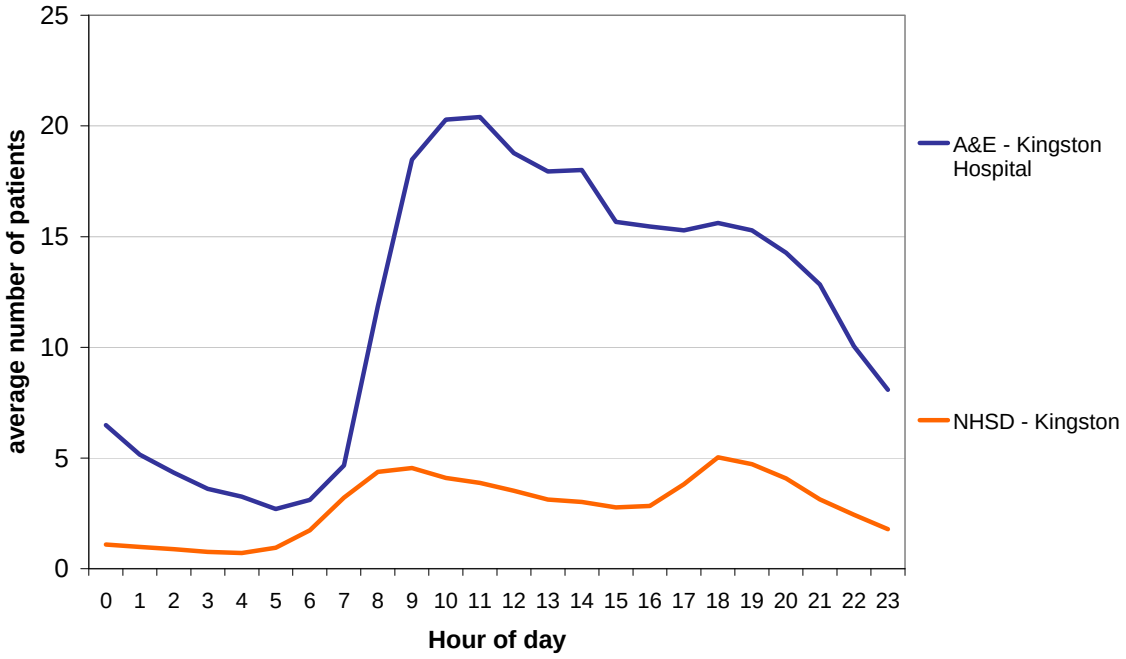


Figure 69: Hourly activity volumes over a day for access points in Kingston



Hammersmith & Fulham

The use of unscheduled care is relatively static across Hammersmith and Fulham over the year. The A&E attendances to Charing Cross A&E dropped slightly in November and December. This is not in line with trends across the country. NHS Direct has a similar number of calls as the number of attendances to the Parsons Green WIC. The December peak in the NHS Direct calls are in line with national trends.

Figure 70: Monthly activity volumes over 2007 for access points in Hammersmith & Fulham

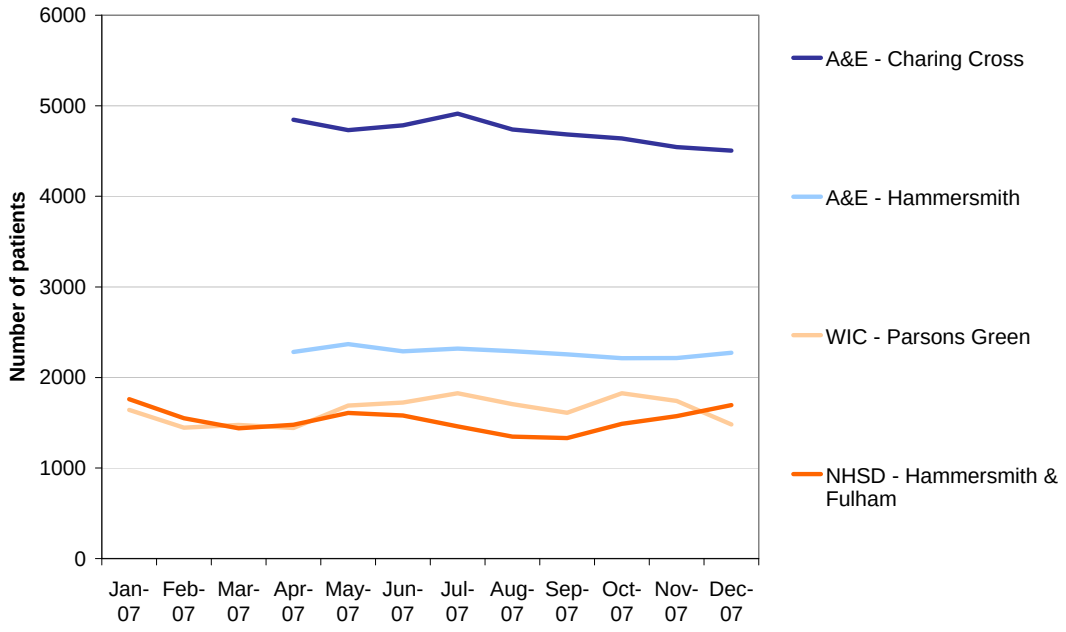
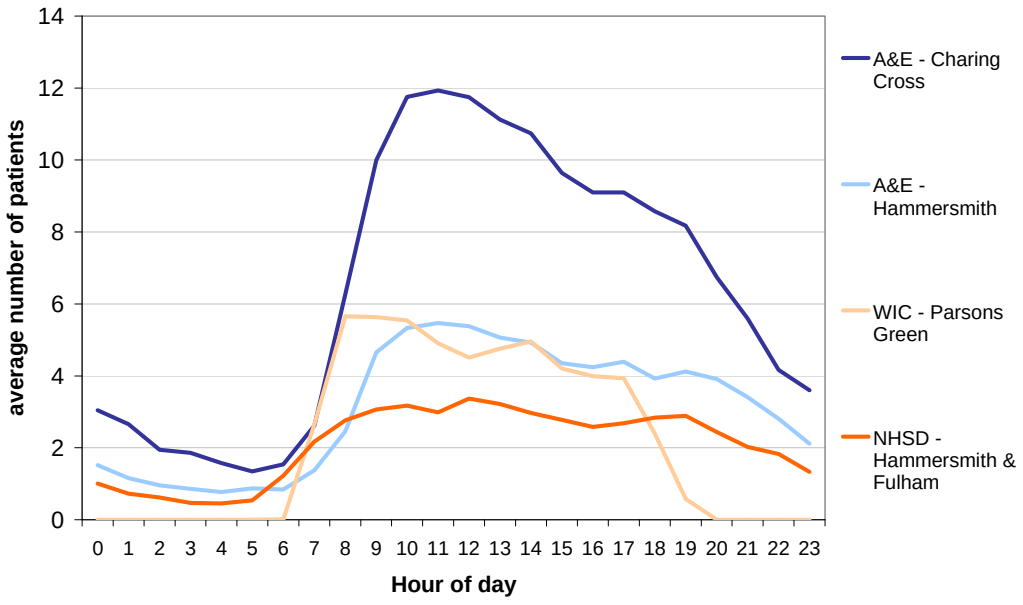


Figure 71: Hourly activity volumes over a day for access points in Hammersmith & Fulham



Camden

There is no significant monthly variation across the year, aside from GP OOH which experiences a sharp increase in activity in December which can be explained by the Christmas holiday season. This data shows the patterns in arrival time taking into account the volumes of attendees and time of day. (Please note that the out of hours services for Camden also cover Islington, Haringey Teaching and , City and Hackney Teaching PCTs.) The access patterns show that the services are utilised to the greatest degree between the hours of 9 am and 9 pm. There is a particular peak between 11 am and 1 pm.

Figure 72: Monthly activity volumes over 2007 for access points in Camden

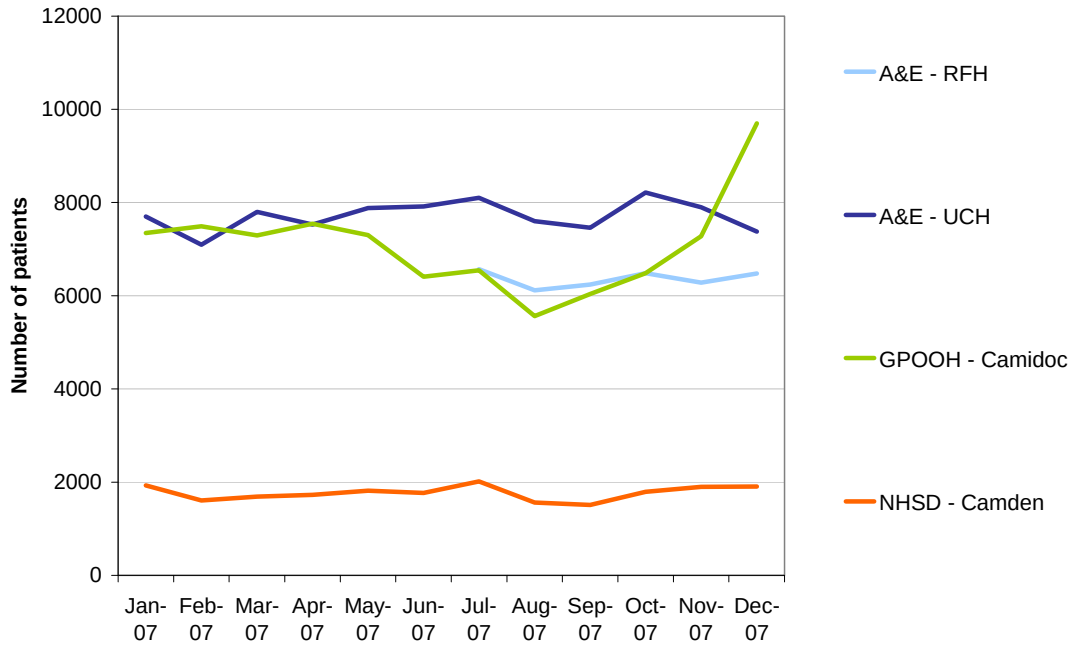
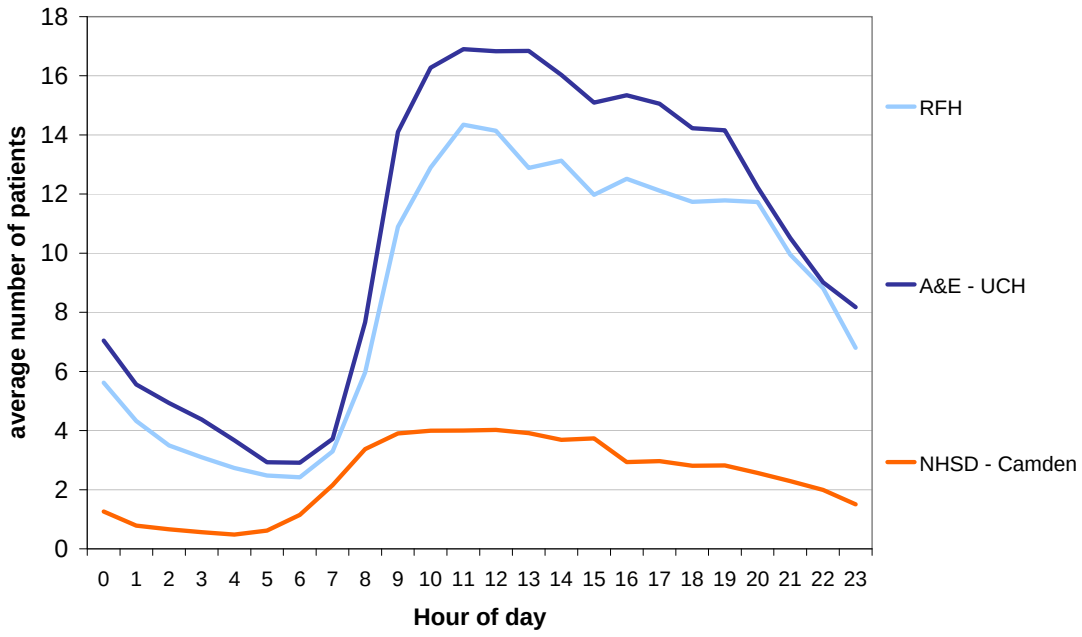


Figure 73: Hourly activity volumes over a day for access points in Camden



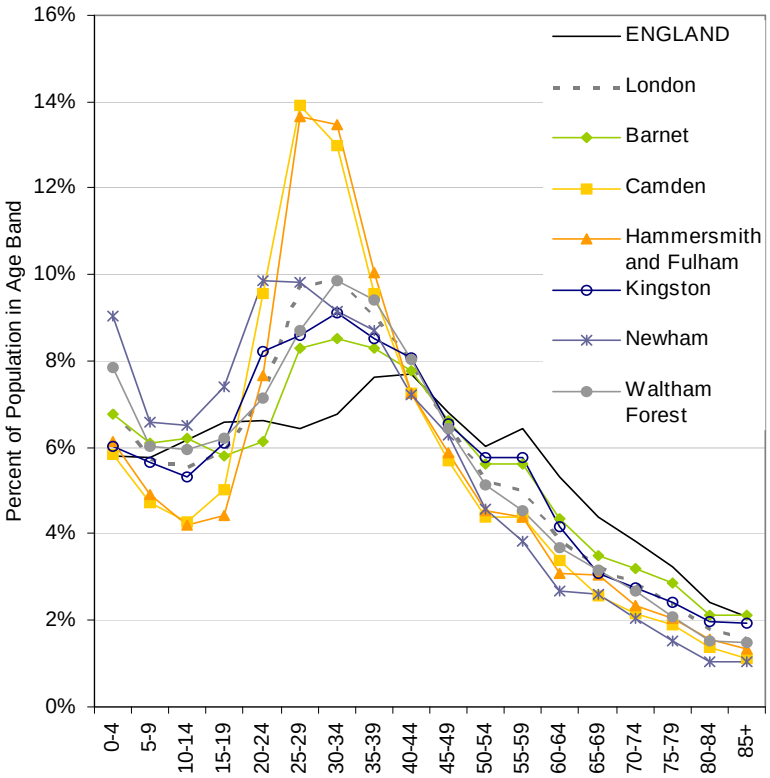
Appendix D: Socio-demographic usage of unscheduled care

This section displays socio-demographic PCT level information based on live data capture and electronic data where this is available from access points. To the best of our knowledge this constitutes the most extensive survey of patients who access GPs and pharmacies for unscheduled care.

D.1 PCT demographic profiles

Population demographics vary significantly across London. In general, London has a younger population than the rest of England, but there are large inter-area variations. Both Camden PCT and Hammersmith & Fulham PCT have a higher proportion of 20 to 40 year olds than other PCTs in the study. All PCTs have a greater proportion of 20 to 40 year olds than the national population profile.

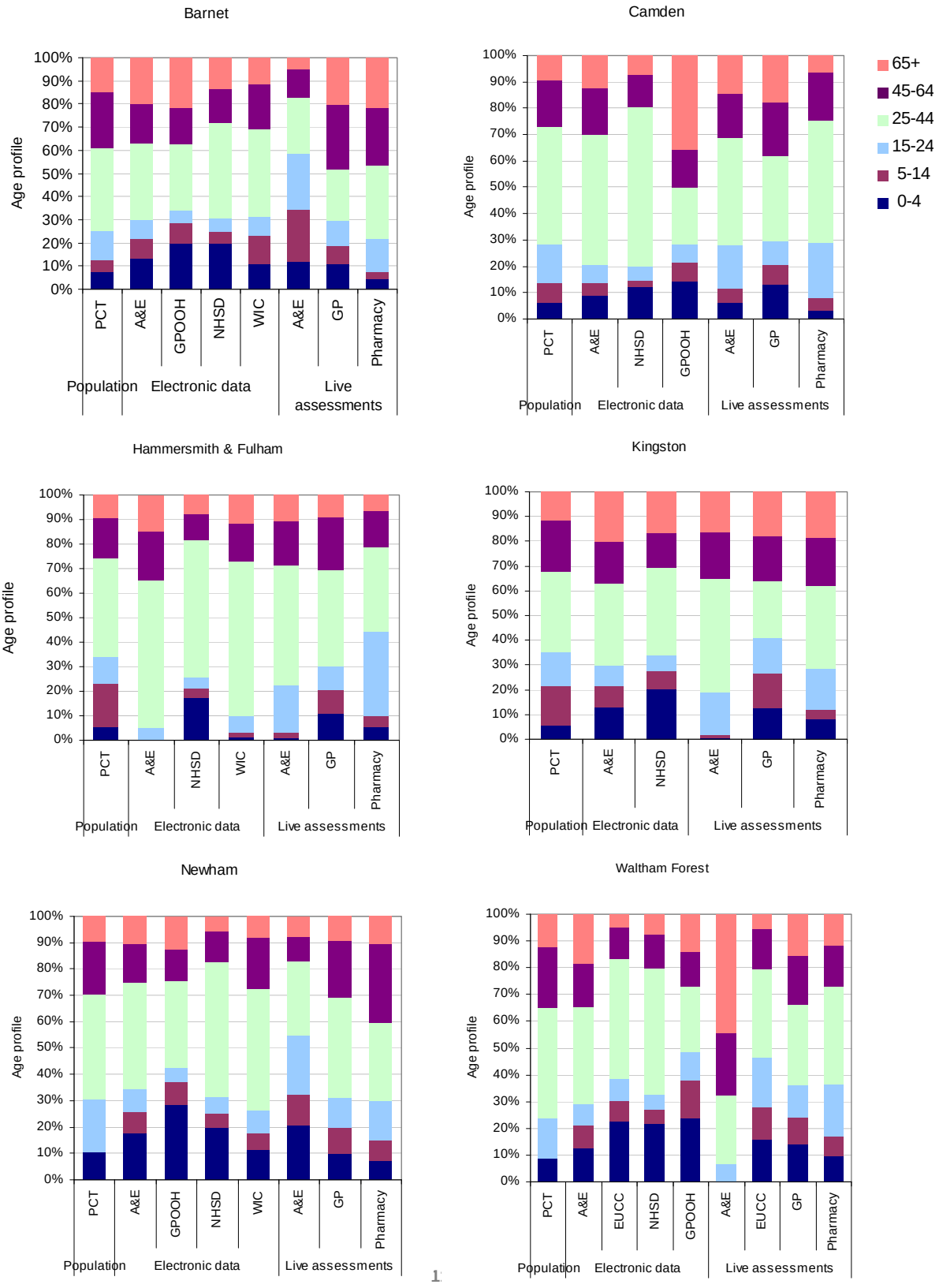
Figure 74: Age breakdown of PCT populations and London & England population



D.2 Age profile of study & PCT

Patients in different age groups access and use unscheduled care services differently. The charts on this page provide information about age profiles of service users of access points in each PCT. The difference in service use by different age groups is discussed in Section 6.

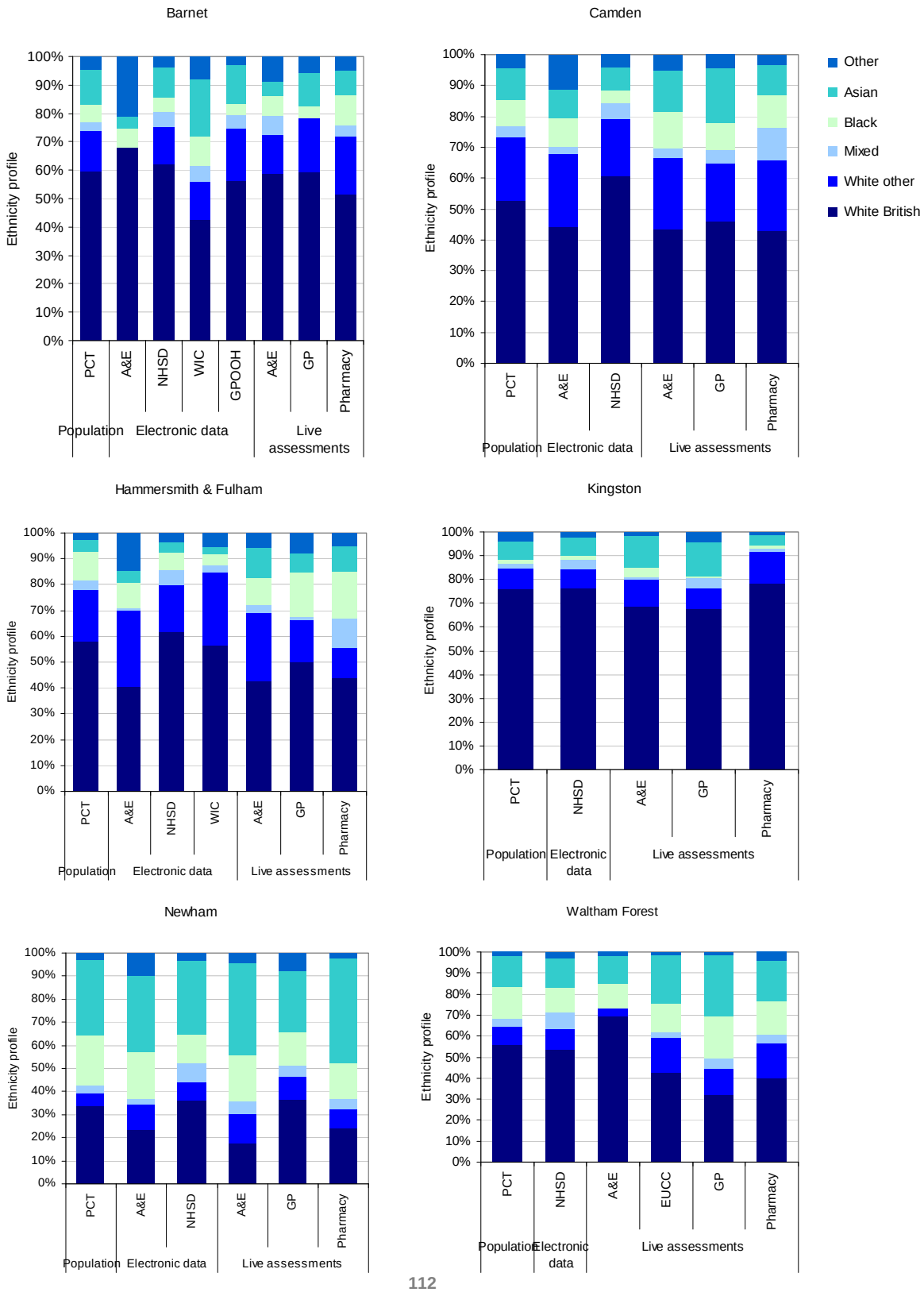
Figure 75: Age profile of unscheduled care users by PCT



D.3 Ethnicity profile of study & PCT

Use of unscheduled care services differ between ethnic groups. The charts on this page provide information about the ethnicity profiles of service users of access points in each PCT. The difference in service use by ethnic groups is discussed in Section 6.

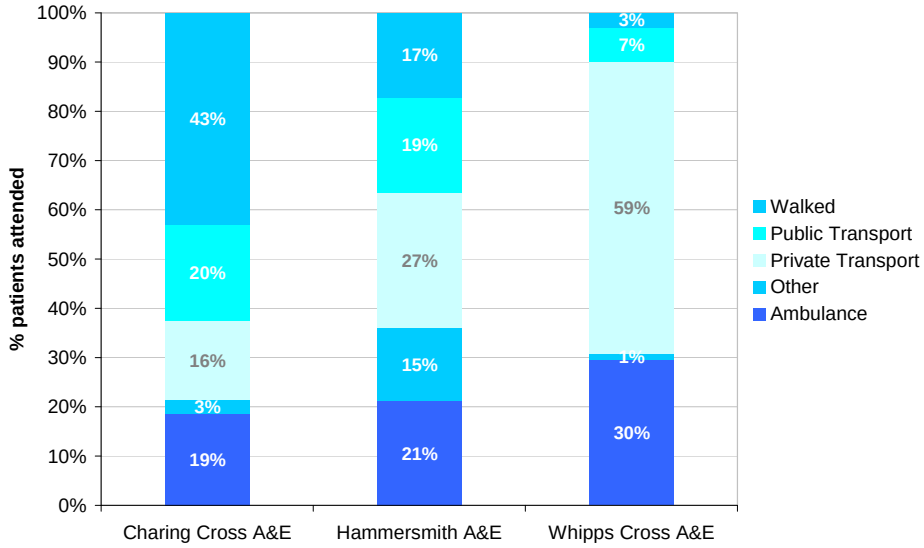
Figure 76: Ethnicity profile of unscheduled care users by PCT



Appendix E: Travel to access points

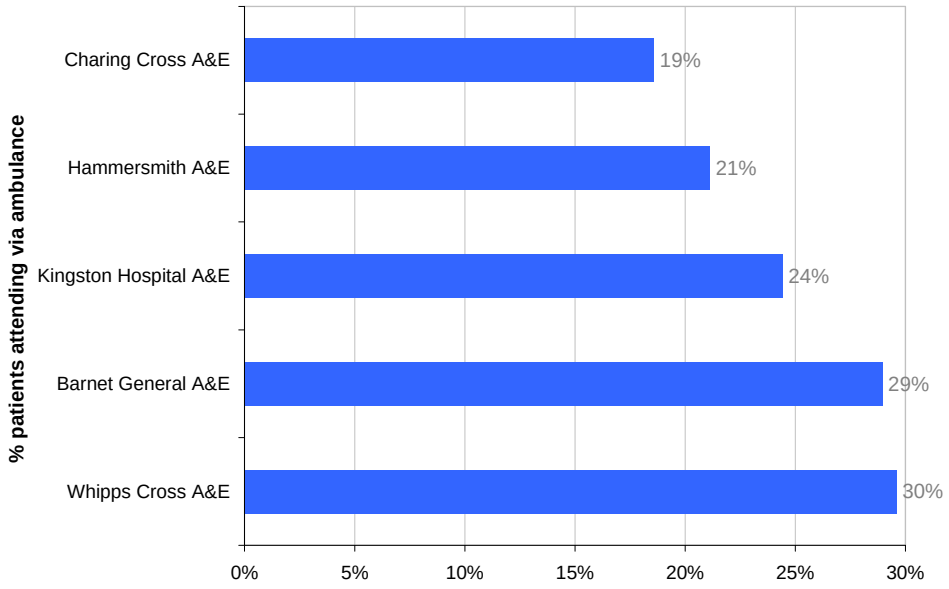
The chart below shows the mode of arrival for patients attending A&E departments during 06-07 where local data is available. Clearly, arrival mode varies depending on location and parking facilities, with Charing Cross showing a far greater proportion of patients walking or taking public transport compared to Whipps Cross who see a greater proportion of patients using private transport.

Figure 77: Mode of travel to A&E departments



The proportion of patients attending A&E departments via ambulance, shown in the chart below, varies from a low of 19% at Charing Cross to a high of 30% at Whipps Cross. The high proportion of ambulatory attendances at Whipps Cross reflects their provision of trauma services.

Figure 78: Percent of A&E attendees arriving by ambulance



Appendix F: Presenting condition

This section looks at the conditions with which patients presented across the various access points in the study.

Poor data quality and consistency was a common problem encountered during the study, and this was particularly true for condition information. This was one of the reasons for conducting the live data capture exercises where existing data was not detailed enough for retrospective clinical assessment.

An important element of the validation of the live data capture exercise was to compare the conditions seen in the A&E department live data capture exercise, with the local data recorded in each A&E department. This comparison was not possible at a detailed coding level, due to the inconsistency of coding systems used across A&E departments, and the poor data quality. Where possible a comparison was made by viewing the top conditions recorded in the live assessments and ensuring that they aligned with similar categories in the live data exercise. The data and charts for these comparisons are contained in each individual PCT report.

Live Data Capture condition summary

As expected, the conditions patients present with differed by access point.

- Top conditions presenting to A&E are laceration, gastrointestinal and joint injury
- Top conditions presenting to GPs are Respiratory – Upper Respiratory tract infection, dermatological and gastrointestinal
- Top conditions presenting to Pharmacists are Viral infection, pain relief and Respiratory – Upper Respiratory tract infection
- Top 10 conditions tended to represent between 50% and 75% of conditions presented

Table 79: Top 10 conditions recorded across the 3 access points in the live data capture exercise

(Percentages indicate the proportion of patients these conditions covered)

TOP 10 A&E	44%	TOP 10 GP	48%	TOP 10 PHARM	64%
laceration	89	respiratory - upper respiratory tract infection	176	viral infection	221
gastrointestinal - other including diarrhoea and vomiting	80	Dermatological	103	pain relief	134
joint injury	79	gastrointestinal conditions	77	respiratory - upper respiratory tract infection	85
sprain/ligament injury	77	repeat prescription	68	Dermatological	79
urological conditions	69	gynaecological conditions	63	ENT - conjunctivitis	70
ENT - Other ENT condition	69	gastrointestinal - other including diarrhoea and vomiting	61	allergy	60
cardiac conditions	64	urological conditions	59	repeat prescription	56
gynaecological conditions	63	respiratory - lower respiratory tract infection	58	urological conditions	55
gastrointestinal conditions	62	ENT - Other ENT condition	57	gastrointestinal conditions	52
respiratory - upper respiratory tract infection	55	viral infection	42	gastrointestinal - other including diarrhoea and vomiting	50

There are conditions which present across all three access points, namely

- Upper respiratory tract infection
- Gynaecological conditions
- Gastrointestinal conditions
- Urological conditions

This would suggest that these are common conditions for unscheduled care requirements

F.1 A&E majors vs. minors

A comparison of the classification of patients as Majors or Resus/Critical care shows that there is significant variation between A&E departments. This is partially a result of inconsistencies in how this classification is used, with the layout of the department and the areas that patients are treated in often also playing a part in the classification. It therefore gives some indication of the severity of condition, but can also reflect capacity and layout. Because of these inconsistencies, this information is not included in the national returns for A&E departments.

Table 80: Classification of patients into majors and resus by A&E department

A&E department	Resus and majors as % of total	Data source
Charing Cross A&E	48%	Local A&E data 01/04/07-31/01/08)
Hammersmith A&E	66%	Local A&E data 01/04/07-31/01/08)
Kingston A&E	38%	Local A&E data 01/04/07-31/04/07)
Newham A&E	66%	Local A&E data 01/07/07-31/12/07)
Royal Free	41%	A&E Target weekly survey
Barnet A&E	37%	A&E Target weekly survey
Average for above A&E departments	49%	

It is possible that A&E departments reporting lower levels of major and resus patients are more reflective of patient's conditions than those reporting higher levels. If this is the case, patients presenting as majors and resus are likely to be in the range of 40-50% and minors are likely to be in the range of 50-60% of all patients.

Table 81: Average daily A&E attendances per hospital

PCT Name	A&E department	Average no of A&E attendances per day	
Barnet	Barnet General	209	
Camden	RFH	209	
	UCH	254	
H&F	A&E - Charing Cross	154	
	A&E - Hammersmith	75	
Kingston	Kingston Hospital	282	
Newham	NUHT	234	
Waltham Forest	Whipps Cross	272	

Data source: Local A&E data

F.2 Conditions presented at A&E

Top 10 conditions presented at A&E during live data collection

Figure 82: Top 10 conditions presenting at A&E during live data capture exercise - broken down by age group

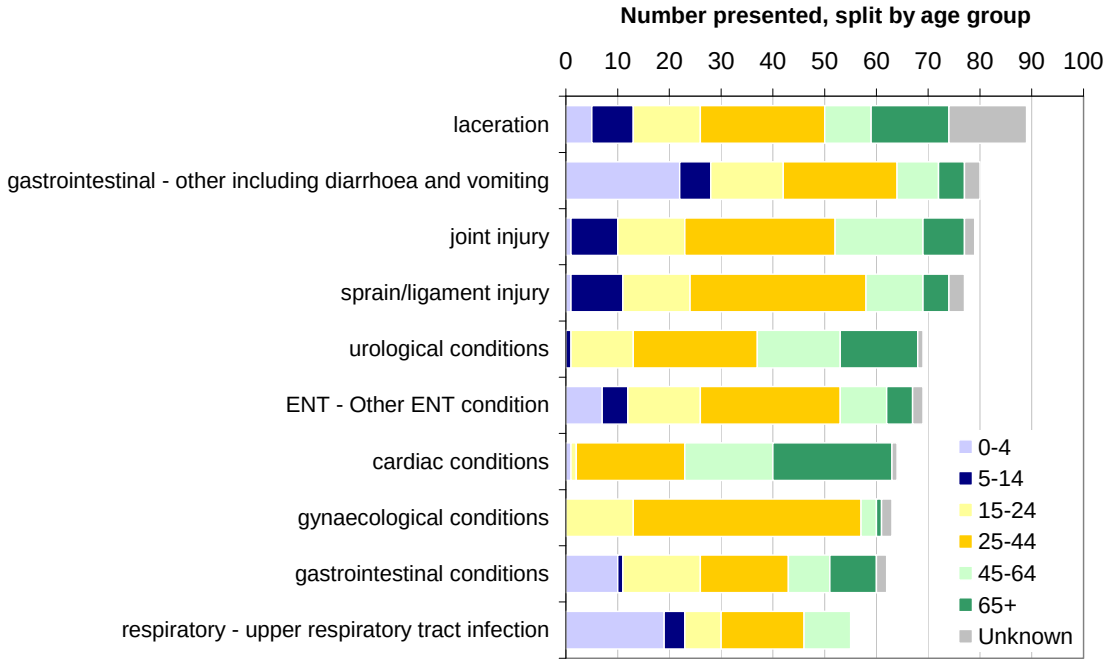


Figure 83: Top 10 conditions presenting at A&E during live data capture exercise - broken down by ethnicity

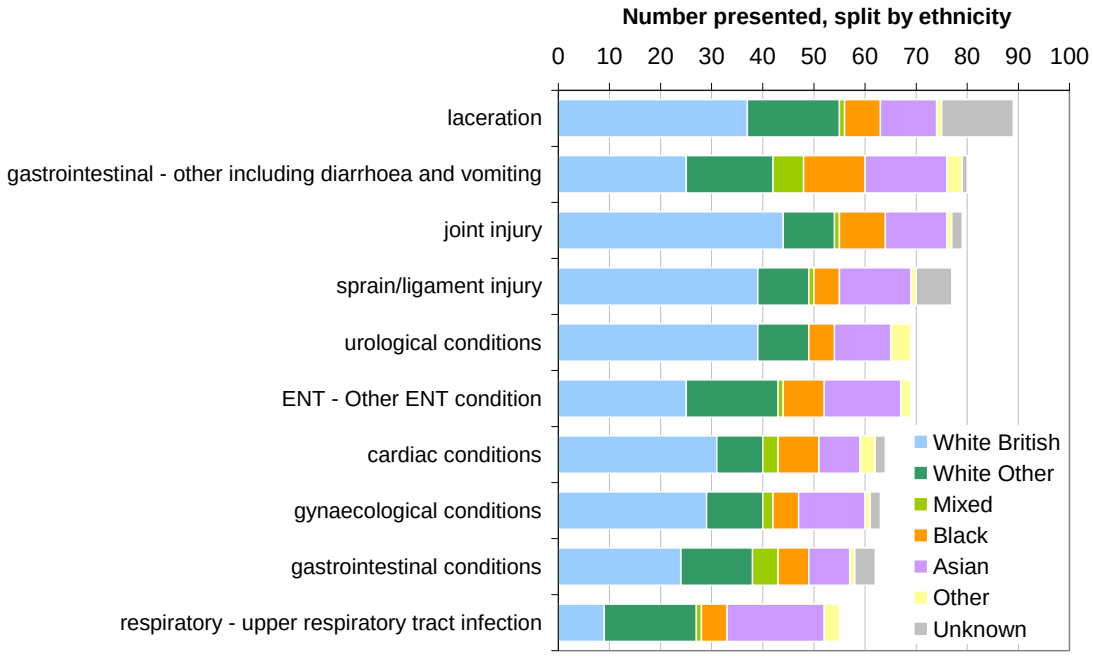
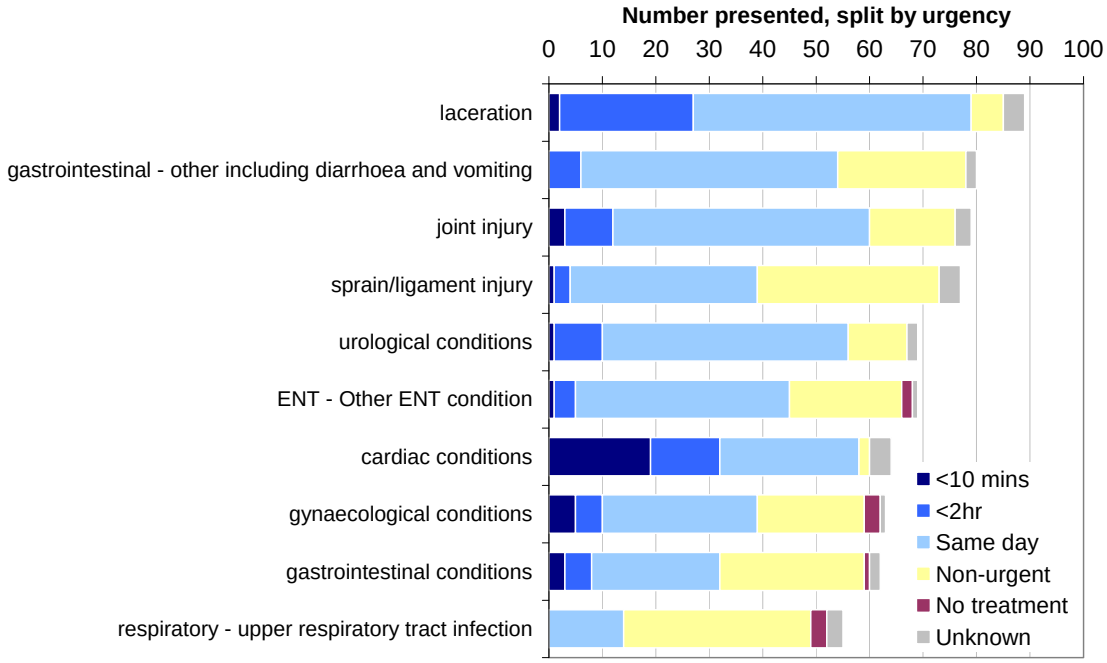


Figure 84: Top 10 conditions presenting at A&E during live data capture exercise - broken down by urgency



Summary of top 10 conditions presented at A&E during live data collection

Interpretation of these charts can be found in the main report.

Top 10 conditions presented at A&E during live data capture exercise who were assessed not to require an A&E clinician

Figure 85: Top 10 conditions presenting at A&E during live data capture exercise (assessed to not require an A&E clinician) split by age group

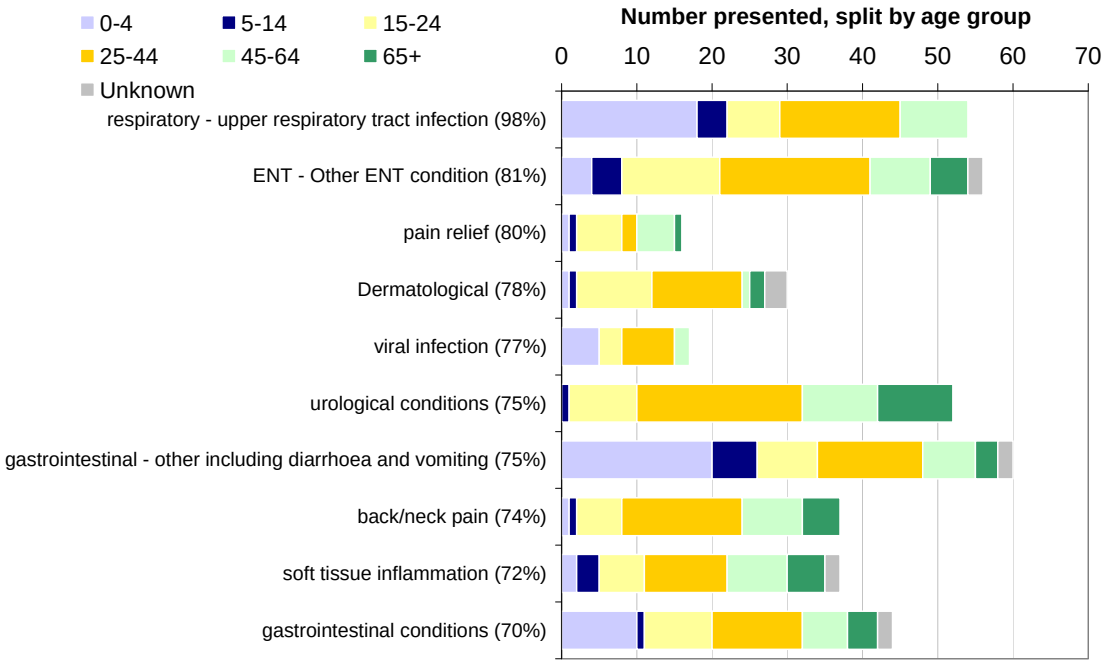


Figure 86: Top 10 conditions presenting at A&E during live data capture exercise (assessed to not require an A&E clinician) split by ethnicity

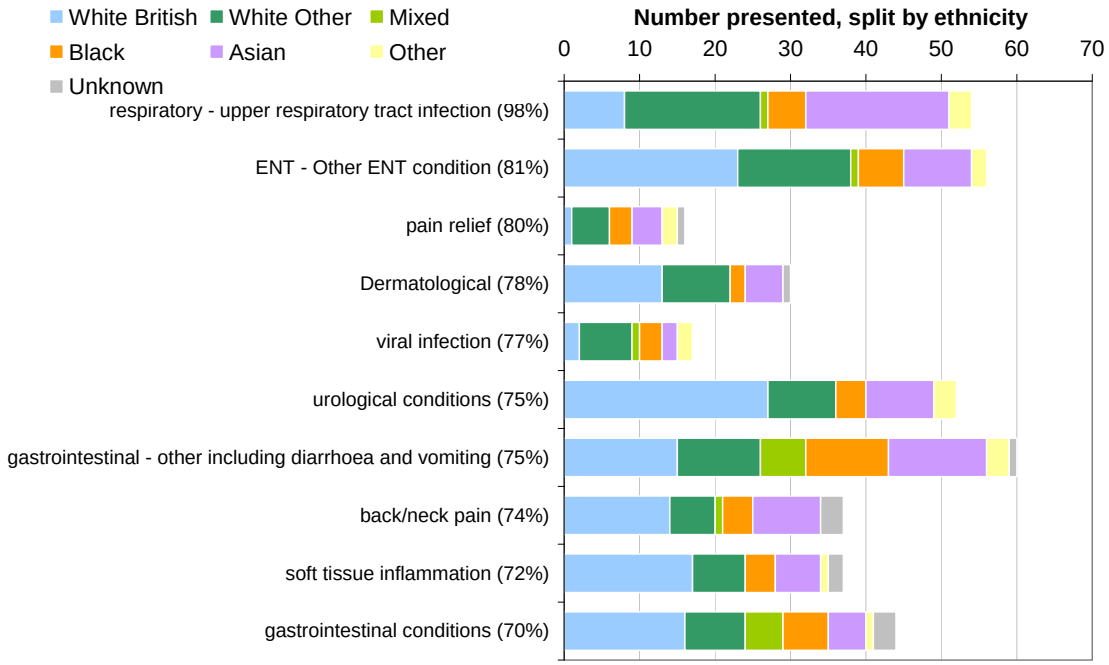
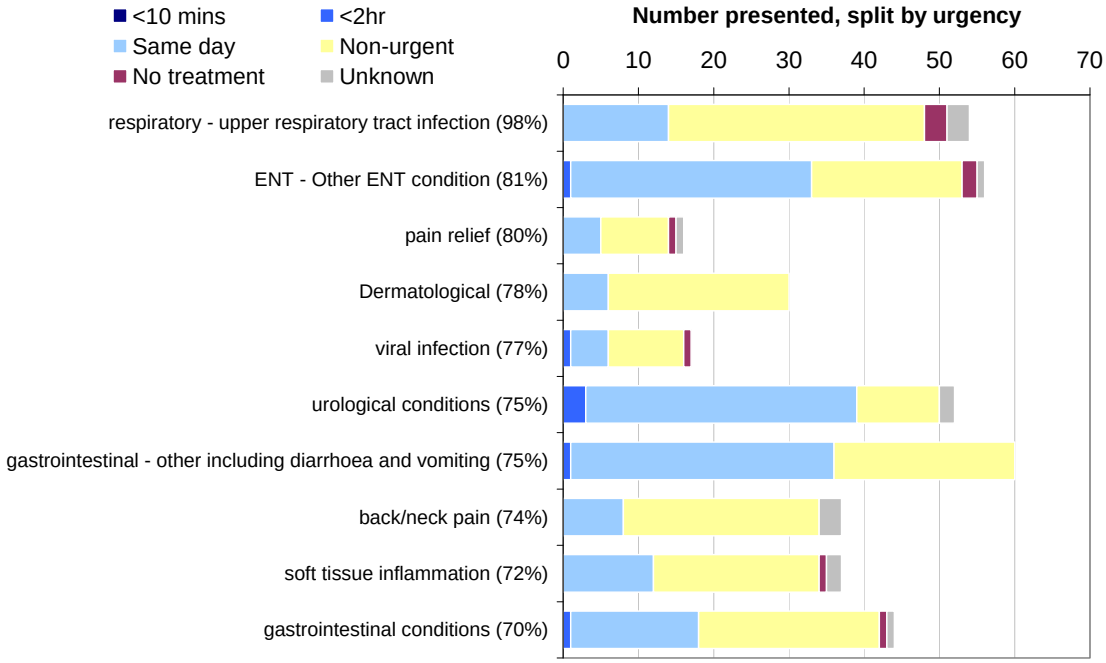


Figure 87: Top 10 conditions presenting at A&E during live data capture exercise (assessed to not require an A&E clinician) split by urgency



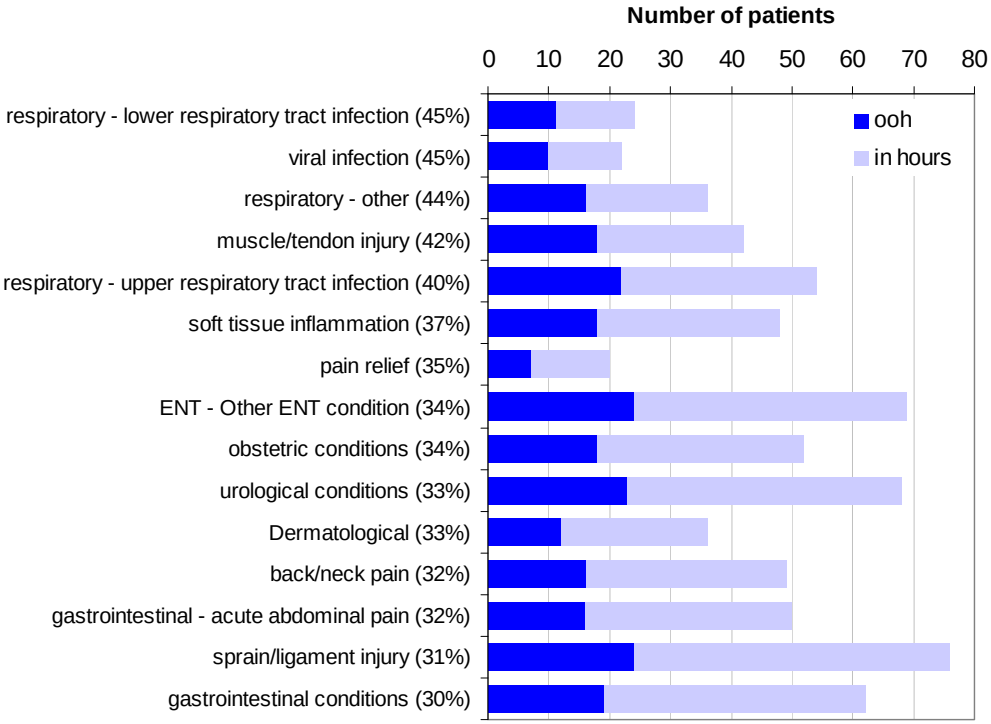
Summary of top 10 conditions presented at A&E during live data capture exercise who were assessed not to require an A&E clinician

Young children and babies presenting with respiratory and gastro conditions form a large part of the cohort of patients who were assessed as not requiring an A&E clinician. Other conditions which feature are dermatological conditions (mainly White British and White other, young and middle aged adults), back/neck pain (mainly adults and elderly) and urological conditions (amongst the elderly).

Some conditions such as urological and gastro conditions were not assessed to require A&E clinicians for most appropriate treatment, but still required same day treatment. This would suggest that people felt they could only get the same day treatment required at the A&E access point,

Top out of hours conditions presented at A&E

Figure 88: Out of hours conditions presented at A&E during live data capture exercise (number in brackets indicated % of cases which were presented between 6pm and 8am)



The conditions most likely present at A&E out of hours were respiratory conditions and viral infections, with over 40% of these cases presenting outside the hours of 8am-6pm.

F.3 Conditions presented at GP Practice

Figure 89: Top 10 conditions presenting at GPs during live data capture exercise - broken down by age group

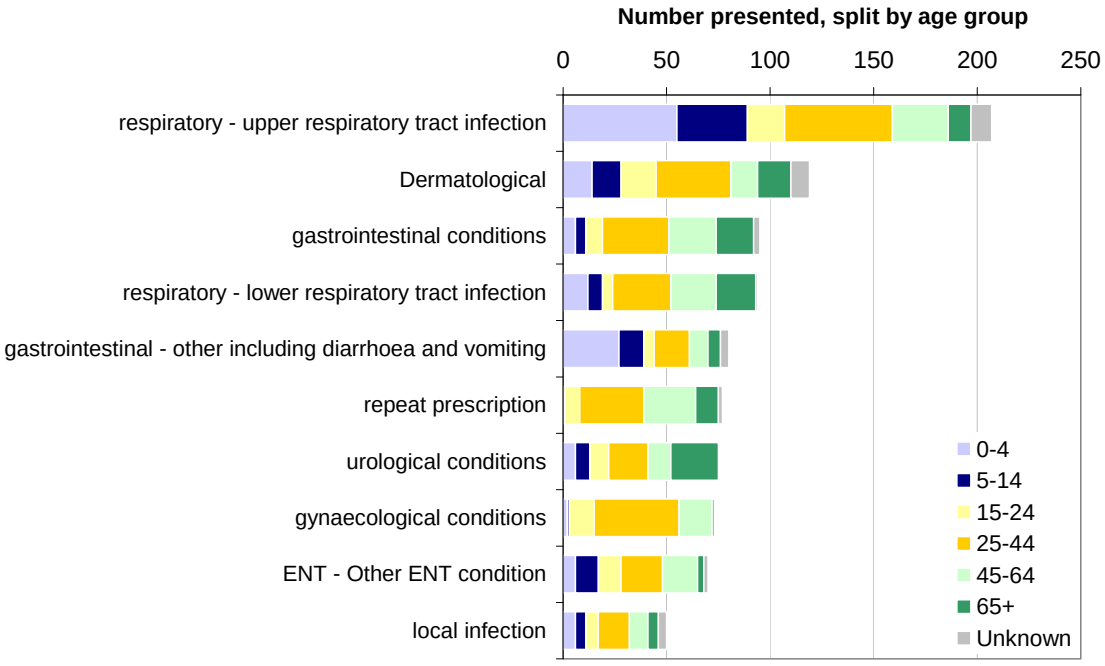


Figure 90: Top 10 conditions presenting at GPs during live data capture exercise - broken down by ethnicity

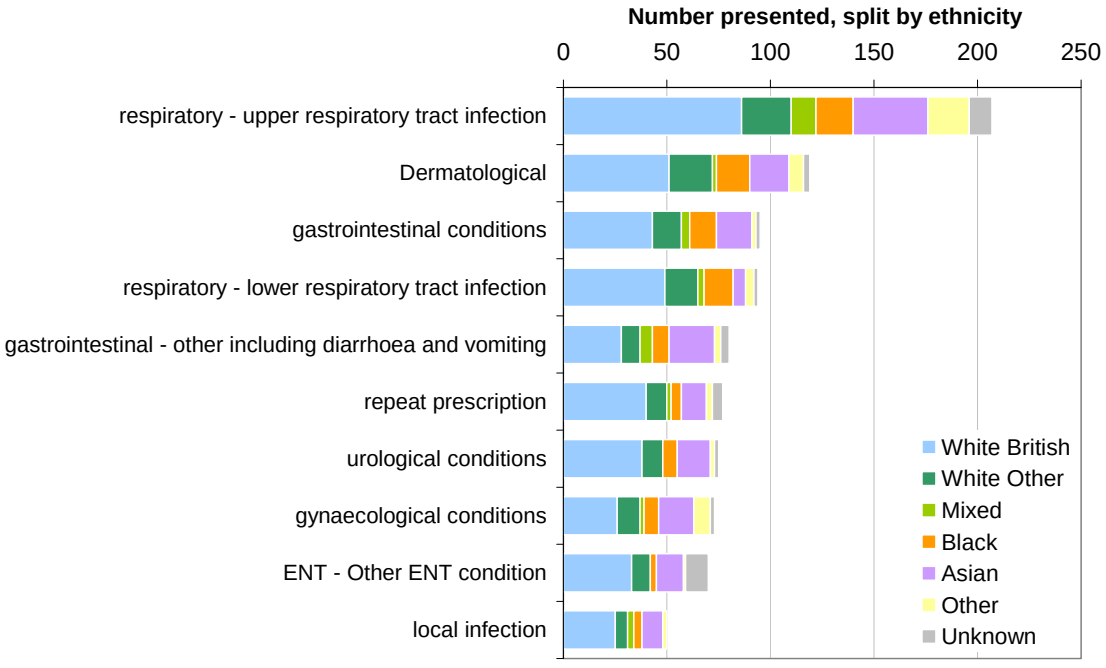
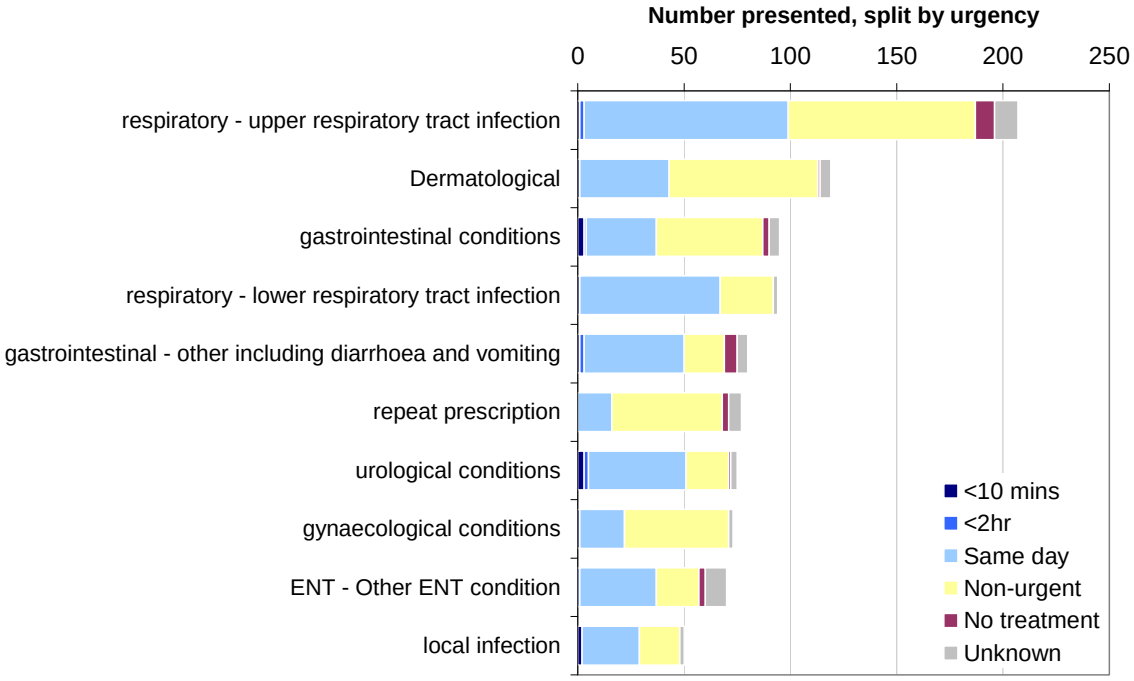


Figure 91: Top 10 conditions presenting at GPs during live data capture exercise - broken down by urgency



The most common condition presenting at GPs for unscheduled care was upper respiratory tract infection, which was particularly common amongst young children and babies from BME backgrounds.

The top 5 conditions also included dermatological condition and gastrointestinal conditions.

F.4 Conditions presented at Pharmacies

Figure 92: Top 10 conditions presenting at pharmacies during live data capture exercise - broken down by age group

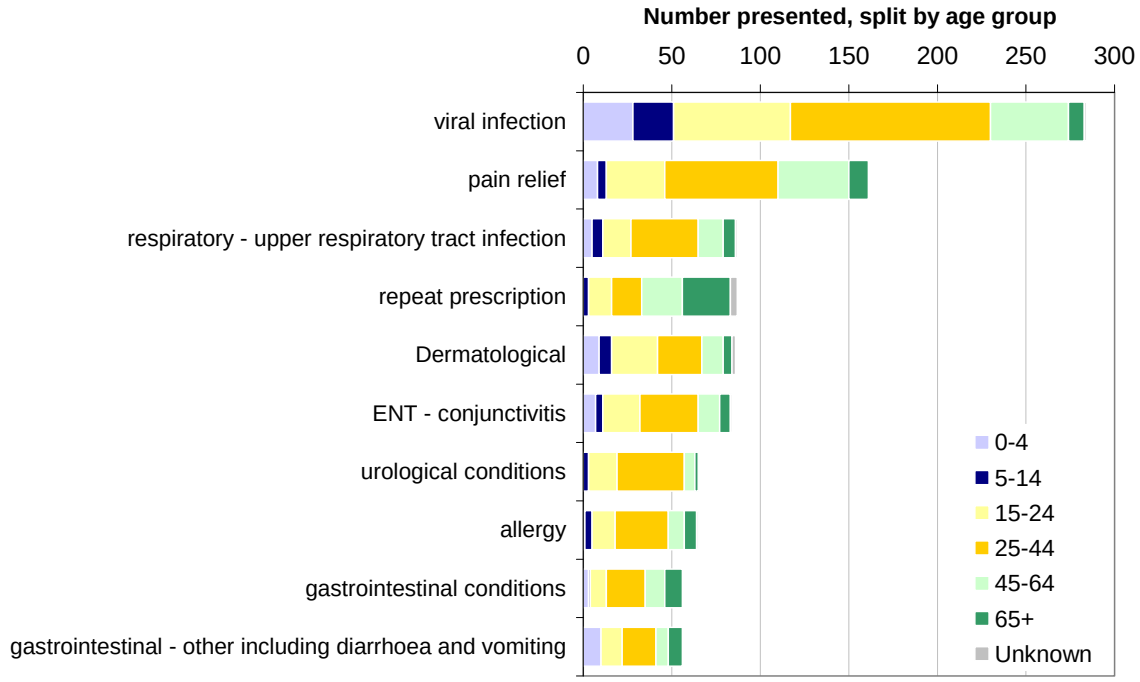
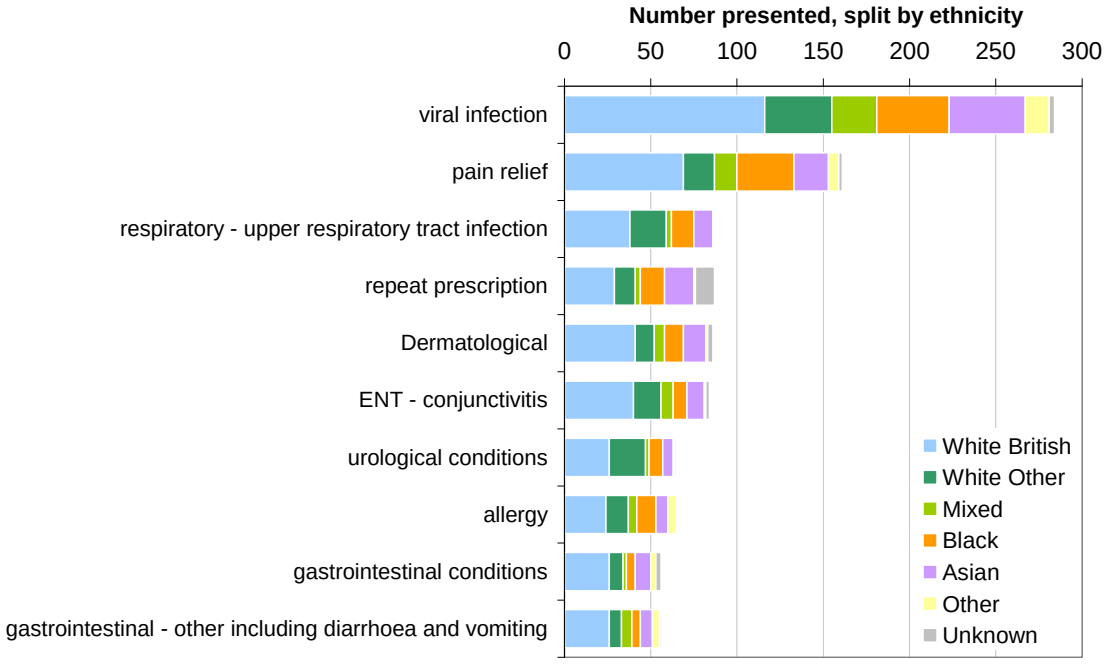


Figure 93: Top 10 conditions presenting at pharmacies during live data capture exercise - broken down by ethnicity



F.5 Conditions presented at Walk-in centres

The coding of conditions at Walk-in Centres is of variable quality. In many cases, patient's condition is either not always recorded, or it is recorded in a non-detailed category.

Figure 94: Top 10 conditions presenting at Edgware walk-in centre

(Conditions shown represent 93% of total activity)

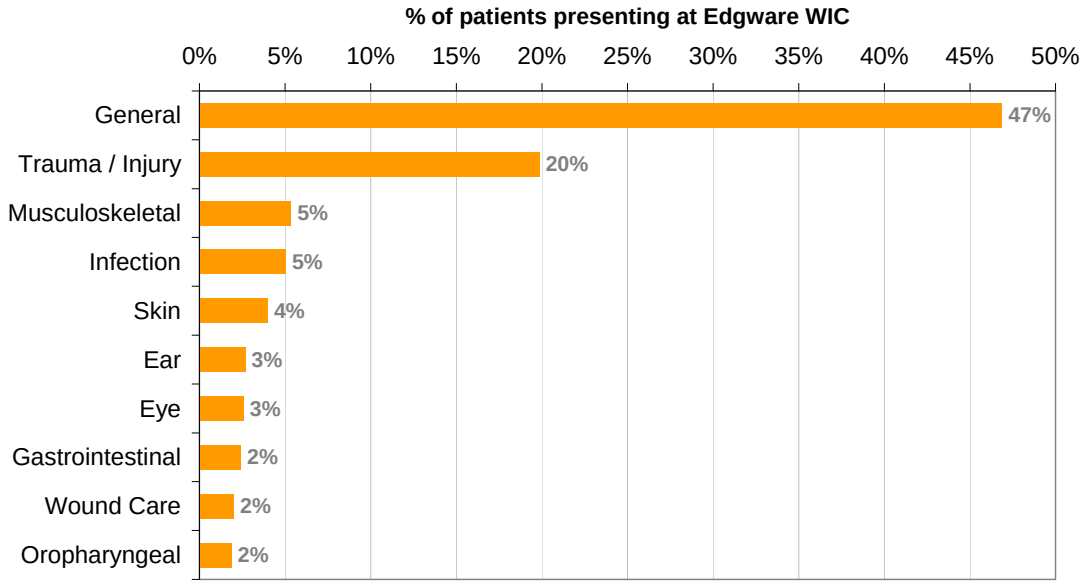


Figure 95: Top 10 conditions presenting at Finchley walk-in centre

(Conditions shown represent 47% of total activity)

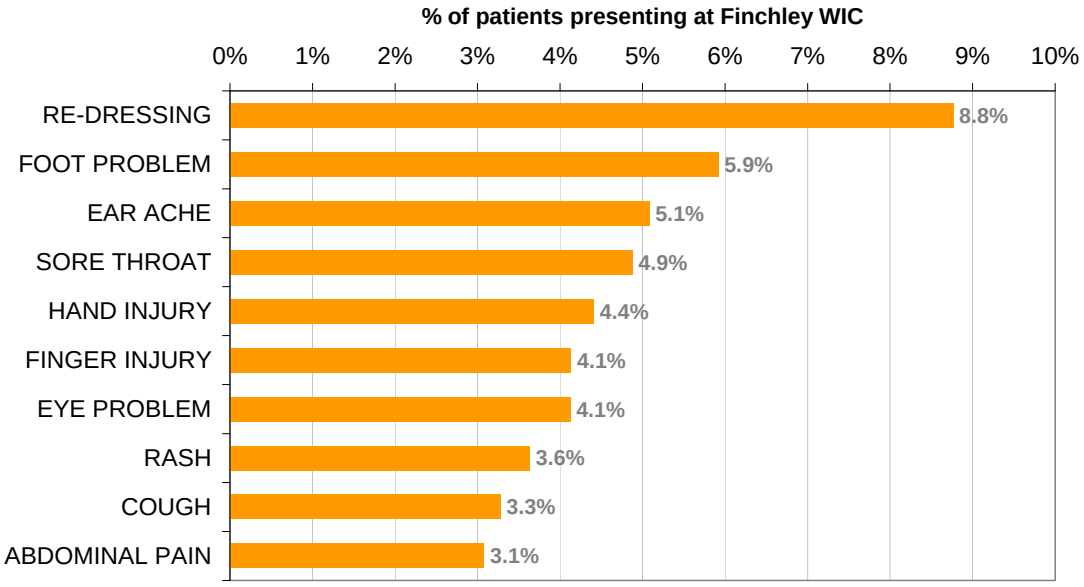
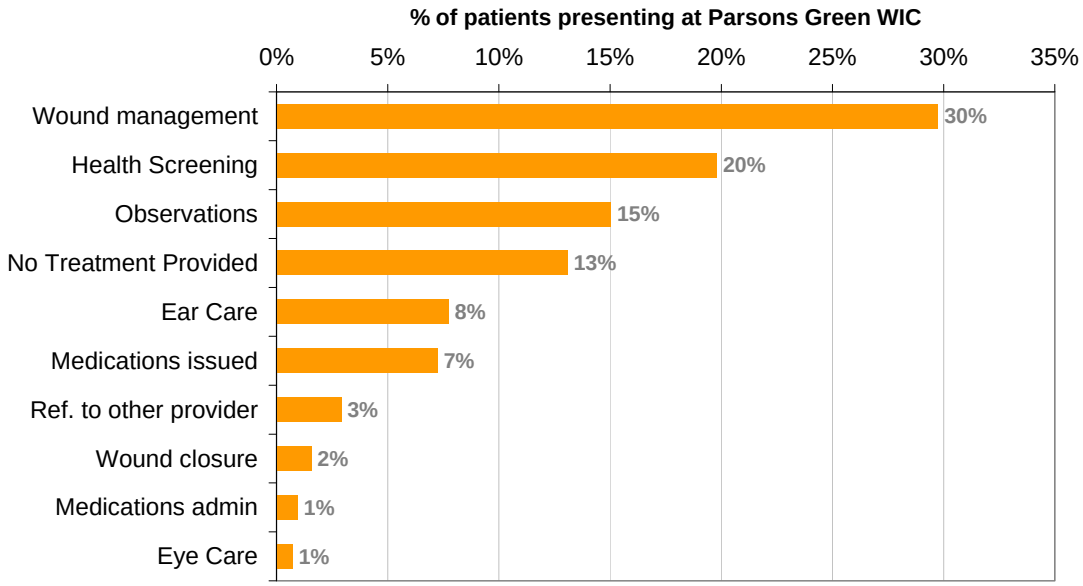


Figure 96: Top 10 conditions presenting at Parsons Green walk-in centre

(Conditions shown represent 99% of total activity)



Although walk in centre data was inconsistently coded it can be seen that the conditions presenting differed significantly between the different walk in centres. This is due to the difference in set up and facilities, with some, for example Parsons Green (where the top 4 conditions do not include any direct treatment), providing ongoing and follow up care.

F.6 Conditions presented at NHS Direct

Figure 97: Top 10 conditions handled by NHS Direct

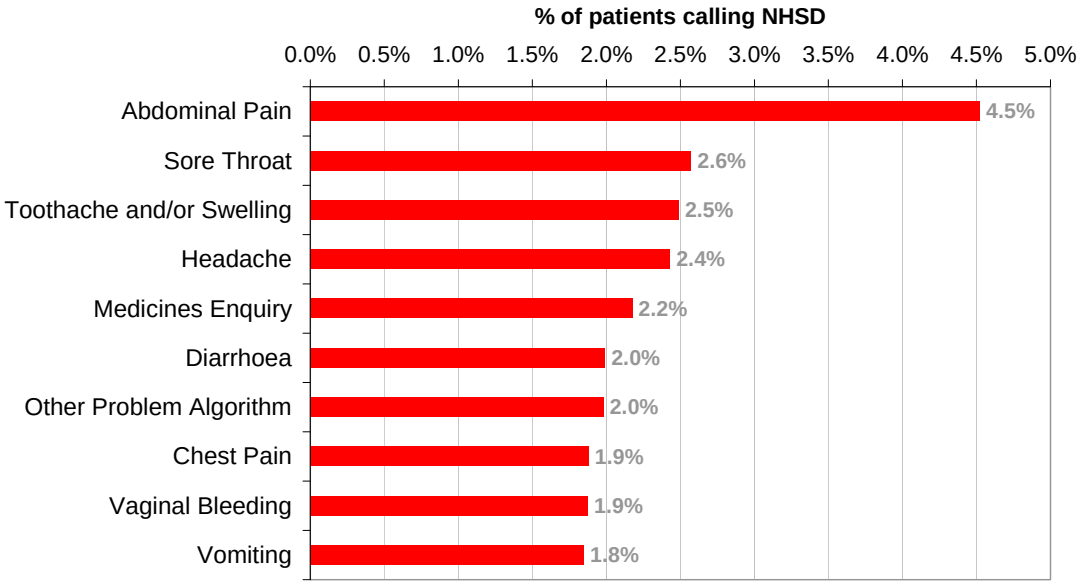
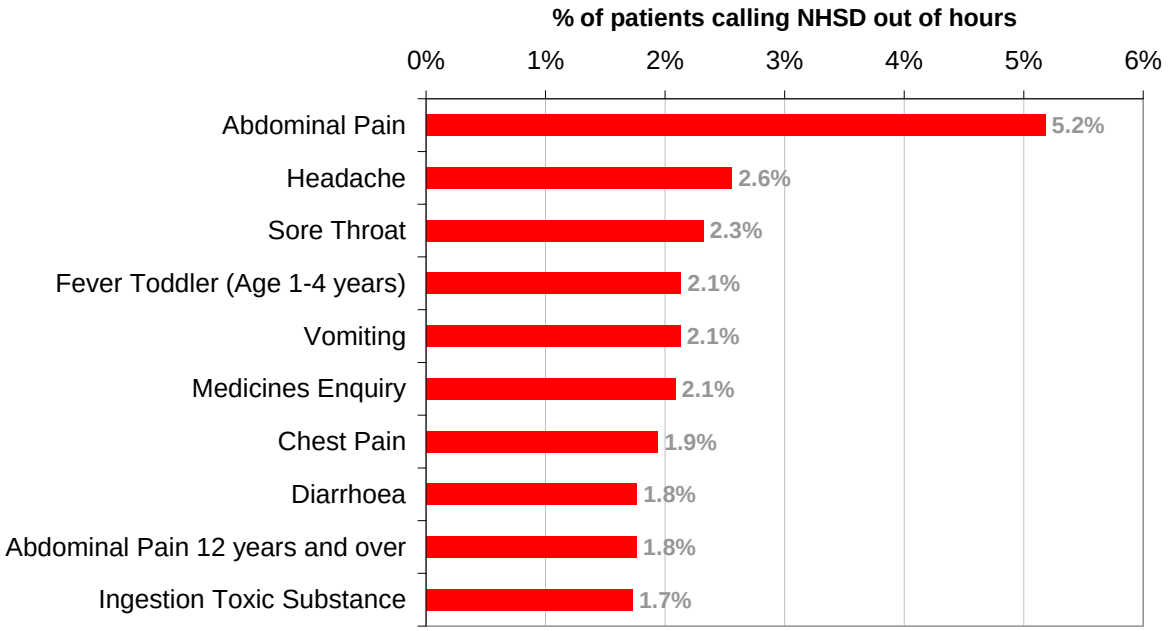


Figure 98: Top 10 conditions handled by NHS Direct out of hours



Conditions which feature in NHSD out of hours are Toddler Fever and Abdominal Pain. These do not feature in hours access points.

Appendix G: Outcomes

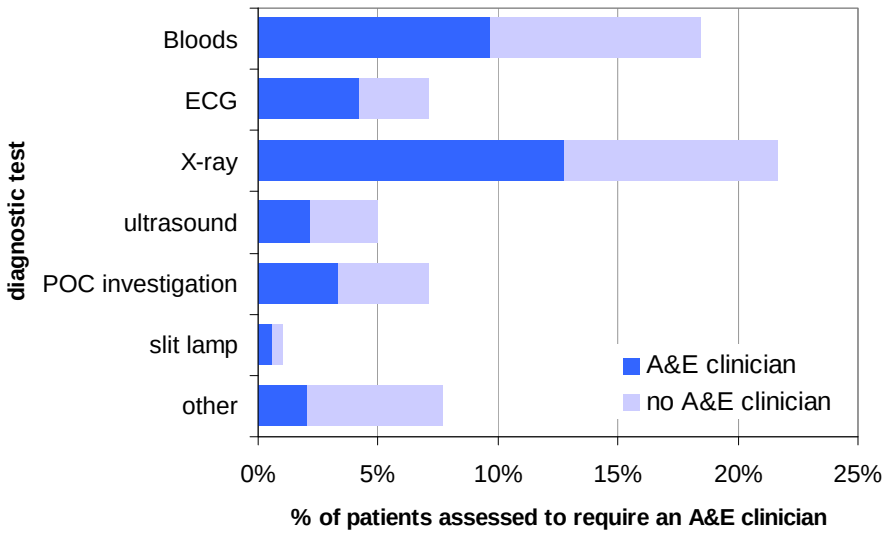
This section explores the outcomes in terms of the type of treatment, tests and/or advice unscheduled patients receive when they present for care. The information is based on the live data capture of more than 5000 patients across GP surgeries, pharmacies and A&E departments.

G.1 A&E outcomes

Diagnostic tests

Bloods and X-ray are the most common diagnostic tests required by minor patients assessed at A&Es, with more than 20% of patients requiring X-rays, and over 15% requiring bloods. A similar profile of tests is required for patients who needed to be seen at A&E compared to those who could have be seen by an alternative professional or in alternative setting. These tests, together with appropriately skilled staff, would be required to treat this cohort of patients if they are to be seen in an alternative setting.

Figure 99: Tests GPs assessed were required for patients presenting in A&E during the live data collection.



Admissions

About 20% of A&E attendances results in the patient being admitted to a hospital bed. The level of admissions per attendance vary significantly between the resident populations in each PCT with Waltham Forest residents having the highest level of admissions per attendance at 22%. Newham residents in contrast, have only 13% admissions per attendance (see Section 5).

G.2 GP practice outcomes

In GP practices, the majority of unscheduled patients are provided with advice along with treatment and/or prescriptions. Around 10% of patients were referred on to other healthcare providers, mostly to hospital consultants, with less than 2% being referred on to A&E for further treatment.

Figure 100 shows the outcomes recorded for the patient assessments, with the dark green slices indicating where the GP selected multiple outcomes e.g. advice given and further routine appointment booked. For all patients who were referred on to other providers, Figure 101 shows where they were referred on to.

Figure 100: Outcome of patients assessed at GP surgeries in live data capture exercise

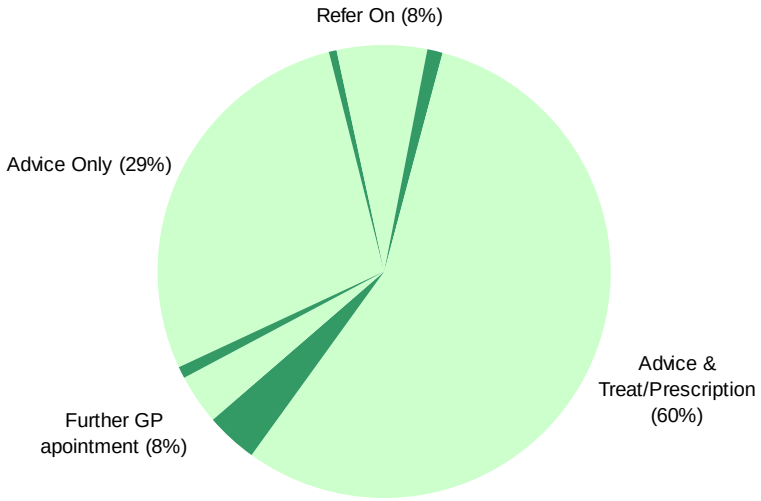
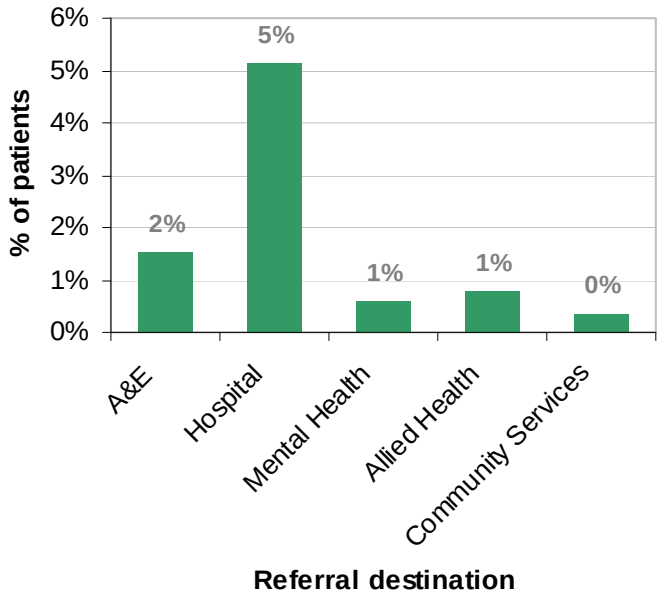


Figure 101: Destination of patients referred on from GP surgeries in live data capture exercise



The most common reason for onward referral was that the patient requires tests; this accounts for around 40% of referrals. The most common tests required for patients who were referred by GPs were bloods and ECG.

Figure 102: Reasons GPs provided for onward referrals in the live data capture exercise

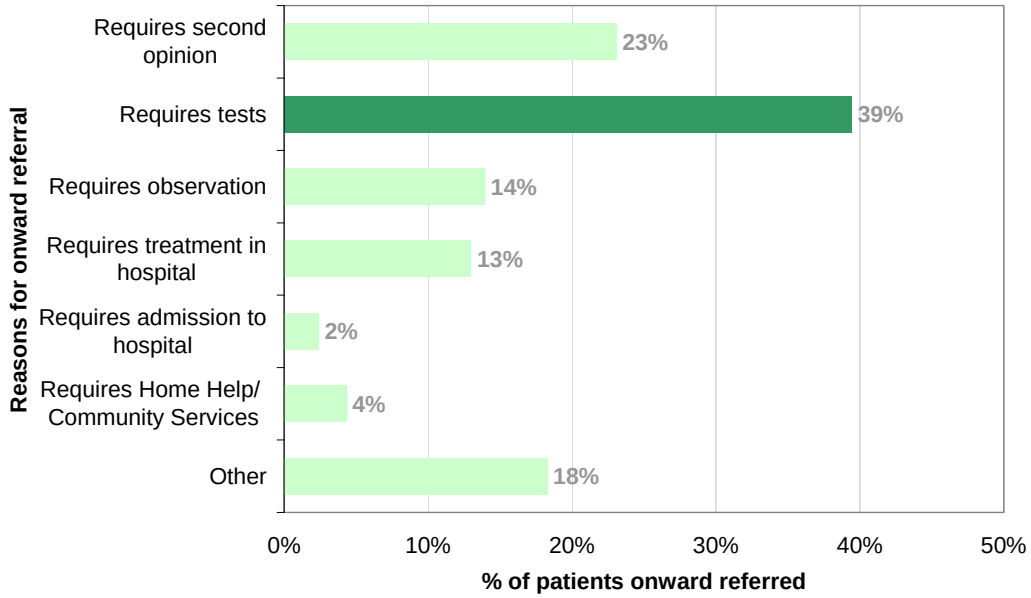
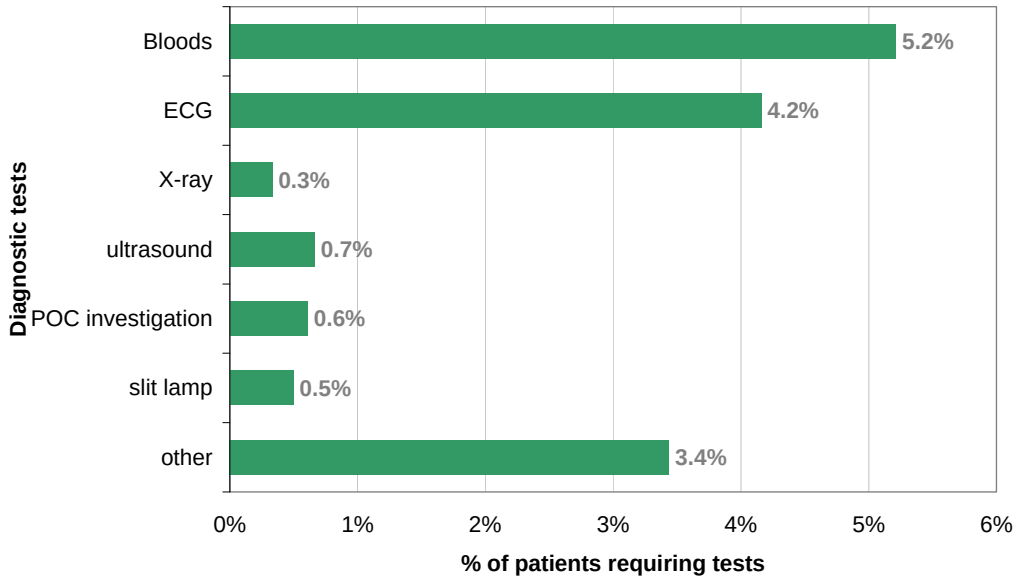


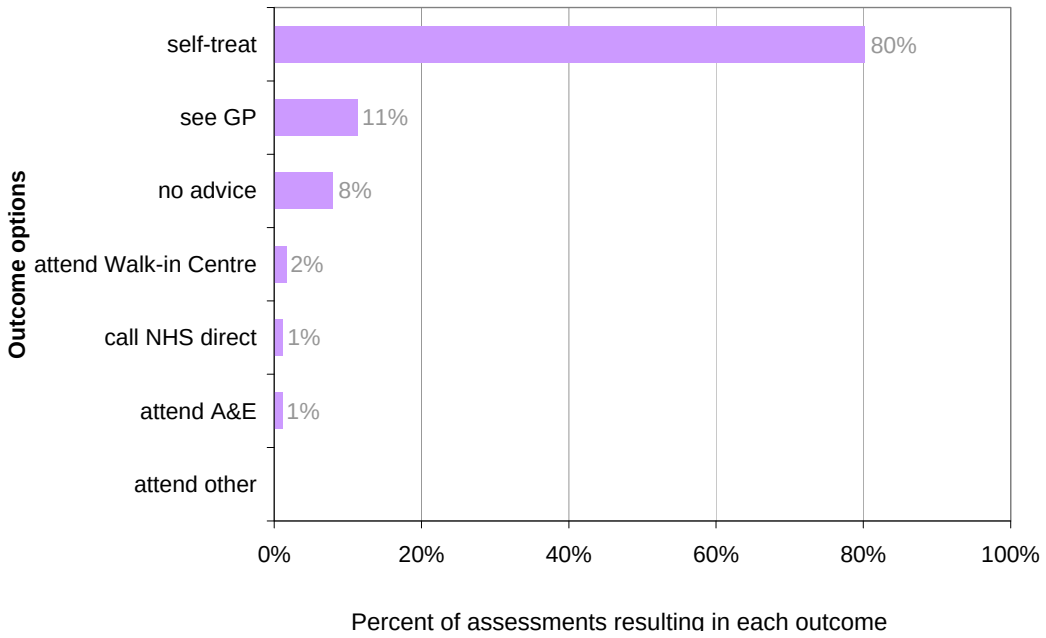
Figure 103: Tests required when GPs referred on in the live data capture exercise



G.3 Pharmacy outcomes

In pharmacies the most common outcome was advice on how to self-treat. About 1 in 10 patients were advised to see their GPs. Only a very small number of patients were advised to access other services.

Figure 104: Outcomes for patients in the Pharmacy live data capture exercise



G.4 Walk-in and urgent care centre outcomes

This section shows outcomes recorded in local data from Walk In Centres. The codes vary by centre and, therefore, the information is not directly comparable. However at both Edgware and Finchley WICs 4-5% of patients are advised to go to A&E departments.

Figure 105: Top 10 outcomes at Edgware walk-in centre

(Outcomes show capture 99% of all outcomes)

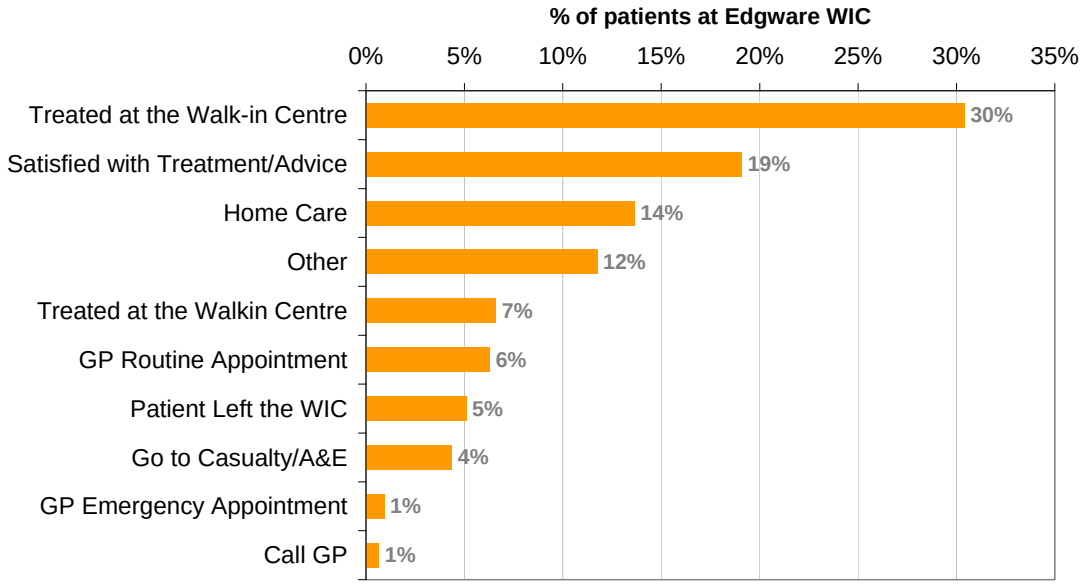


Figure 106: Top 5 outcomes at Finchley walk-in centre

(Outcomes shown capture 92% of all outcomes)

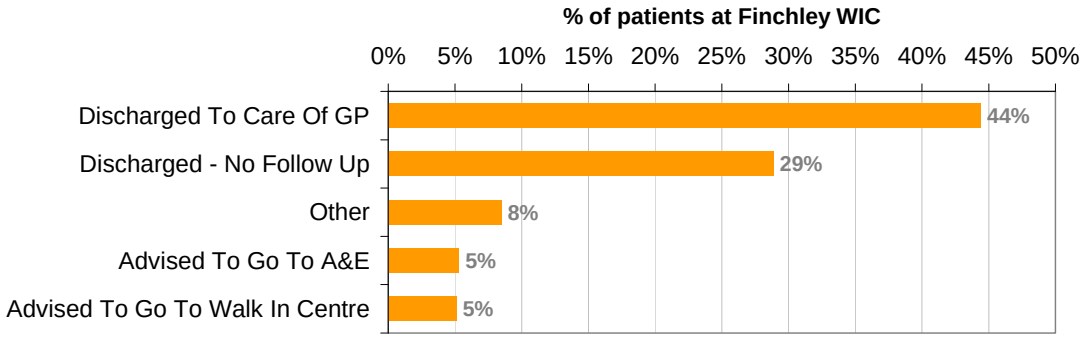
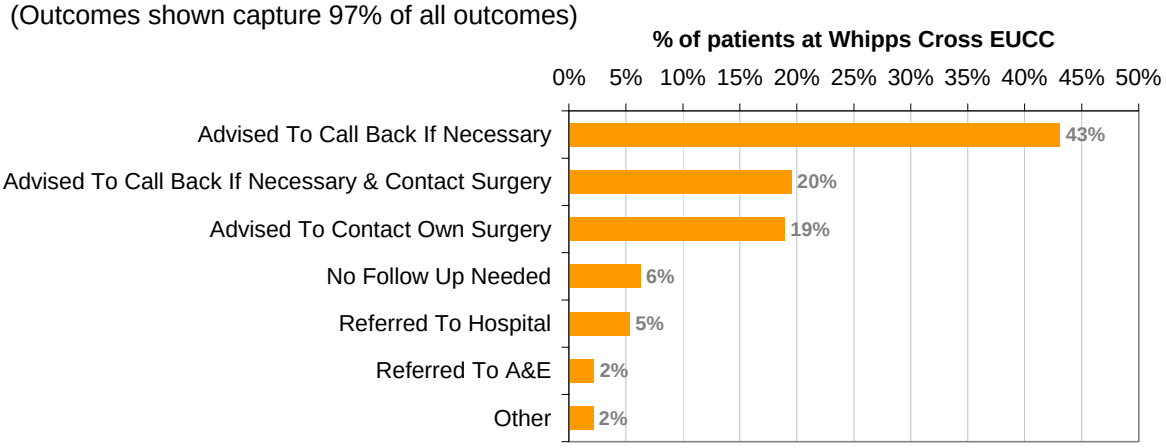


Figure 107: Top 7 outcomes at Whipps Cross urgent care centre

(Outcomes shown capture 97% of all outcomes)



Whipps Cross EUCC is located at the front of the A&E department and is a GP led service. A high proportion of patients are advised to "call back to the EUCC if necessary", which contrasts with the WICs and A&Es which mostly advise patients to return to the care of their own GP.

G.5 GP out of hours service outcomes

This section provides information on the type of consultations, and the outcomes for patients who access GP Out of Hours (OOH). There are significant differences between OOH providers.

Case types for patients using GP OOH services

Figure 108: Case types for patients calling the Barnet GP out of hours service

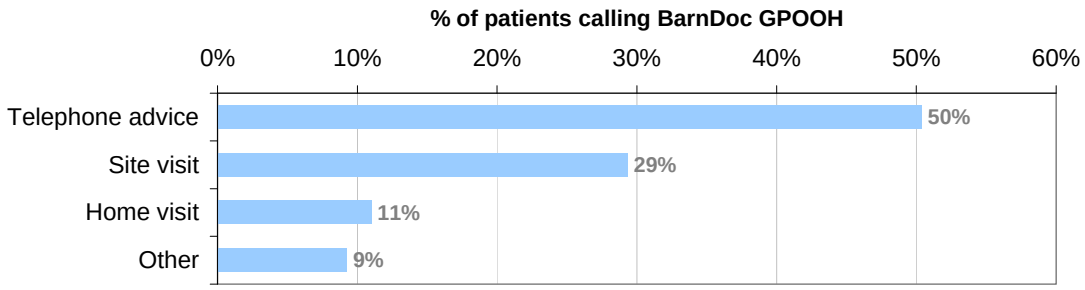


Figure 109: Case types for patients calling the Camden GP out of hours service

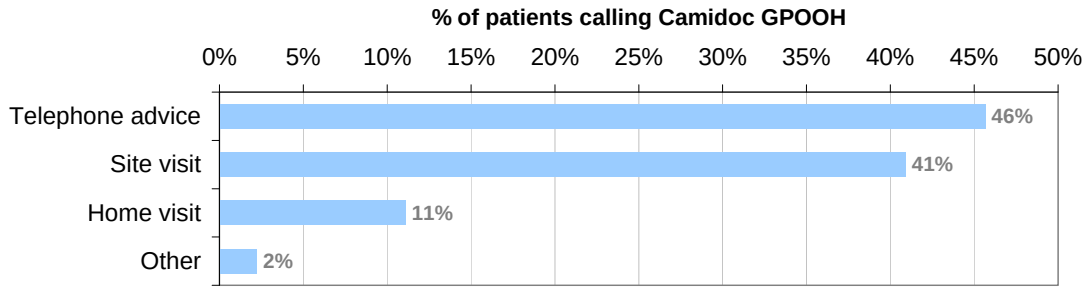
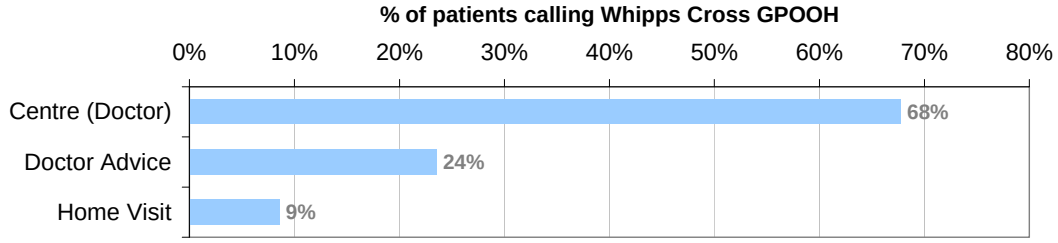


Figure 110: Case types for patients calling the Waltham Forest (Whipps Cross) GP out of hours service



Outcomes for patients using GP out of hours services

Figure 111: Top 7 outcomes at Camden GP out of hours service

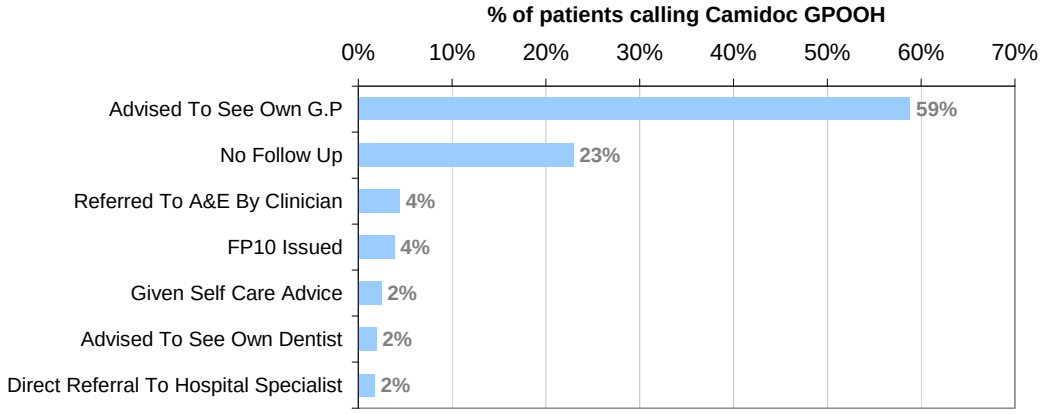
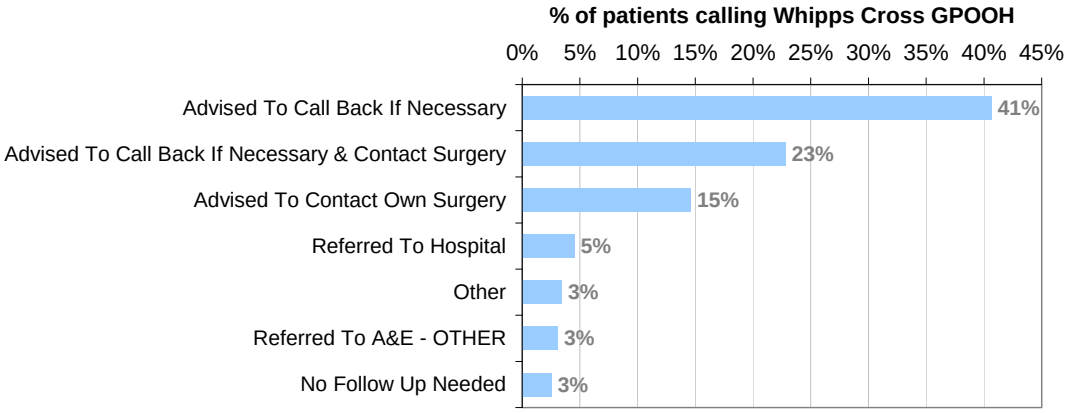
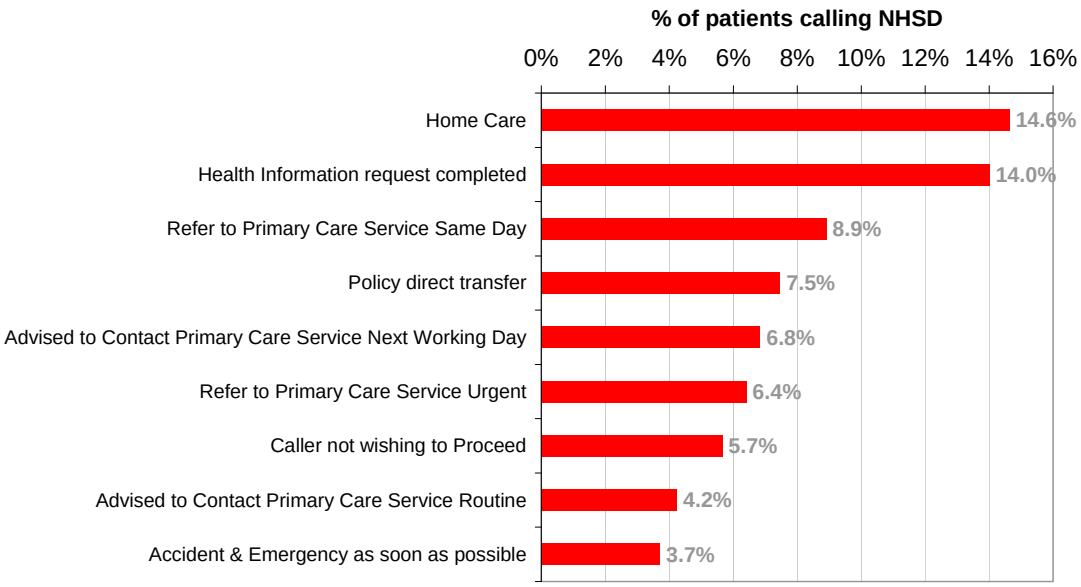


Figure 112: Top 7 outcomes at Waltham Forest (Whipps Cross) GP out of hours service



G.6 NHS Direct outcomes

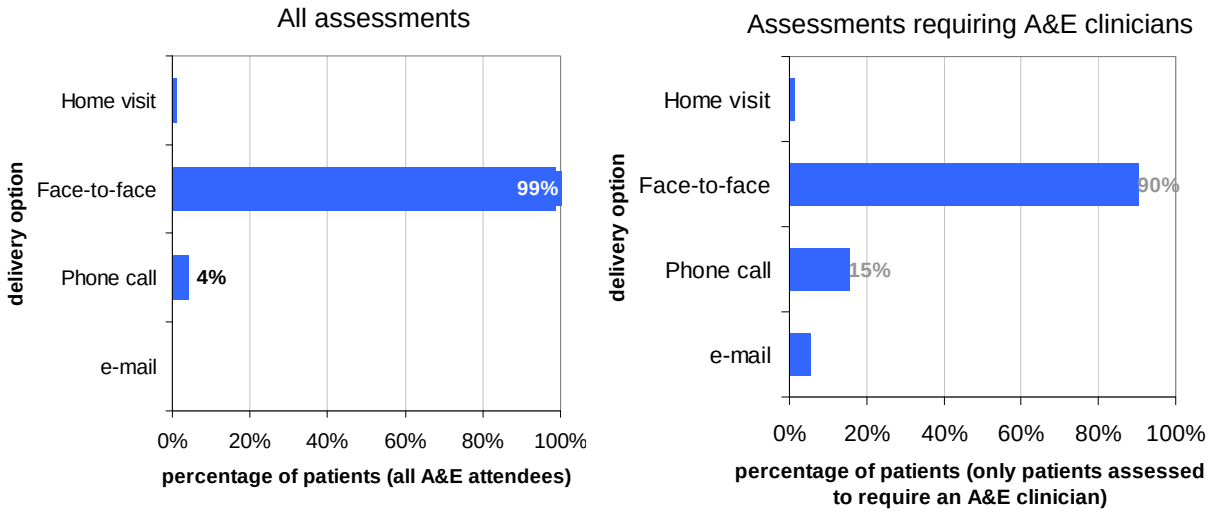
Figure 113: Top 9 outcomes of calls to NHSD



Appendix H: Alternative delivery options

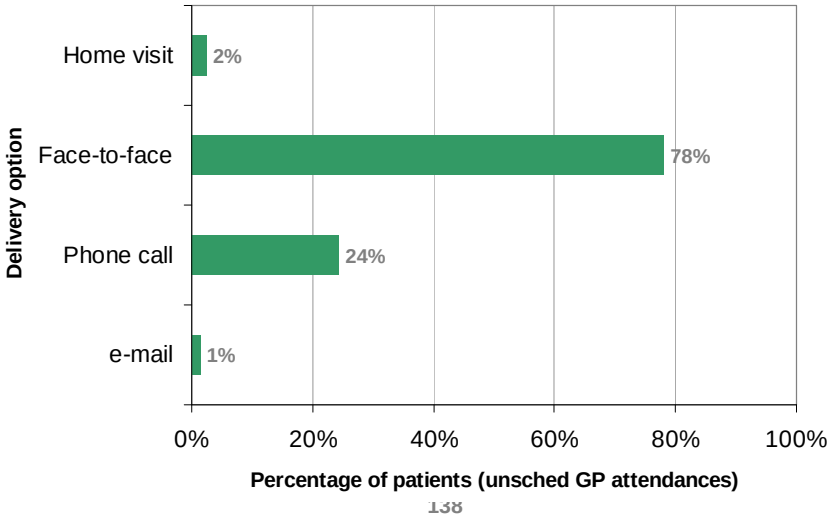
For approximately 90% of patients assessed at A&Es, a face-to-face consultation/treatment was considered the most appropriate delivery option. Almost all cases that required an A&E clinician for appropriate treatment also required a face to face visit. Phone-calls were considered an appropriate delivery method for 4% of cases presenting at A&E.

Figure 114: Appropriate delivery methods patients presenting at A&E in live data capture



Face-to-face consultation was the most appropriate form of delivery for the majority of unscheduled care patients assessed at GPs (nearly 80%). However, there were a significant number of patients assessed by GPs who could have been appropriately dealt with over the phone (around 20%). This shows that access to GP advice by telephone during the day could patients with effective care.

Figure 115: Appropriate delivery methods for all patients presenting at GPs in live data capture



Appendix I: Where patients choose to access care relative to where they live

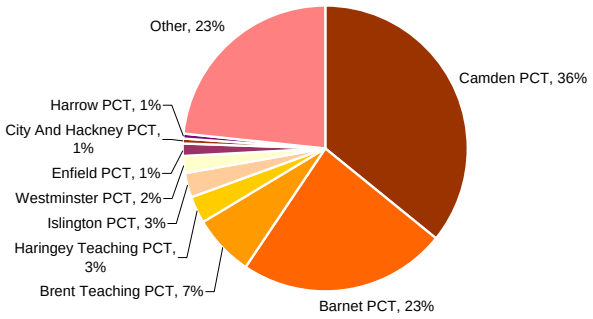
Patients state that closeness to home or work is a top priority for choosing where to go for unscheduled care services. This is confirmed by analysing the geographic spread of attendees to a variety of unscheduled care access points across London. However, the analysis also shows interesting variation in service use per population in areas close to access points. The top findings are that:

- Patients are most likely to seek care close to where they live or (presumably) work.
- There are significant differences in the level of service use per population for within areas close to an access point.
- There are indications of more frequent use of A&E services in general for those living closer to A&E departments.
- PCT boundaries appear to impact on patient's choice of access points for unscheduled care.

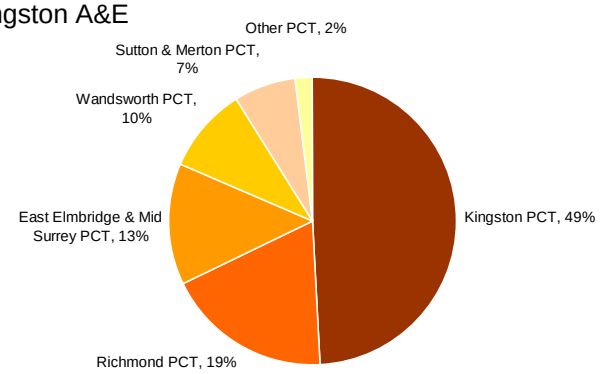
Centrally located unscheduled care access points, like the UCH A&E department have attendees from a wider part of London, compared to less central access points. This indicates that patients seek care both close to where they live, and otherwise close to where they work. About 27% of UCH attendees are from Camden PCT, whereas Barnet and Newham A&E departments have high numbers of attendees from the local PCT population (>80%). These clearly serve a more stable, less transient, residential population compared to other PCTs. This means that unscheduled care services needs to be tailored both for the needs of the PCT resident population, and also for the more transient population. The below charts shows PCT of residence for patients attending the Royal Free and Kingston A&E departments. Half of all patients visiting Kingston A&E reside within the commissioning PCT.

PCT of residence for attendees to Royal Free and Kingston A&Es

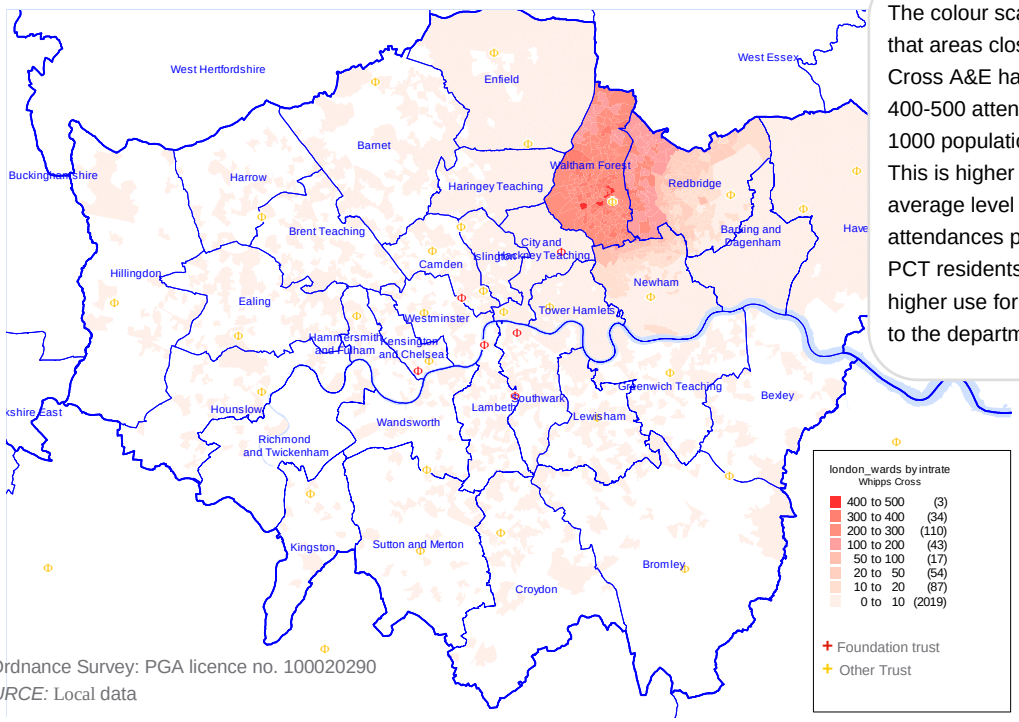
Royal Free A&E



Kingston A&E



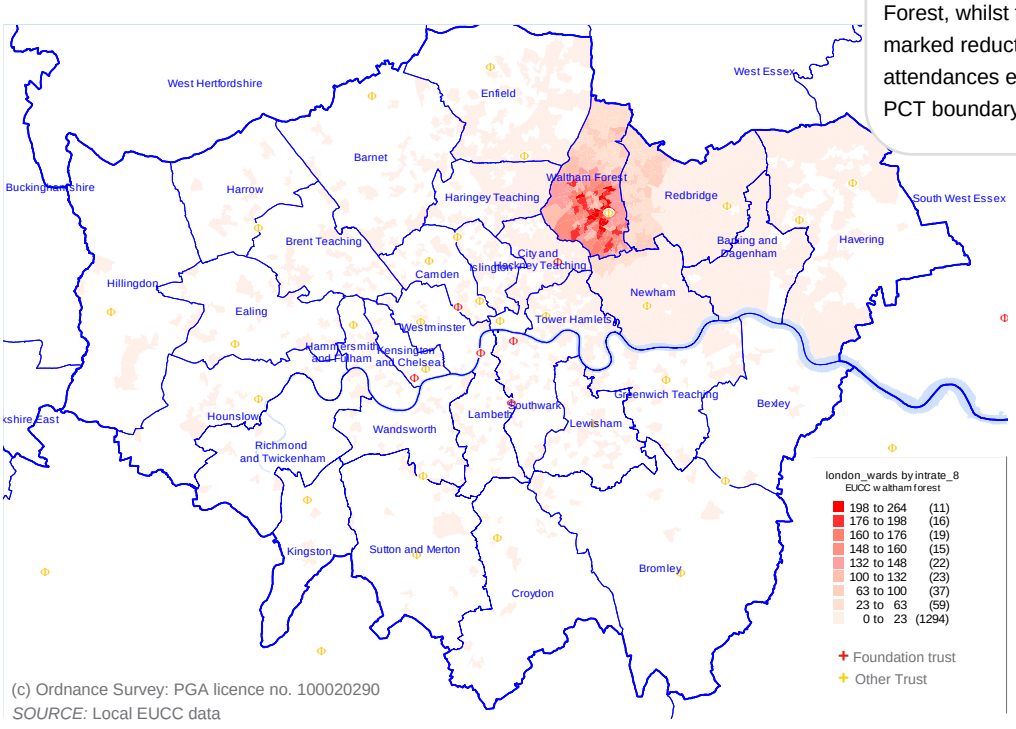
Heat map of annual attendances to Whipps Cross A&E per 1000 population



The colour scale indicates that areas close to Whipps Cross A&E have up to 400-500 attendances per 1000 population per year. This is higher than the average level of 330 attendances per year for PCT residents, indicating higher use for those close to the department

SOURCE: Local data

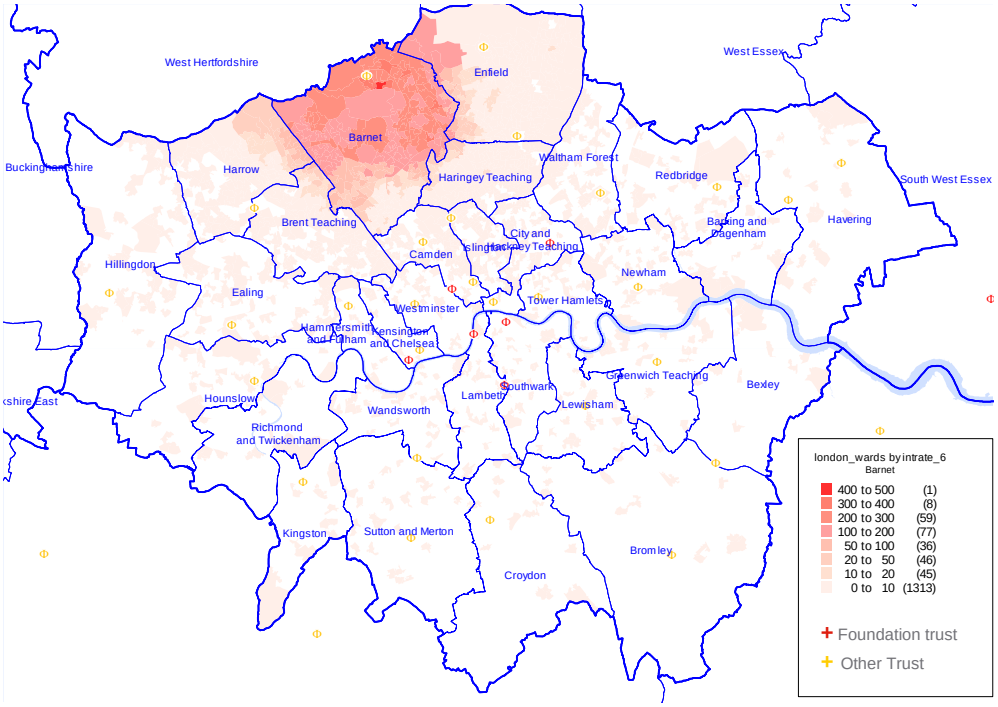
Heat map of annual attendances to Waltham Forest EUCC per 1000 population (the EUCC is co-located with the A&E at Whipps Cross Hospital)



Areas west of the PCT are much more likely to use services in Waltham Forest, whilst there is a marked reduction in attendances east of the PCT boundary.

SOURCE: Local EUCC data

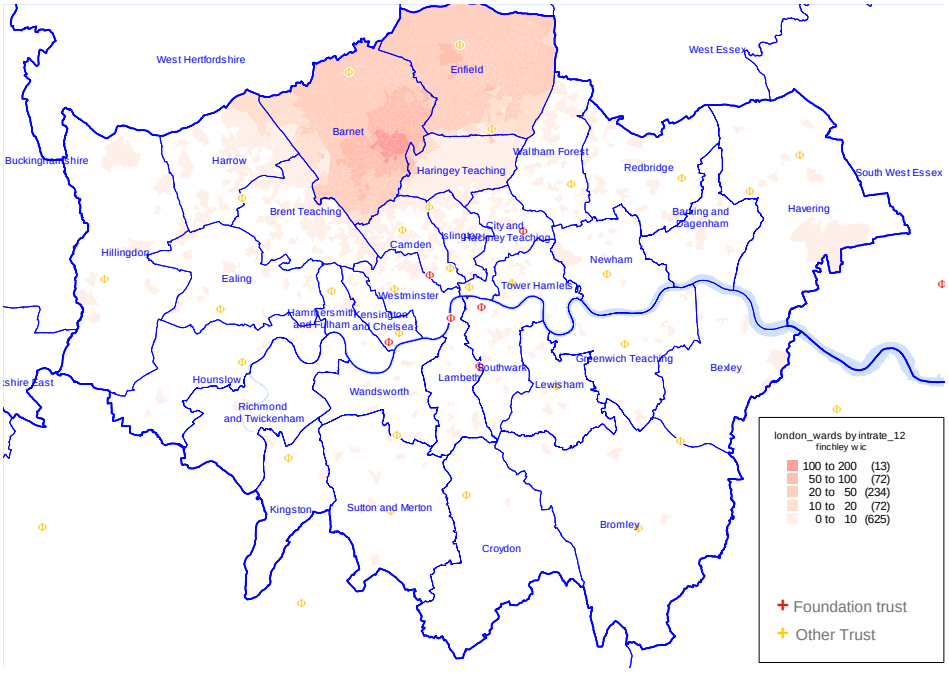
Heat map of annual A&E attendances to Barnet General per 1000 population



(c) Ordnance Survey: PGA licence no. 100020290

SOURCE: Local A&E data

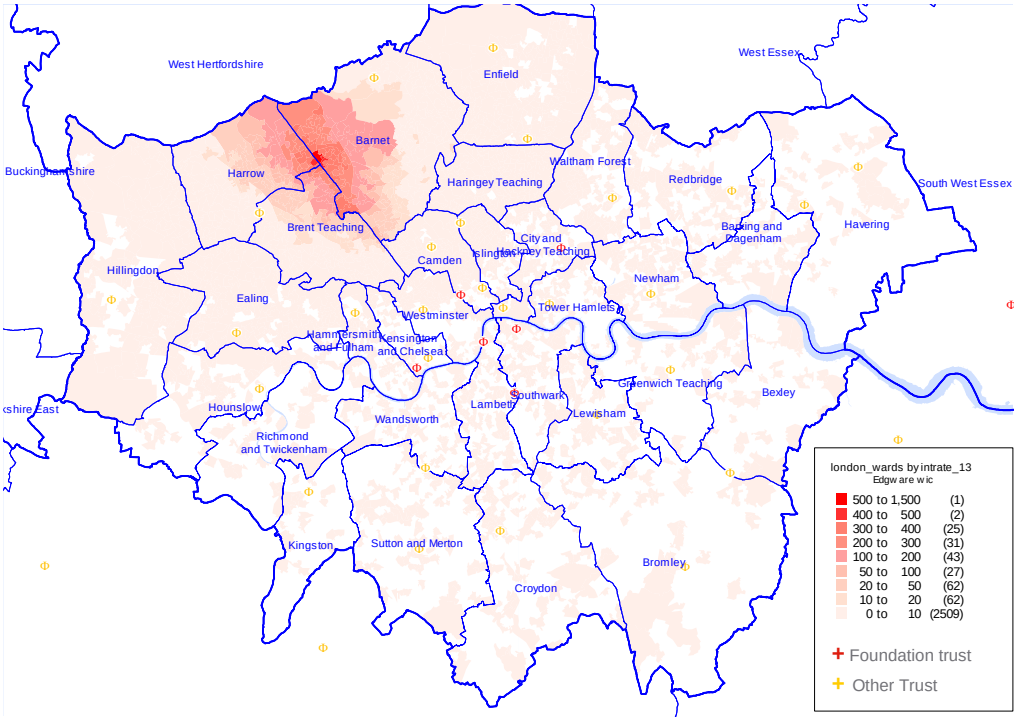
Heat map of annual attendances to Finchley WIC in Barnet PCT



(c) Ordnance Survey: PGA licence no. 100020290

SOURCE: Local WIC data

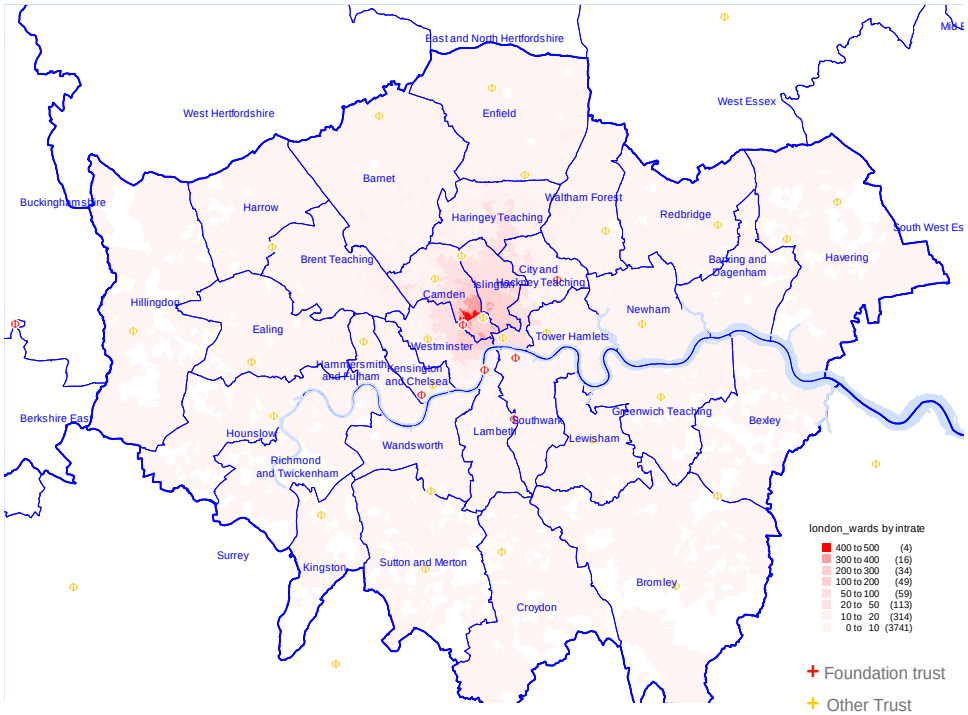
Heat map of annual attendances to Edgware WIC per 1000 population



(c) Ordnance Survey: PGA licence no. 100020290

SOURCE: Local WIC data

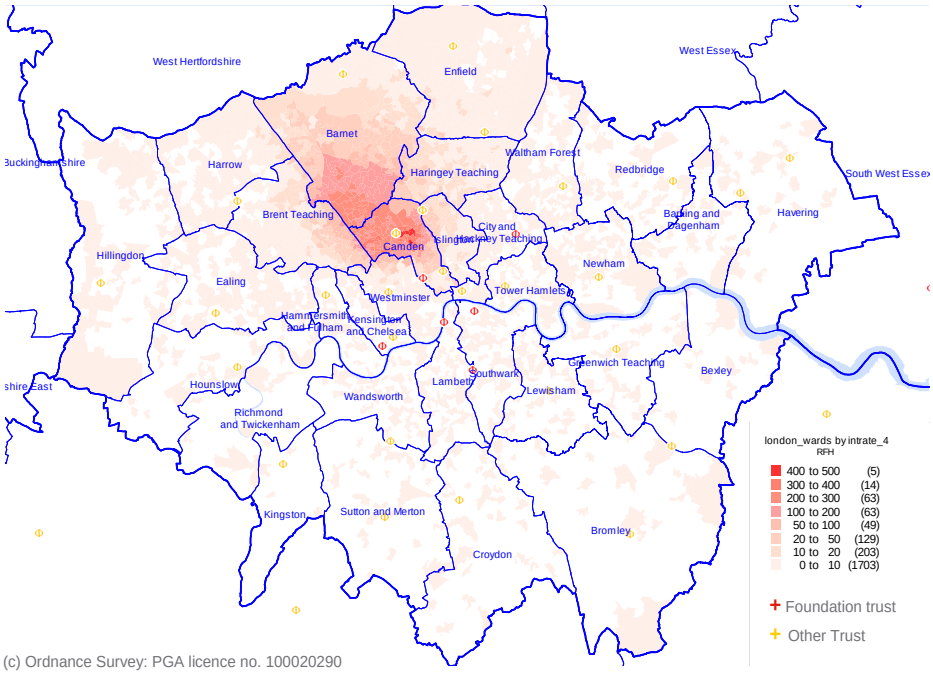
Heat map for annual attendances to UCH A&E per 1000 population



(c) Ordnance Survey: PGA licence no. 100020290

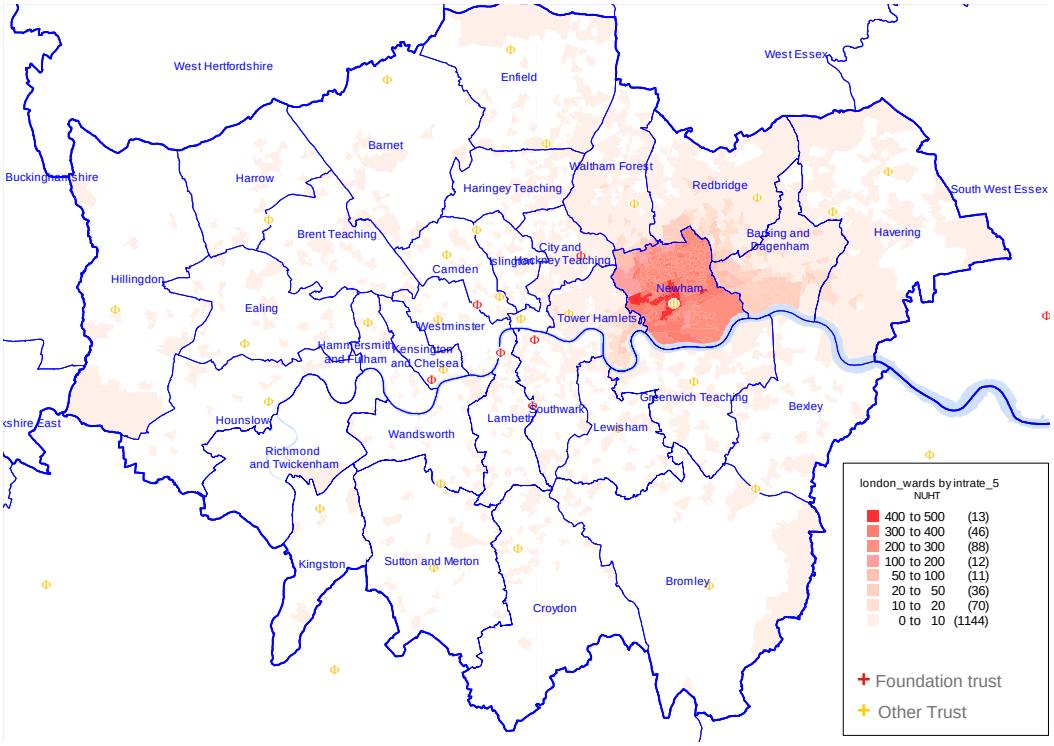
SOURCE: Local A&E data

Heat map for annual attendances to Royal Free A&E per 1000 population



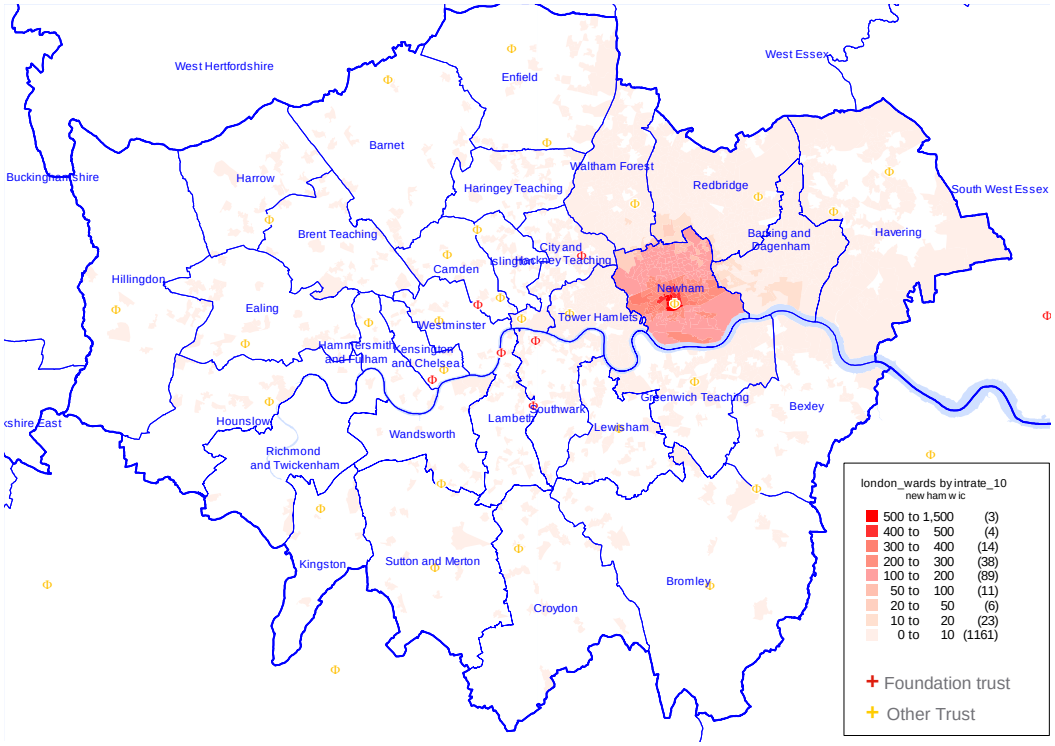
SOURCE: Local A&E data

Heat map for annual attendances to Newham A&E per 1000 population



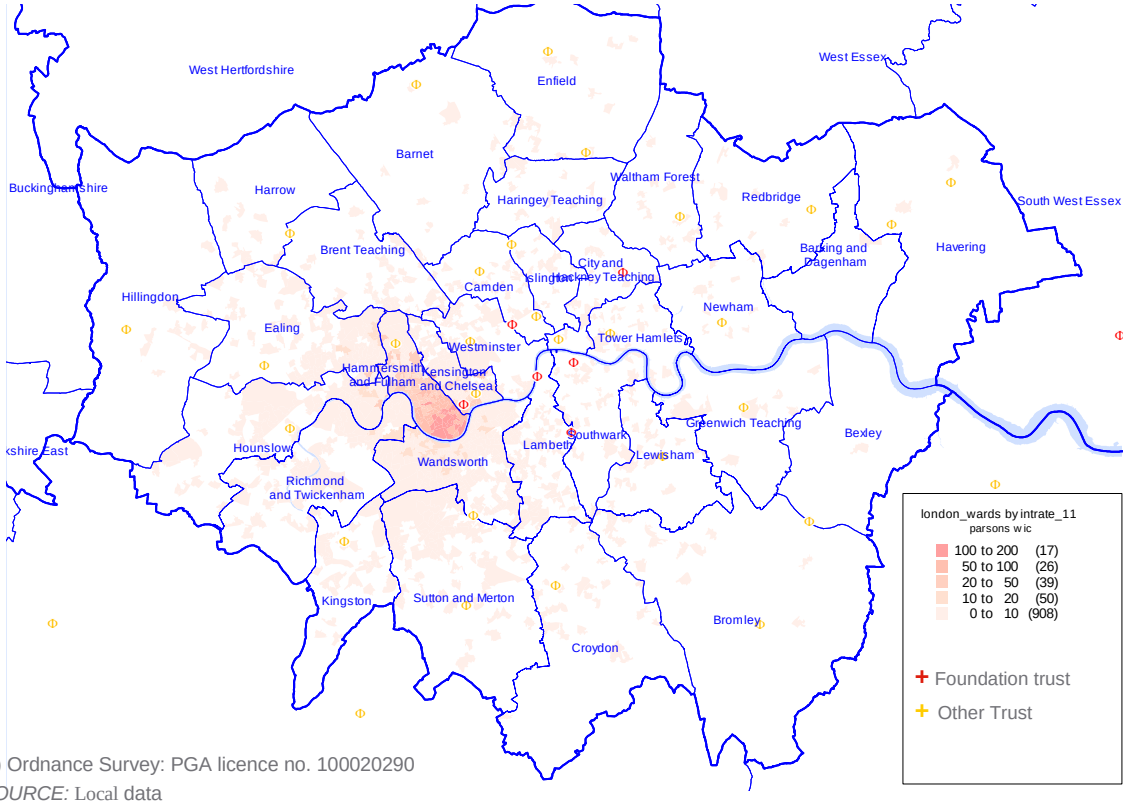
SOURCE: Local A&E data

Heat map of annual attendances to Newham WIC per 1000 population



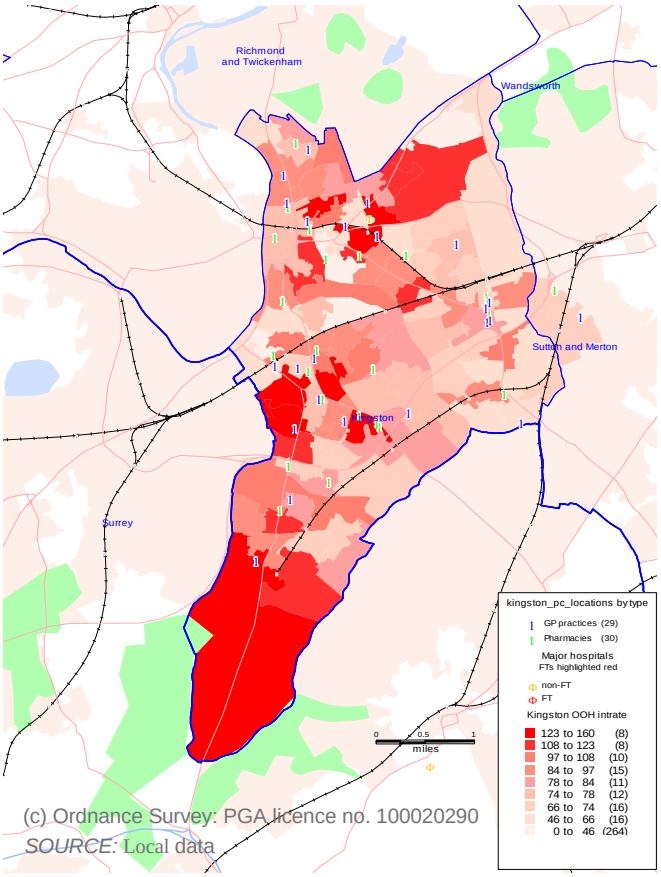
SOURCE: Local WIC data

Heat map of annual attendances to Parsons Green WIC per 1000 population



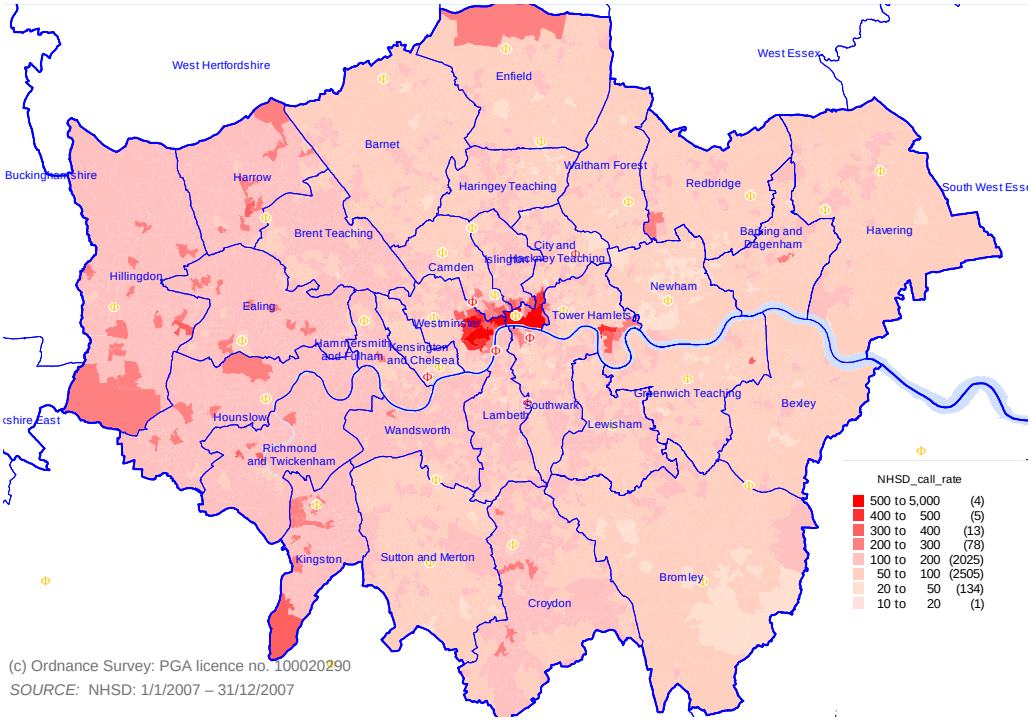
SOURCE: Local data

Heat map of calls to Kingston OOH service by 1000 population per year



This map shows the number of calls to Kingston OOH service per 1000 population per year, along with the location of GP practices and pharmacies.

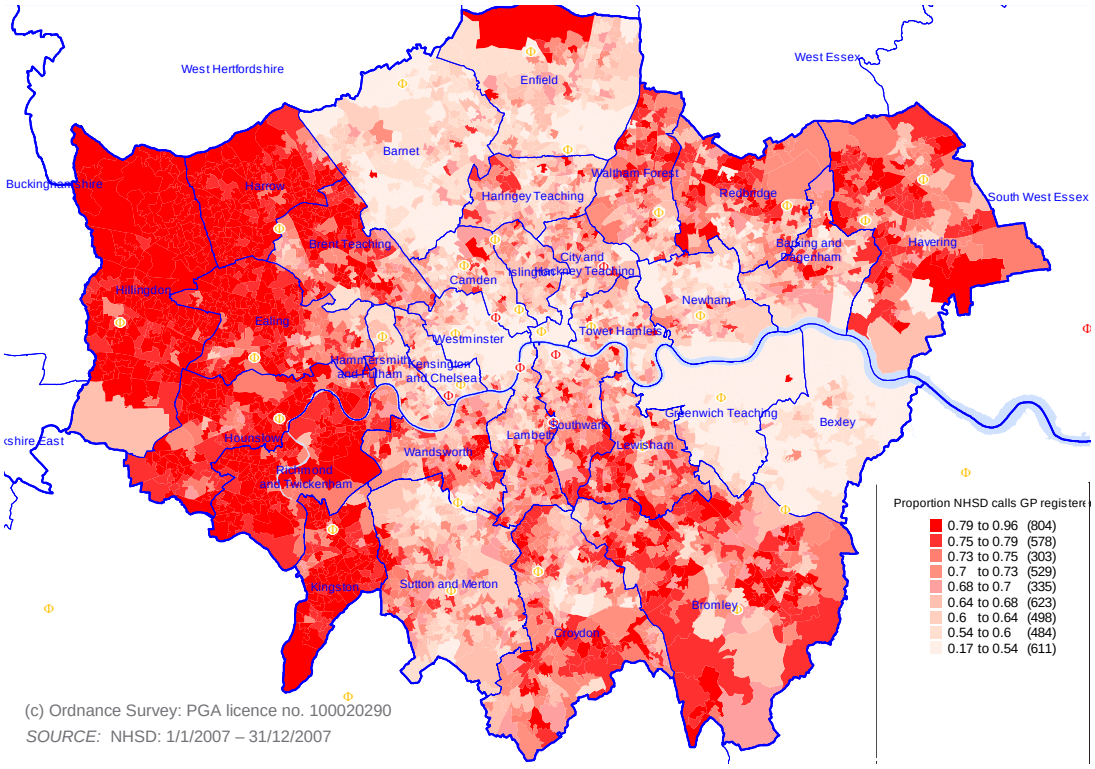
Heat map of calls to NHS Direct per 1000 population per year



(c) Ordnance Survey: PGA licence no. 100020290
SOURCE: NHSD: 1/1/2007 – 31/12/2007

This map shows the average number of calls over a year to NHS Direct per 1000 population. Residents in West and Central London appear to make a greater number of calls. The below map illustrates the percent of calls to NHS Direct from GP registered patients. The level of calls for non-GP registered patients (lighter areas) is much higher in central and south east London than in other areas.

Percent of NHS Direct calls made from GP registered patients



(c) Ordnance Survey: PGA licence no. 100020290
SOURCE: NHSD: 1/1/2007 – 31/12/2007

Appendix J: Findings from focus groups

Key findings from Focus Groups

- Respondents from across the groups said that A&E was an obvious choice or urgent care as it is always open and there is the reassurance that the facilities are in place there to give them the correct treatment. A common complaint about A&E was the lack of cleanliness and lengthy waiting times
- A common factor in many of the groups was the difficulty in accessing a GP. Many respondents suggested that GP's appointments were difficult to get and, in some cases, they just ended up being referred on to A&E anyway
- There was some positivity amongst patients who had used Walk in Centres or Minor Injuries Clinics. However, there were a number of comments that the waiting times could be just as long as at A&E, with patients attending MICs or WICs often being referred on to A&E
- Pharmacies were generally not spontaneously mentioned as a source of urgent care. However, when they were discussed there was some support for pharmacies offering consultation regarding minor ailments and a number of positive experiences concerning care received in pharmacies
- Many people from across the groups had not used NHS Direct. Those who had were generally positive about the service provided, although others felt that the service often just referred people to A&E or their GP
- Extended hours in GPs surgeries, increased private consultation in pharmacies and a telephone line, with potential GP support via the phone were all broadly supported as potential future models.

Barnet group – 19th March, aged 55+, mixed social grades

A&E

The minority of participants were aware – and used – other out of hours services, but most considered A&E the obvious destination when their GP surgery was closed. As in other focus groups, the opening hours and comprehensive range of services on offer were the overriding factors. Surprisingly, standards of care, or location, were less influential in deciding where to go.

Participants were critical of the cleanliness, and the long waiting times at A&E, but saw it as a question of assessing the seriousness of the illness and the urgency of the situation. There was a perception of taking a risk by not going to A&E – i.e. potentially underestimating the seriousness of an illness, and by being in A&E you are at least 'in the right place' if its worse than you think. This was particularly important when participants were asked to consider how they would care for any urgent illness for a child.

GP Surgeries

Experience of GP surgeries varied considerably within the group – from those with a responsive phone booking system, to others who reported positive experiences to turning up for emergency appointments and being seen promptly, while others reported long waiting times to see a GP.

Within this age group, many had on-going long term conditions and when an urgent episode occurred they were generally keen to be seen by the practice nurse, and would only resort to A&E if it was out of office hours, and the situation was beyond their scope for self-management.

There was also some criticism of the GPs. While they acknowledged that it was unrealistic to expect to see the same GP each time they went to the surgery, this meant that the GP would not know their history, they would have to give a lengthy briefing on their condition, and often resort to self-diagnosis when the GP suggested drugs that they had already tried and found ineffective. This was in marked contrast to practice nurses with whom they had consistent contact, and who knew their history.

Minor Injuries Unit

Knowledge of the local Minor Injuries Unit was low, with participants aware of the hospital's existence, but knowing little about the range of treatments it could offer, and when it is open.

Those who had used the Unit were positive about the staff, but there were mixed reports as to how long one would wait to be seen. Some reported waiting as long as at A&E, and then eventually being referred to A&E – and were disparaging about the point of attending this type of Unit.

In addition to a general lack of knowledge, this age group mentioned that they did not know which bus routes served this hospital, and that this was enough to deter them using the Minor Injuries Unit, rather than A&E, even though they appreciated they would probably wait longer at A&E. Others mentioned that the nearest bus dropped you 5-10 minutes walk from the Unit, and that again this was a deterrent to using the Unit.

NHS Direct

Knowledge and experience of NHS Direct varied greatly. The minority who had used it were very positive – reporting helpful, appropriate advice, and, in the example of an angina 'attack', an ambulance arrived within minutes of the NHS Direct call finishing.

However, most had not tried the phone line, were unaware of the number, and needed guidance on its role and scope.

Pharmacy

The group had a relatively clear perception of the range of minor ailments that they would take to a pharmacist for advice. They mentioned skin rashes or back pain as examples that they did not consider worth using up a GPs time, and illnesses that were not sufficiently uncomfortable or disabling to take any further.

Future Models

Among this group there was only limited demand for extending GPs opening hours. The greater concern was the availability of appointments – rather than the time of day they were available.

Participants did not raise concerns about discussing personal complaints with their pharmacist. While greater privacy may encourage more use, a greater factor was the perception that the pharmacist's knowledge only extended to a very limited range of minor ailments – ailments where participants often felt relatively confident of self-diagnosis.

The minority of group participants who had used NHS Direct were positive – and would be open to an extension of the service. However, most knew little about current provision, and were unaware how and when it could be helpful.

Camden group – 20th March, aged 16-35, mixed social grades

A&E

This group focused on the twin factors of convenience and comprehensive service. Despite concerns about lack of cleanliness and sharing the waiting room with drunks, the fact that they knew where to find A&E, that it was always open, and that whatever was wrong with them, they were in the right place to receive treatment were compelling factors for this group.

Several were aware that the UCH A&E department was fronted by what they described as, an 'assessment unit staffed by nurses', from which you would either be treated, or sent on to doctors in what they perceived as the 'real A&E'. This triage unit was seen as very helpful, so that they could present the full range of problems from flu to life-threatening urgent conditions.

"If it's a question of A&E or waiting three weeks for an appointment, I know which I'd rather have"

Female, aged 16-35

GP Surgeries

Experience of GP surgeries varied hugely, with most participants critical of availability of appointments. This meant that many did not even consider their GP as an option when they had an urgent care need, as they were often told the first appointment was in 2-3 weeks time.

In contrast, the participants with children reported flexibility from GPs when they had an urgent situation with a child, and getting last minute appointments when necessary.

Drop-in/ Walk-in Centres

A minority had used a Walk-in Centre. Its appeal was its proximity to participants' workplace, and the fact that an appointment was not necessary. They were very positive about the experience – citing prompt, and polite service – while others were aware that there can be long waiting times. Participants felt they could take minor problems to be treated that would otherwise have become major ones by the time they had an appointment with their GP.

Minor Injuries Unit

Again, a minority of the group were aware of a Minor Injuries Unit, but despite praising the quality of care, were conscious that the waiting time could be as long as that experienced at A&E, and they may well be referred on to A&E – meaning that they sometimes circumvented the Minor Injuries Unit, going straight to A&E. Notably, it was the group members with children who were aware of the Unit and more likely to use it.

However, it is not the lack of specialist staff that deters patients from using this type of service. It's the fact that the service isn't as comprehensive as A&E, and that they may be referred on to A&E anyway.

NHS Direct

Half of the group had made use of NHS Direct. This was either because they had a poor relationship with their GP, and so used the phone line as an alternative source of health advice, or because it was used by those with children to help assess whether or not a situation was sufficiently serious to take the chid to A&E.

Pharmacy

The group did not spontaneously consider their local Chemist as a source for urgent care, but when prompted reported using it for advice/treatment on minor ailments. They often described these as being situations that they did not feel warranted a GPs time, nor were seriousness to present at A&E.

Future Models

There was considerable interest among this age group in extending GPs opening hours – although this was mixed with scepticism whether this would really make it any easier to get an appointment.

"You can open the doctors from 6am till midnight, but if there's still not a doctor there who can see you, what's the point"

Female, 16-35

Opinion was divided on whether early mornings, late evenings or weekends would be more convenient. However, participants did acknowledge that this service need only be limited – for example, to one evening a week, or every alternate Saturday.

There was positive support for greater privacy at the Chemist, enabling private consultations with the Pharmacist. If a rapid service, with short waiting times, the majority felt that this would encourage them to make greater use of the service – and some thought that this option of a private consultation was already available at a large local Boots branch.

"I'd use it where I'd mostly otherwise drop in to see the doctor – but it depends if I could drop in and be seen in five minutes, rather than wait 45 minutes at the doctors"

Male, 16-35

The group were strongly supportive of increasing the range of services on offer by NHS Direct, but saw no point in these being established on a separate, new phone line. They felt that an additional phone line would simply add to the public's confusion on where to get advice. They supported the idea of being given information on where to get local treatment, or which local pharmacies might be open. One user of NHS Direct said they already received that advice. While participants welcomed the idea of the phone line being able to make an appointment with your GP, they were sceptical about the ability of the NHS IT network to make this happen.

They did not see the need for the phone line to be staffed by more doctors – saying that the service currently provided was good, and that you sometimes spoke to a doctor, when necessary. They were also doubtful that the computer system would be capable of showing the NHS Direct Doctor their full medical records, and without these the consultation would be limited. While they appreciated the potential convenience of a prescription being given over the phone, and sent directly to a local pharmacy, they felt that this was open to such wide-scale abuse that it was not viable.

Hammersmith group – 19th March, aged 16-35, mixed social grades

A&E

The general feeling in the group was that they go to A&E since it has all the facilities, the specialist doctors and consultants and generally can provide help for all 'urgent' matters.

However, they feel that going there is a necessity rather than a choice:

I do not choose to go to A&E since it is all dirty, you have to sit next to drunk people and can end up waiting for hours to be seen,

Female, 16-35

There were many comments about the lack of cleanliness in hospitals – examples of blood on the floors and things not being tidied up. They acknowledged that the nurses are busy but feel there should be more cleaners.

Many said that they often called NHS Direct or went to their GP for 'urgent' matters, but that they were then sent to A&E. Sometimes they therefore decided that they may as well go straight there and bypass their GP or another health service.

When considering their own health, they were likely to self-diagnose before deciding where to go. In contrast, when it came to their children, they were more likely to take them straight to A&E since they said that you can not always tell what is wrong with children and illnesses can be more severe, and fast-changing with them.

"If a child loses blood, it is more serious since they are smaller"

Female 16-35

GP surgeries

The group felt that they could go to GP surgeries for a range of illnesses and were happy to go there, however lack of accessibility was frequently mentioned and seen as a key reason for not using the GP as often as was appropriate.

"I would go to the GP more often. However, often when things happen, the GP surgery is closed, so I have to go to A&E. It also then makes me automatically think of going to the A&E, rather than my GP if something does happen"

Male,16-35

They said they would go there more often if their opening times were extended.

Many mentioned the positive side of having a regular GP and building a relationship with them, including the advantage of having awareness of their medical history. This was seen as a positive thing, however a number said that having moved to London, they found always seeing the same GP was more difficult (although experiences did vary).

Drop-in/ Walk-in Centres

Participants mentioned that people tended to use Walk-in Centres if they did not have a GP (such as those not in the country for long or those struggling to get onto a GP list).

People who had used these services said that they had found these centres offer a good range of services for most illnesses and injuries (unless obviously a life threatening situation where they would go directly to A&E). However, they said that the waiting times were extremely long, sometimes longer than in A&E, which did put them off going there.

They mentioned they went to other health centres, where services such as Family Planning, maternity and other services were available. They were satisfied with these centres and the services they offer.

Minor Injuries Unit

Only a small number of the respondents had used this service. The group participants felt that these centres were a good idea and would go there for minor, non-life threatening injuries. The reaction to them was generally positive, although only a minority had used them or were aware of them.

Along with the Drop-In centres, respondents said that these units are not always the first thing that comes to their mind when they are ill or injured. They admitted sometimes they had been to A&E when they could have gone along to a Minor Injuries Unit.

NHS Direct

NHS Direct was not spontaneously mentioned at first. Opinions about NHS Direct were quite positive with participants saying that they had received a good service with the phone being answered straight away. There were negative comments that you do sometimes have to wait a little while for a response – this was seen as acceptable if the situation was not an emergency, but not acceptable for urgent concerns.

It was also mentioned that often NHS Direct just send you to A&E anyway (particularly when concerning children), so not always that helpful.

Pharmacy

This was mentioned quite low down in the spontaneous question about health services in the area. People mentioned that they would use them more if they were closer to GP surgeries and hospitals.

Future models

All the respondents said that when in A&E, they accepted that they would first be seen by the triage nurse and then the doctor or consultant afterwards. They were aware this was the normal procedure, although they were not always happy about it.

In an ideal world, they said that they would prefer to be seen straight away by a doctor or consultant. They did say however that if a nurse could treat them then they would be happy to be seen only by the nurse. They did not like that they had to explain their symptoms to three different people when they go to A&E, so ideally would like to be treated by just one person.

The key priority for the future and improving services was to make more people aware of all the different health services available and what people can get treated for in each of these. They said there needs to be more advertising of these services in GP surgeries, hospitals, local community centres, phone books etc. Participants felt that A&E is an automatic, top of mind response to an urgent care situation, produced from experience of being referred there from other services, and also lack of knowledge of the other options available to them.

Kingston group – 19th March, aged 35-55, mixed social grades

GPs

The general feeling about GPs was very negative, with the majority mentioning that they are often not very understanding, patients feel they are being ‘treated like cattle’, and occasionally rude, particularly GPs receptionists.

"You have your five or 10 minute appointment slot and then you are turned out, even if you have something further to ask"

Female, aged 35-50

"I once booked a double appointment since I needed more than five minutes. I was then told off for doing so!"

Female, aged 35-50

A further major issue was around access to the GP. As in other groups, getting an appointment was mentioned as difficult. The participants felt all the early morning appointments were booked up in advance by the elderly and retired. The working age group members felt that retired people (particularly for regular check ups) should visit the doctor during the day and leave the early morning, evening and weekend slots (if they offered them) to those who work. Some also mentioned there should be certain appointment times for elderly and other times for younger (working) people.

Other complaints were around the picking up of bugs when waiting to see the doctor, and GPs over prescribing drugs rather than listening to what the patients really are asking for.

A few said that they would use this service more often if access and their relationship with their GP were improved.

A&E

Spontaneous mentions were that the service from A&E is good, but slow.

"There are such long waits due to understaffing"

Male, aged 35-50.

Participants said the experience was good, once they were actually seen by staff.

They said that the service was better if children were involved, since they tend to be fast-tracked, whatever the issue. Others found this annoying when seeing lots of children passing through the system while they were waiting there for hours.

Many choose to go here in the first instance for urgent care. However, a few said they would be hesitant to go there first, and would normally go to a minor injury unit or drop in centre if their GP surgery was closed or they could not get an appointment.

When it came to children however, most of the respondents were more inclined to take them to A&E straight away rather than using any other health service, due to greater levels of concern/risk.

NHS Direct

Participants were very positive about NHS Direct, although is not highly used by the group.

Drop/walk in Centres and Minor Injury Units

These again have not been used frequently by the group, although there was good awareness surrounding what you would go there for. A couple of people had been to both the Drop-in and Minor Injury Units and had positive experiences, mentioning that waiting times were better than in A&E.

My experience was very positive. I was seen very quickly and would go there again.

Female, 35-50

Location was raised as a key consideration in deciding whether or not to use this service, rather than A&E. They mentioned that if Walk-In Centres were more local to them than the nearest A&E then they would consider going there instead, as long as the service delivered to them was as good. (As elsewhere, the quality of the service provided was generally taken as 'a given').

One person did mention that there were only nurses at some Walk-In Centres so treatment was therefore limited.

Pharmacies

This was one of the last health services to be mentioned by the group. It was acknowledged as a good service but it again shows that it does not initially spring to mind when thinking about where to go for urgent or other unplanned care.

What is important to people when thinking about where to go for urgent care?

The top issues were:

- Feeling like a human – being treated with respect
- Speed of being seen
- Opening hours (particularly around access to GPs)
- Facilities
- Previous experiences

Future models:

GP surgery with extended hours: Since access and ability to get appointments was mentioned as one of the major negative issues with GP surgeries, extended hours were seen as necessary.

Pharmacy for advice and treatment (private area): This was viewed very positively with respondents saying that pharmacists should be utilized more, particularly since they may have more knowledge about certain health aspects, and that this innovation would encourage them to make greater use of the service.

New telephone line that can provide urgent health care advice and give you local information: This was viewed as a good idea. They said they would use this service to advise them where best they should go, as people do not always know, and this would fill an acknowledged information gap. Participants felt it may even reduce their likelihood to attend A&E.

NHS Direct telephone line where can speak with a GP: This was also viewed very positively by most of the group. They felt that this had a number of benefits such as people being more inclined to call about certain issues that they may feel uncomfortable speaking about face-to-face.

"I think people with certain illnesses, particularly embarrassing things, may be more inclined to call a doctor rather than looking at one face to face when explaining what their problem is"

Male, aged 35-50

Other advantages included the ability to call at any time of the day and from any location, so avoiding having to wait in the surgery where they could pick up more bugs etc. However one or two respondents said they would not feel comfortable

Newham Group – 25th March, aged 16 – 35, mixed social grades

A&E

The group were fully aware of the one hospital in Newham – Newham University Hospital – and some had experience of visiting Accident and Emergency. With just one main hospital in the area, this group's views reflect the fact that it might be a stretched resource and therefore not the most effective place for some types of urgent care.

There was a significant level of frustration over the waiting times and it was recognised that often they were referred back to their GPs – who hold patient records - for further treatment, or when they have to prescribe particular specialist medicine. The way they are dealt with in the Triage area of A&E was mentioned as a particular frustration, as they feel they are being passed from pillar to post before receiving actual treatment, and they express concern at not being able to see what is going on behind the waiting area. Some people also recounted stories of perceived poor service at hospital e.g. a broken finger not corrected properly.

While most people felt that A&E was the obvious place to go for urgent treatment (e.g. breathing restrictions), not all participants felt that it was the obvious place to go for treatment out of hours, some preferring to wait to see their GP or visit a local walk-in-centre.

"I would take a chance, if my daughter has a rash, I wouldn't sit for six hours in A&E…I would just go to a GP the next day."

Female, aged 16 - 35

GP Surgeries

Most people valued their GPs, and expressed confidence and trust in them. Some said they would choose to go there rather than use out of hours services, such as A&E. Only one person had used an out of hours GP service, where they were able to speak to a GP, who then advised them to go to A&E. The rest of the group considered being able to actually talk to a GP out of hours very low on their list of priorities for urgent care.

The idea of extended opening hours received mixed reactions, as there was scepticism over how this would be managed and what it would mean for the workloads and energy levels of GPs. Others thought that they should work longer as they feel GPs currently get paid too highly for the hours they work.

"Why can't one work eight hours, and another work eight hours in the evening?"

Male, aged 16 - 35

It was suggested that a balance could be struck by opening the surgery slightly earlier (8am) and staying opening slightly later (8pm), as some surgeries currently do on selected days of the week. A rotation system was mentioned at the other extreme, so that doctors are available 24/7.

"They should have a rotation system so a GP is available at all times."

Male, aged 16 - 35

One participant mentioned a new system at her GP which helps alleviate the stress of waiting in crowded waiting rooms, in the form of a screen that gives them information about waiting times.

"You know what doctor is seeing who, so you know when you're next. It lets you know, if you're third or whatever."

Female, aged 16 - 35

Drop-in/ Walk-in Centres

Walk in centres were seen as useful for dealing with minor injuries, e.g. bleeding and cuts. It was recognised that they have nurses not doctors, whereas you are treated by doctors at A&E. There were concerns that they were just another form of triage and chances of being sent to A&E are high, so some preferred to by-pass this stage.

"They're qualified, but just not qualified enough"

Male, aged 16 - 35

"With the Walk-In Centre, you go there and then they have to assist you and they send you to (A&E) triage anyway, so it's a waste of time to go there in the first place."

Male, aged 16 - 35

Minor Injuries Unit

Knowledge of a specialist Minor Injuries Unit was low, with most participants seeing the Walk-In Centre as the place to go for minor injuries. One participant mentioned that first aid is important in these cases, and self care should come first before rushing to A&E/Walk-in Clinics.

NHS Direct

NHS Direct was not spontaneously mentioned as a service available to them in their area, but one member of the group pointed out that the council has a dedicated phone line for sick employees to call to get advice (as well as to formally report in sick).

One participant had used, and was an advocate of, NHS Direct, with good and timely advice given.

"It was quite useful actually. I had something (which) I wasn't sure what it was. It was like more reassuring than anything else. They helped me calm down, I was a bit hyper. Quite late at night it was."

Female, aged 16 - 35

Once NHS Direct was introduced to the group, some of whom weren't aware of the service, some people thought that it could be a useful service, particularly out of hours when can't get to A&E.

"I didn't know about that, I didn't know I could call up and find information."

Male, aged 16 - 35

Pharmacy

Pharmacies weren't mentioned spontaneously as a service that would be useful for urgent care, or even for general health reasons. They were recognised as being a valuable service, however, when it comes to colds and flu, when you know what your symptoms mean.

"They seem very knowledgeable, the pharmacists."

Female, aged 16 – 35

"They get the same education; they know exactly what they're giving you. If you know your symptoms then I think it's better to just go and explain to the pharmacist."

Male, aged 16 - 35

"If my kids have a rash, I would never take them to a pharmacist. You can get three hundred rashes."

Male, aged 16 - 35

What is important to people when thinking about where to go for urgent care?

- Waiting times
- Opening hours (particularly around access to GPs)
- Who is best qualified to deal with the injury
- Relationship with the service provider
- It was suggested that more information on the services available would help people make these decisions, e.g. advertising (particularly NHS Direct, leaflets in GPs surgery etc).

Future Models

GP surgery with extended hours: This was the top preference, due to the waiting times experienced at A&E and the realisation that often A&E refers patients back to GPs anyway. This was driven more by the idea of having an out of hours service than a way of having a shorter wait for an appointment.

Pharmacy for advice and treatment (private area): This was viewed quite positively with respondents for minor ailments, and the group praised pharmacists for their knowledge and expertise. However, it was seen as a supplement, rather than an alternative to GPs or more specialist care.

New telephone line that can provide urgent health care advice and give you local information: Participants felt there is already enough local information about services, and a new service wasn't necessary. It was difficult to see the benefits of this system.

NHS Direct telephone line where can speak with a GP: This was also viewed as unnecessary as there is already NHS Direct and you can already call a GP out of hours, but for those who hadn't heard of NHS Direct it was a welcome alternative to other services, mainly for the advice it offers on ailments as opposed to the local information. A telephone line that was free for mobile users, however, was mooted as a good suggestion.

How unscheduled care could be improved/what does success look like

- Improved quality of treatment at A&E and hospitals
- Reduce the length of waiting times in all services
- Better qualified medical professionals who instil confidence in their diagnoses/treatment

Waltham Forest Group – 26th March, aged 35 - 55, mixed social grades

There was a high level of awareness of local services, including A&E at various hospitals in the area, e.g. Whipps Cross, Queen Elizabeth hospital, and also a high level of usage. A number of participants suffered from illnesses or disabilities, or their children did, so they had a lot of experience of services in the area for long-term or unscheduled care.

A&E

There was considerable experience of A&E in the area, and a good deal of praise for the hospitals. Spontaneous mention of the service was that it was a useful way of dealing with something urgent rather than waiting to see their GP, or for out of hours service.

"Why would you call your GP and wait for hours when you could just go straight to A&E?"

Female, aged 35 - 55

A&E was also seen as the place to go for more serious health concerns, such as asthma attacks, and it was recognised that they can provide treatment straight away.

GP Surgeries

Most participants had used GPs, and there was mention of a new "multi-purpose" surgery which covers specialist clinics. There was some expression of concern over the waiting times.

General feeling towards GPs was that it is a good service as you are seen face to face, and it was felt that one could trust a GP. There was recognition, however, that doctors can offer conflicting opinions to staff in other services, like A&E.

While the out of hours service was considered useful by some participants, others felt let down because their GP might not have come out to them when requested and in the end they have had to go to A&E.

"I prefer the out of hours service to the actual GP, I prefer to wait till later, because I get better treatment than my GP."

Female, aged 35 – 55

Drop-in/ Walk-in Centres

Walk-in Clinics, as well as the out of hours GP service, were mentioned as top of mind places to go for out of hours treatment, but few had used the service.

Minor Injuries Unit

A Minor Injuries Unit wasn't mentioned spontaneously and no-one had used it.

NHS Direct

This also wasn't mentioned spontaneously, and no-one had real experience of it. When pushed on the future scenario, it wasn't welcomed as it was felt that diagnosis over the phone is not effective. It was likened to the GP out of hours service, which some felt could be useful for advice, but not necessarily for treatment due to risk of misdiagnosis.

"*I was prescribed tablets that I ended up being allergic to."*

Female, aged 35 - 55

Pharmacy

Pharmacies weren't top of mind as service providers for urgent care, but were considered very useful, particularly for minor ailments and where you can self-diagnose.

"I think I'd go to the chemist, tell them my symptoms, and after a couple of days go to GP if necessary."

Female, aged 35 - 55

What is important to people when thinking about where to go for urgent care?

- Specialist care e.g. driving further to go to children's specialist hospital rather than general hospital
- Opening hours (particularly around access to GPs)
- Access to services, e.g. not being able to drive so calling an ambulance

Future Models

GP surgery with extended hours: This was seen as the number one priority, as participants preferred to see someone face to face out of hours. Participants also felt that waiting times should be shorter at GPs, which could be solved through greater resourcing. Some people were concerned about the pressure on GPs working lives, however. One interesting suggestion was that a "working peoples" clinic (late hours GP surgery) could be funded by giving the doctors some compensation by clawing money back from the prescription charge.

"The doctors will want more payment for it. People should pay the same amount of money, but rather than all of it going to government, give some of it to the GP."

Male, aged 35 - 55

Pharmacy for advice and treatment (private area): This was welcomed by most and seen as a good initiative, though it was recognised that there is limited mileage as this is already happening in some pharmacies. Its benefit could be from the greater level of information offered by them. However, some participants were concerned that it was impractical for most pharmacies to start offering a private area for consultations and disrupting their normal service.

New telephone line that can provide urgent health care advice and give you local information: This initiative didn't get the same level of response, as participants feel there is already a lot of information available for residents in the area, e.g. local papers or on Pharmacy signage themselves (for out of hours services).

NHS Direct telephone line where can speak with a GP: There was recognition that NHS Direct already does this and you can speak to a doctor through the out of hours service (though not all realised this). Most respondents would prefer to see someone face to face.

How unscheduled care could be improved/what does success look like

More staff and resources, and the resulting greater access to GPs out of hours

Better bedside manner of staff, which was noted as being even more important for urgent care when patients are scared and often disorientated.

Appendix K: Key stakeholders

- Prof. Sir George Alberti - National Director for Emergency Access
- Annette Alcock - Urgent Care Manager (Barnet)
- Pippa Bagnell - London Programme for IT
- Dr. Derek Bangura - GP (Waltham Forest)
- Dr. Jackie Bucknall - Consultant Paediatrician (Hackney)
- Kathryn Collin - Service Improvement Manager (Camden)
- Dr. Deborah Colvin - Chair of City and Hackney LMC (CAG)
- Adam Duncan - Regional Director of Nursing NHS Direct
- Dr. Peter Fermie - GP (Hammersmith & Fulham)
- Siobhan Gregory - Community Nurse (CAG)
- Jatinder Harchowal - Pharmacy Lead (CAG)
- Roger Harris - Director of Planning and Performance (Newham)
- Daniel Heard - Head of Acute Contracts (Newham)
- Dr. Turan Huseyin - A&E Consultant (Barnet)
- Prof. Peter Hutton - Unscheduled Care Lead (CAG)
- Lesley Johnson - AHP Representative (CAG)
- Ruth Lacey - Head of Medicine Management (Waltham Forest)
- Rob Larkman - Chief Executive (Camden)
- Nick Lawrance - Head of Policy London Ambulance Service
- Mike Leviton - LPC Pharmacy Contact (Barnet)
- Dr. Andres Martin - A&E Consultant (Camden - Royal Free)
- Dr. Hugh Millington - GP (Hammersmith & Fulham)
- Louise Morton - Consultant Paediatric Nurse
- Dr. Marilyn Plant - Director for Unscheduled Care (CAG)
- Dr. Ann Robinson - GP (Barnet)
- David Smith - Chief Executive (Kingston)
- Dr. Geraldine Strathdee - Mental Health Representative (CAG)
- Jane Tobin - Kingston Representative
- Dr. Simon Walford - PA Clinical Advisor
- Steven Wibberley - Regional Director NHS Direct

Appendix L: Data collection coverage & results

Data coverage grid

This table shows how multiple data sources were used to ensure complete coverage of information requirements for all access points.

	A&E	WIC/MIU	GPs	Pharmacies	GPOOH	Other
1. Current unscheduled care	Source	Source	Source	Source	Source	Source
Number / Details	**PCT HCS**	**PCT HCS**	**PCT SS**	**PCT SS**	**PCT HCS**	**PCT SHI**
Access Details	**PCT A&E**	**PCT provider**	**PCT SS**	**PCT SS**	**PCT provider**	**PCT SHI**
Staff Details	**PCT A&E**	**PCT provider**	**PCT SS**	**PCT SS**	**PCT provider**	**PCT SHI**
Location	**PCT**	**PCT**	**PCT**	**PCT**	**PCT**	**PCT**
Facilities / Services	**PCT SHI**	**PCT SHI**	**PCT SHI**	**PCT SHI**	**PCT SHI**	**PCT SHI**
Commissioning Method	**PCT**	**PCT**	**PCT**	**PCT**	**PCT**	**PCT**
Commissioning Costs	**PCT HCS**	**PCT HCS**	**PCT HCS**	**PCT**	**PCT HCS**	**PCT**
Access Point History/ Future	**PCT SHI**	**PCT SHI**	**PCT SHI**	**PCT SHI**	**PCT SHI**	**PCT SHI**
2. Current unscheduled care activity (volumes)	**datasets HCS**	**datasets HCS**	**SS**	**SS**	**datasets SHI HCS**	**SHI**
2. Current unscheduled care activity (flows)	**datasets LDC SHI**	**datasets LDC SHI**	**SS LDC SHI**	**SS LDC SHI**	**datasets SHI**	**SHI**
3. Alternative options for unscheduled care	**LDC datasets**	**LDC datasets**	**LDC SS**	**LDC SS**	**LDC datasets**	**SHI**
4. Stakeholder views	**SHI**	**SHI**	**SHI SS**	**SHI SS**	**SHI**	**SHI**
5. Patient and public views (via Ipsos MORI)	**PPS FG**	**PPS FG**	**PPS FG**	**PPS FG**	**PPS FG**	**PPS FG**
6. Future options for unscheduled care	**SHI analysis**	**SHI analysis**	**SHI analysis**	**SHI analysis**	**SHI analysis**	**SHI analysis**

datasets - electronic database

LDC - Live Data Capture

SS - Service Survey

PPS - Patient Preference Survey

SHI - Stakeholder Interviews

FG - Focus Groups

HCS - Healthcare Commission Submission

PCT - info held by PCT

A&E - info held by A&E trust

provider - info held by provider

Data Collection Results

This table shows the number of returns from the various data collection exercises

Collection Method	Live Data Collection	Service Surveys	Preference Surveys	Preference Surveys	Focus Groups
TOTAL	**5,254**	**101**	**673**	**111**	**6**
A&E	1,817		264		
GPs	1,803	18	241		
Pharmacies	1,634	83	51		
WICs			117		
Gen Public				111	6

Appendix M: Data sources for charts

ID	Title	Data Source
1	Figure 1: Unscheduled care study methodology	N/A
2	Figure 2: indicative profiles of total unscheduled care activity and cost across unscheduled care access points	See report for data sources
3	Figure 3: Average commissioning cost per patient by PCT and across all PCTs	See report for data sources
4	Figure 4: Unscheduled care system - flow diagram	See report for data sources
5	Figure 5: Proportion of patients attending A&E who had previously sought treatment for their condition elsewhere	Live data capture (A&E)
6	Figure 6: Whipps Cross monthly unscheduled care attendance	Waltham Forest local electronic data (A&E, EUCC and GPOOH) and NHSD electronic data
7	Figure 7: Peaks in demand for unscheduled care across A&E, WIC and NHSD	Local electronic data (A&E and WICs) and NHSD electronic data
8	Figure 8: Peaks in demand for unscheduled care across GP and Pharmacy	Live data capture (GP & Pharmacy)
9	Figure 9: Peaks in demand for GP OOH services	Local electronic data (A&E and GPOOH) and NHSD electronic data
10	Figure 10: Chart showing the proportion of patients seen in A&E hours broken down by age group	Local electronic data
11	Figure 11: Peaks in demand for unscheduled care across A&E, GP OOH, WIC and NHSD during an average week	Local electronic data (A&E, GPOOH and WICs) and NHSD electronic data
12	Figure 12: Peaks in NHS Direct demand over an average week by PCT	NHSD electronic data
13	Figure 13: The age breakdown across access points for all PCTs involved in the study	Local electronic data and live data capture
14	Figure 14: The age breakdown across access points for all PCTs involved in the study	Local electronic data and live data capture
15	Figure 15: The proportion of GP-registered patients attending A&E broken down by A&E department	Live data capture (A&E)

ID	Title	Data Source
16	Figure 16: The proportion of GP-registered patients attending A&E broken down by ethnicity	Live data capture (A&E)
17	Figure 17: The proportion of GP-registered patients attending A&E broken down by urgency	Live data capture (A&E)
18	Figure 18: The proportion of GP-registered patients attending A&E broken down by age	Live data capture (A&E)
19	Figure 19: Proportion of A&E attendances leading to admission by PCT	Local electronic data
20	Figure 20: Proportion of A&E attendances leading to admission by A&E department	Local electronic data
21	Figure 21: Proportion of A&E attendances leading to admission across age bands	Local electronic data
22	Figure 22: Proportion of A&E attendances leading to admission broken down by referral source	Local electronic data
23	Figure 23: Percentage of minor patients attending A&E broken down by the appropriate skill mix to treat them (multiple selections)	Live data capture (A&E)
24	Figure 24: Alternative access points it was felt that patients attending A&E could have presented to (multiple selections)	Live data capture (A&E)
25	Figure 25: Proportion of patients attending A&E departments by PCT that were most appropriately seen by an A&E clinician against those patients that could have been treated by other professionals.	Live data capture (A&E)
26	Figure 26: PCT Affluence vs. A&E appropriateness	Live data capture (A&E) & PCT demographics
27	Figure 27: Top 10 conditions presenting at A&E broken down by age group	Live data capture (A&E)
28	Figure 28: Top 10 conditions presenting at A&E broken down by ethnicity	Live data capture (A&E)
29	Figure 29: Top 10 conditions presenting at A&E broken down by urgency	Live data capture (A&E)
30	Figure 30: Percentage of patients whose appropriate treatment required an A&E clinician broken down by age group	Live data capture (A&E)
31	Figure 31: Percentage of patients whose appropriate treatment required an A&E clinician broken down by ethnic group	Live data capture (A&E)
32	Figure 32: Percentage of unscheduled GP attendances (walk-ins and same day appointments) that could have been appropriately treated by other professionals (multiple selections)	Live data capture (GP)
33	Figure 33: Percentage of unscheduled GP attendances (walk-ins and same day appointments) that could have visited a more appropriate access point	Live data capture (GP)

ID	Title	Data Source
34	Figure 34: Percentage of patients visiting pharmacies that could have been appropriately treated by other professionals (multiple selections)	Live data capture (Pharmacy)
35	Figure 35: The proportion of patients whose unscheduled visit to A&E or a GP practice could have been prevented by the options show	Live data capture (Pharmacy)
36	Figure 36: GP and pharmacist opinion regarding the ways in which unscheduled care could be improved	Live data capture (GP & Pharmacy)
37	Figure 37: Where patients went for treatment in the last 12 months and the average number of times they visited	MORI patient preference surveys
38	Figure 38: Patient satisfaction at access points	MORI patient preference surveys
39	Figure 39: Whether patients had previously sought treatment for their condition over the last 7 days	MORI patient preference surveys
40	Figure 40: Where patients first went for medical advice or care for their condition in the past seven days (total patients and proportions are shown on the chart)	MORI patient preference surveys
41	Figure 41: Where patients presenting at A&E first went for medical advice or care for their condition in the past seven days (total patients and proportions are shown on the chart)	MORI patient preference surveys
42	Figure 42: Patients' perception of how urgently they needed to be treated	MORI patient preference surveys
43	Figure 43: Comparison of patient perception of urgency against GP assessment of patient urgency	Live data capture (A&E) and MORI patient preference surveys
44	Figure 44: Other than A&E, which other health services did patients feel could have provided them with treatment	MORI patient preference surveys
45	Figure 45: Reasons cited by those patients who attended A&E even though they felt their condition could have been treated by their GP	MORI patient preference surveys
46	Figure 46: The factors patients rate as 'very important' when choosing an unscheduled care access point	MORI patient preference surveys
47	Figure 47: Series of four charts showing the top 5 reasons patients gave for choosing the access point they attended (questions were free form and unprompted)	MORI patient preference surveys
48	Figure 48: Patient views regarding how unscheduled care could be improved in the future (questions were free form and unprompted)	MORI patient preference surveys
49	Figure 49: Whipps Cross EUCC model	N/A
50	Table 50: Calculation of A&E attendances per 1000 population per year	See report for data sources

ID	Title	Data Source
51	Figure 51: Monthly attendance volumes for A&E departments in 2007	Local electronic data
52	Figure 52: Monthly attendance volumes of activity for WIC and GPOOH services in 2007	Local electronic data
53	Figure 53: Monthly call volumes for NHSD in 2007	NHSD electronic data
54	Figure 54: Daily attendance volumes to A&Es	Local electronic data
55	Figure 55: Daily attendance volumes over a year for GPOOH	Local electronic data
56	Figure 56: Daily attendance volumes over a week for GPOOH	Local electronic data
57	Figure 57: Daily attendance volumes over a week for WICs	Local electronic data
58	Figure 58: Hourly attendance volumes over 24 hrs for A&Es	Local electronic data
59	Figure 59: Hourly attendance volumes over 24 hrs for WICs	Local electronic data
60	Figure 60: Hourly attendance volumes over 24 hrs for NHSD	NHSD electronic data
61	Figure 61: Hourly call volumes over 24 hrs for LAS	LAS electronic data
62	Figure 62: Monthly activity volumes over 2007 for access points in Barnet	Barnet local electronic data (A&E, WICs and GPOOH) and NHSD electronic data
63	Figure 63: Hourly activity volumes over a day for access points in Barnet	Barnet local electronic data (A&E, WICs and GPOOH) and NHSD electronic data
64	Figure 64: Monthly activity volumes over 2007 for access points in Waltham Forest	Waltham Forest local electronic data (A&E and EUCC) and NHSD electronic data
65	Figure 65: Hourly activity volumes over a day for access points in Waltham Forest	Waltham Forest local electronic data (A&E, EUCC and GPOOH) and NHSD electronic data
66	Figure 66: Monthly activity volumes over 2007 for access points in Newham	Newham local electronic data (A&E, GPOOH and WIC) and NHSD data
67	Figure 67: Hourly activity volumes over a day for access points in Newham	Newham local electronic data (A&E, GPOOH and WIC) and NHSD data
68	Figure 68: Monthly activity volumes over 2007 for access points in Kingston	Kingston local electronic data (A&E, PCS and GPOOH) and

ID	Title	Data Source
		NHSD electronic data
69	Figure 69: Hourly activity volumes over a day for access points in Kingston	Kingston local electronic data (A&E) and NHSD electronic data
70	Figure 70: Monthly activity volumes over 2007 for access points in Hammersmith & Fulham	Hammersmith & Fulham local electronic data (A&E and WIC) and NHSD electronic data
71	Figure 71: Hourly activity volumes over a day for access points in Hammersmith & Fulham	Hammersmith & Fulham local electronic data (A&E and WIC) and NHSD electronic data
72	Figure 72: Monthly activity volumes over 2007 for access points in Camden	Camden local electronic data (A&E and GPOOH) and NHSD electronic data
73	Figure 73: Hourly activity volumes over a day for access points in Camden	Camden local electronic data (A&E) and NHSD electronic data
74	Figure 74: Age breakdown of PCT populations and London & England population	Local electronic data and live data capture
75	Figure 75: Age profile of unscheduled care users by PCT	Local electronic data and live data capture
76	Figure 76: Ethnicity profile of unscheduled care users by PCT	Local electronic data and live data capture
77	Figure 77: Mode of travel to A&E departments	Local electronic data
78	Figure 78: Percent of A&E attendees arriving by ambulance	Local electronic data
79	Table 79: Top 10 conditions recorded across the 3 access points in the live data capture exercise	Live data capture
80	Table 80: Classification of patients into majors and resus by A&E department	Local A&E data (electronic & survey)
81	Table 81: Average daily A&E attendances per hospital	Local A&E data
82	Figure 82: Top 10 conditions presenting at A&E during live data capture exercise - broken down by age group	Live data capture (A&E)
83	Figure 83: Top 10 conditions presenting at A&E during live data capture exercise - broken down by ethnicity	Live data capture (A&E)
84	Figure 84: Top 10 conditions presenting at A&E during live data capture exercise - broken down by urgency	Live data capture (A&E)
85	Figure 85: Top 10 conditions presenting at A&E during live data capture exercise (assessed to not require an A&E clinician) split by age group	Live data capture (A&E)

ID	Title	Data Source
86	Figure 86: Top 10 conditions presenting at A&E during live data capture exercise (assessed to not require an A&E clinician) split by ethnicity	Live data capture (A&E)
87	Figure 87: Top 10 conditions presenting at A&E during live data capture exercise (assessed to not require an A&E clinician) split by urgency	Live data capture (A&E)
88	Figure 88: Out of hours conditions presented at A&E during live data capture exercise (number in brackets indicated % of cases which were presented between 6pm and 8am)	Live data capture (A&E)
89	Figure 89: Top 10 conditions presenting at GPs during live data capture exercise - broken down by age group	Live data capture (GP)
90	Figure 90: Top 10 conditions presenting at GPs during live data capture exercise - broken down by ethnicity	Live data capture (GP)
91	Figure 91: Top 10 conditions presenting at GPs during live data capture exercise - broken down by urgency	Live data capture (GP)
92	Figure 92: Top 10 conditions presenting at pharmacies during live data capture exercise - broken down by age group	Live data capture (Pharmacy)
93	Figure 93: Top 10 conditions presenting at pharmacies during live data capture exercise - broken down by ethnicity	Live data capture (Pharmacy)
94	Figure 94: Top 10 conditions presenting at Edgware walk-in centre	Edgware WIC local electronic data
95	Figure 95: Top 10 conditions presenting at Finchley walk-in centre	Finchley WIC local electronic data
96	Figure 96: Top 10 conditions presenting at Parsons Green walk-in centre	Parsons Green WIC local electronic data
97	Figure 97: Top 10 conditions handled by NHS Direct	NHSD electronic data
98	Figure 98: Top 10 conditions handled by NHS Direct out of hours	NHSD electronic data
99	Figure 99: Tests GPs assessed were required for patients presenting in A&E during the live data collection.	Live data capture (A&E)
100	Figure 100: Outcome of patients assessed at GP surgeries in live data capture exercise	Live data capture (GP)
101	Figure 101: Destination of patients referred on from GP surgeries in live data capture exercise	Live data capture (GP)
102	Figure 102: Reasons GPs provided for onward referrals in the live data capture exercise	Live data capture (GP)
103	Figure 103: Tests required when GPs referred on in the live data capture exercise	Live data capture (GP)

ID	Title	Data Source
104	Figure 104: Outcomes for patients in the Pharmacy live data capture exercise	Live data capture (Pharmacy)
105	Figure 105: Top 10 outcomes at Edgware walk-in centre	Edgware WIC local electronic data
106	Figure 106: Top 5 outcomes at Finchley walk-in centre	Finchley WIC local electronic data
107	Figure 107: Top 7 outcomes at Whipps Cross urgent care centre	Whipps Cross EUCC local electronic data
108	Figure 108: Case types for patients calling the Barnet GP out of hours service	BarnDoc local electronic data
109	Figure 109: Case types for patients calling the Camden GP out of hours service	Camidoc local electronic data
110	Figure 110: Case types for patients calling the Waltham Forest (Whipps Cross) GP out of hours service	PELC local electronic data
111	Figure 111: Top 7 outcomes at Camden GP out of hours service	Camidoc local electronic data
112	Figure 112: Top 7 outcomes at Waltham Forest (Whipps Cross) GP out of hours service	PELC local electronic data
113	Figure 113: Top 9 outcomes of calls to NHSD	NHSD electronic data
114	Figure 114: Appropriate delivery methods patients presenting at A&E in live data capture	Live data capture (A&E)
115	Figure 115: Appropriate delivery methods for all patients presenting at GPs in live data capture	Live data capture (GP)

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