

The state of care in urgent primary care services

Findings from CQC's programme of comprehensive
inspections in England



 STATE OF CARE

Care Quality Commission

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Foreword from the Chief Inspector

Urgent primary care services, such as walk-in and urgent care centres, NHS 111, and GP out-of-hours services, play a vital role in England's healthcare system. They are the first step to ensure that people are seen by the professional best suited to deliver the right care and in the most appropriate setting.

A quick, safe and effective response from urgent care services in the primary setting provides not only a good outcome for patients, but also takes pressure off other parts of the urgent care system, particularly the pressure on emergency departments during the winter period.

The urgent care sector is complex and continually evolving – both in how services are commissioned and how they are delivered. This complexity makes it difficult to present a holistic picture of quality and has required CQC to develop a regulatory approach that is flexible but robust, to take account of different service delivery models. In our inspections, although we take into account performance against the specified service model that has been commissioned nationally or locally, our focus is always on the quality and safety of care for patients.

Overall, we have found the quality of the vast majority of all types of urgent care service to be good, and their current ratings reflect this. Our first inspections in 2014 were in response to the greatest potential risk to patients, and we saw a considerable variation in quality across providers. Early inspections found some poor quality and inadequate care, which required enforcement action and special measures. Through re-inspection, we have seen improvement and services delivering outstanding care by embracing new and innovative ways of working, working jointly with other services in the urgent care system and showing some outstanding leadership.

The very nature of urgent primary care services presents some common challenges to providers, which then can adversely affect the quality of care. One of the major challenges we found relates to staffing. We know that staff can be dispersed over large areas and often work remotely, with little opportunity to build local teams among sessional and locum clinicians. They also work under pressure at times of high demand and unsocial hours, which affects recruitment and retention. Many NHS 111 services have experienced very high turnover, and in some cases we found the numbers of call handlers and clinical advisors were too low to deliver a safe and effective service. Interestingly, despite these challenges, our ratings have consistently shown that performance in all services is best for the caring key question.

Another challenge is the complex commissioning arrangements for urgent care services: contracts to provide a service in an area are often re-procured, and when an incumbent provider fails to win the tender, with a less experienced organisation taking over the contract, this leads to disruption, lost continuity and lost organisational memory and learning. We found that where providers were commissioned by a series of different geographically remote CCGs, there was an adverse impact on the quality of service at some locations.

To enable primary urgent care services to ease the pressure on acute hospitals, they need to be properly resourced. There is therefore a real need for sensible, flexible and realistic commissioning, as well as sufficient resource into the sector to make it work. This needs commissioners to look strategically at the value of primary urgent care services to the wider system – not just at the cost of the service. Too often, this funding isn't sufficient for the scale of change that is needed in order to bring about an integrated urgent care clinical assessment model.

This isn't just about funding to recruit more staff – it's also about using technology and more innovative ways of working to map capacity against demand in a local area and provide better communication between staff and other services, for example using teleconferencing and other digital communication. It also involves providing clinical support to develop existing staff, as well as designing pathways to deliver care that enables patients to stay out of hospital, with support in the community.

As we have found across all our regulatory work, to enable services to move towards working as an effective system, there needs to be better integration so that demand from patients is balanced across the system, and the system can better respond to its local population in the right way at the right time. Integration between services is a key area where people can benefit in both a health and social care setting. We are pleased to see this being delivered through the roll-out of the Integrated Urgent Care Clinical Assessment Service, which brings together NHS 111 and GP out-of-hours services to provide 24/7 access to urgent care, clinical advice and treatment.

CQC also welcomes initiatives to help providers to improve quality, such as NHS England's work to embed pharmacy into the urgent care pathway by deploying prescribing pharmacists in integrated services, and the roll-out of the National Urgent Medicine Supply Advanced Service (NUMSAS), allowing NHS 111 services to direct patients who need emergency supplies of repeat medicines to participating pharmacies.

NHS England aims for people to “get the right care in the right place, whenever they need it”: through regulation, CQC aims for this care to be safe, effective and high-quality for all people.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Introduction

Urgent care is provided in many forms by many parts of the NHS, from telephone-based care through NHS 111 to the emergency departments of major trauma centres. In this report, we present an overview of what we have found from our regulation of urgent care providers in the primary care sector, specifically our inspections of:

- NHS 111 services
- urgent care/walk-in centres
- GP out-of-hours services
- the small number of GP practices that also provide a walk-in service for patients not registered with them.

These services were inspected by CQC's Primary Medical Services Directorate. In this report we refer to urgent care centres that deal with minor injuries and illness only (described as a type 3 A&E and commonly called urgent treatment centres, minor injuries units and walk-in centres). Most are 'stand-alone', that is, not run by an NHS hospital trust.

The NHS definition of urgent care is that there is a need, or perceived need, for care the same day. This may be because of a new medical condition or injury or an existing one becoming worse. Urgent care services deal with a wide range of illnesses and injuries that are not life-threatening, such as sprains and strains, and minor head injuries as well as conditions that are potentially life-threatening such as stroke, sepsis or meningitis, which people may be unaware of.

Each year, the NHS provides approximately 110 million urgent same-day patient contacts. Around 85 million of these are urgent GP appointments, and the rest are emergency department (A&E) or minor injuries-type visits. Some estimates suggest that between 1.5 and three million people who visit an emergency department each year could have their needs addressed in other parts of the urgent care system. The local emergency department is the default choice for many – they turn here first because it seems like the best or only option.¹ The [Keogh review](#) into the urgent and emergency care system found that one of the contributory factors that led people to attend emergency departments as the first point of urgent care was confusion about the wide range of urgent care services available, and labelling such as walk-in centres, urgent care centres, minor injuries units and others with local names, as well as differing opening hours and levels of service.² A recent study found a high demand for 'instant access' to care, and that people went to the emergency department at their local acute hospital as they knew they would be seen.³

In this report we present some common themes and characteristics that we have found through our inspections in this sector. These are based on our knowledge and experience from inspections, with expert opinion and input from our National Professional Advisor for urgent care services, and senior inspection staff.

To include the perspective of providers, we discussed these themes with CQC's External Advisory Group for urgent care services, which advises us on our regulatory approach. We also discussed some of the issues with groups from the voluntary sector representing patients and the public to gain their perspective, and we include their views as appropriate. CQC values the views and experiences of people who use services as these are vital to inform how we look at quality.

We celebrate the fact that the majority of urgent care services in England are currently rated as good for the quality of their care, and provide some examples of good and outstanding practice so that other providers can learn and adapt this to their own services.

Types of urgent care services

Urgent care centres

Most urgent care centres are based in the community, either in stand-alone premises or co-located with other services such as GP out-of-hours services. Some are located on a hospital site, but are run by a provider organisation that is not the hospital itself. Despite being run by different organisations, urgent care centres on a hospital site usually work closely with the hospital's emergency department, which may stream patients to the urgent care centre after assessing them for suitability and re-directing them.

Urgent care centres are commissioned by clinical commissioning groups (CCGs). Some providers run only one or two urgent care centres, whereas others are large organisations that may also provide other types of services, such as GP out-of-hours services. Many of these larger organisations hold contracts across England and have centralised governance for their services, which are co-ordinated locally by service managers and senior clinicians.

Clinicians may be directly employed, self-employed contractors or a mixture of both. Urgent care and walk-in centres also regularly use locums as well as staff employed through a contract. Many contracted staff may also carry out their duties for the same provider from more than one of its registered locations.

NHS 111 services

NHS 111 provides access to both treatment and clinical advice.⁴ It was set up in 2012 to replace NHS Direct as a free urgent but non-emergency number to work alongside 999, available 24 hours a day, 365 days a year. It covers England, Scotland and parts of Wales (CQC only regulates services in England), but with services delivered by different providers in different geographical areas, each commissioned by the local CCG. By integrating technology, calls can be directed to services around the country to enable available resources to handle demand when national contingency plans are invoked. The NHS 111 Directory of Services enables calls to be directed to the most appropriate and locally available service.

A number of these services are provided as part of wider out-of-hours services or urgent care services by the same provider. Some 111 services are commissioned by a CCG and delivered by an independent provider, whereas some providers are social enterprises that re-invest any profits back into services rather than passing them on to shareholders as some other 111 providers do. Others are provided by ambulance services.

Calls to the 111 number are directed to the local 111 provider. They are answered by a non-clinical call handler who is trained to use a computer decision support system called NHS Pathways to manage calls. NHS Pathways is a nationally-validated algorithm built on clinical expertise combined with a real-time directory of services available for patients, which identifies the best source of help for the caller. This may be to speak to a clinician working for NHS 111, to attend another service, such as the patient's own GP, or to self-care. In emergencies, the call handler will arrange a 999 ambulance transfer to an emergency department where necessary.

The quality of NHS 111 services is monitored using both the NHS 111 Minimum Data Set and a set of nationally-agreed key performance indicators (KPIs). All NHS 111 providers are assessed against the same set of KPIs though, in some cases, providers have also agreed local KPIs with their commissioning CCG. In CQC's inspections, we consider the provider's achievement of KPIs as part of assessing whether the service is effective. We also look more broadly at the provider's performance in our other four key questions.

GP out-of-hours services

Out-of-hours services provide urgent primary care when GP surgeries are closed. They usually provide face-to-face consultations in primary care centres, home visits and telephone consultations. Most patients are directed to these services by NHS 111 or, in some cases, emergency departments. Some primary care centres accept walk-in patients, while others require patients to have called NHS 111 before they arrive.

Despite their name, GP out-of-hours services use nurses, advanced nurse practitioners, pharmacists and paramedics, as well as GPs. Typically, most out-of-hours GPs are self-employed sessional contractors, whereas the other clinicians may be directly employed or contractors. Some services use a high number of agency staff.

Some GP practices also provide both the usual GP services to their registered patient list as well as an urgent care service for patients registered with other practices or who are not registered with a GP. Many were set up as part of Lord Darzi's polyclinic initiative in 2008/09 and use a combination of directly employed and sessional clinicians, although some are long-standing GP partnerships that have also been awarded a separate contract to provide urgent care and are typically staffed by the partners and the GPs and nurses whom they employ directly.

Challenges to the sector

The aim of urgent primary care services is to increase efficiency to relieve the pressure on hospitals and provide better outcomes for patients. By their very nature, services in the urgent care sector face many challenges.

Fluctuating and increasing demand

Demand for urgent primary care services fluctuates dramatically throughout the year, with demand greatest over bank holidays and winter weekends. A study from the Nuffield Trust found that each Christmas and New Year since starting, NHS 111 has struggled to deliver the standards set for it (such as answering calls within 60 seconds, or minimising the number of people who hang up after 30 seconds).⁵

NHS England reports that NHS 111 now takes 16 million calls each year, up from 7.5 million three years ago.⁶ In December 2017, the NHS 111 Minimum Data Set recorded 54,100 calls a day to the NHS 111 service in England, an increase of 13.5% on December 2016 (47,600 a day).⁷ This is the largest number of calls in a month since data collection began in August 2010.

Demand follows seasonal patterns, and established services are able to look back over years to monitor performance and trends and implement plans to manage it. However, by awarding short-term contracts to different providers there is a resulting loss of organisational learning and memory. This can lead to unexpected mismatches between capacity and demand for less experienced organisations that take on new urgent care contracts.

Capacity

In the 10 years from 2007/08 to 2017/18, there was an overall increase in attendances at emergency departments of 25.2%, with an increase of 57.1% for attendances at type 3 departments (those that deal with minor injury and illness, as opposed to the type 1 emergency departments that deal with severe illness and major trauma).⁸

All parts of the urgent care system experience the most challenging workload in the winter. As the population ages, more people are living with long-term medical conditions for longer, which puts them at greater risk of becoming seriously unwell if they catch the cold and flu-type illnesses that are more common in winter. So workload in the urgent care system is driven both by the total number of patients requiring care and the severity of the illnesses they experience. Christmas and Easter holidays place particular demands on the service, which is made worse by the closure of general practice provided in normal hours in some areas.

Where demand exceeds capacity, patients may experience long waits. It is essential to have processes to identify the sickest patients and those at risk of deterioration. This is a particular challenge for patients who need home visits or those waiting for a clinical telephone assessment. When there are long waits, demand for ambulance services can spike as patients dial 999 instead.

Members of CQC's Urgent Care External Advisory Group have told us that where demand or acuity increases, then resource also needs to increase. But having the capacity to respond to patients presenting can be an issue as providers need to make sure they have the right staff to triage patients. Therefore, call-handlers need an effective clinical decision support tool to stream patients, particularly when triaging patients with a mental health condition. The idea of having a qualified clinician 'at the front' would seem to be cost-effective as it would stop people presenting inappropriately further down the line, but this needs appropriate resource.

Recruitment and retention

Linked with problems around capacity above, many urgent care providers experience difficulties in recruiting and retaining staff. NHS 111 providers, like all call centre-based employers, tend to experience high staff turnover. Recruitment is often difficult as urgent care work is intense, the hours are unsociable and rates of pay cannot compete with the private sector. The high-pressure environment in an NHS 111 call centre has been well-documented in the media, with some staff speaking about feeling unprepared for the volume of calls and the responsibility placed on them to advise callers. The training for the NHS Pathways algorithm is at least six weeks and requires considerable input before call handlers can be used effectively.

There are also many well-documented factors affecting the availability of the GP workforce:

- Providing extended hours in GP surgeries means that fewer GPs are available to work in urgent care centres and out-of-hours services in addition to their regular work.
- The intensity of work in general practice has increased, with a 15% increase in the number of consultations between 2010/11 and 2014/15, and a large cohort of GPs are nearing retirement.⁹
- Although the winter indemnity scheme for GPs addressed rising indemnity costs, working in busy and understaffed services is perceived as high risk.

Widely dispersed and sessional workforce

The workforce of urgent care providers is usually dispersed, both in time – as many staff work shifts – and often in place, as many providers have multiple locations. Other than NHS 111, many urgent care providers rely on a large cohort of sessional clinicians. In some cases, all a provider’s clinicians are self-employed sessional contractors rather than employed clinicians. This creates logistical challenges for providers as they cannot rely on team meetings to build a team ethos or to share learning, so they need reliable systems for sharing information and for ensuring that managers listen to staff, particularly when they raise concerns.

Voluntary sector perspective

We spoke with Mind, who said that people with long-term physical health conditions are far more likely to have poor mental health, and those working in urgent care services will often be working with people with complex needs and multiple morbidities. For this reason, they feel it is imperative that all healthcare staff are trained to understand and deal with mental health problems.

Resources and commissioning

To realise government policy of reducing pressure on emergency departments and keeping patients out of hospital, the primary care sector has been asked to take on an increasing proportion of the workload. Although CQC does not look at the finances of providers, there is a growing risk in this area, with the value of contracts not reflecting the true costs of delivering them. There have been a number of notable service failures in areas where contracts have been awarded at an unrealistic price and providers also report having to go back to CCGs to ask for additional funding to continue to run contracts.

Operating at a financial loss without further funding from the commissioning CCG may adversely affect staffing levels and therefore the quality of care. In these cases, CCGs need to be confident that if a contract is operating at a loss, there is an adequate level of staff to safeguard patients, as well as to provide ‘behind the scenes’ governance, such as audit programmes.

Voluntary sector perspective

We spoke with the patient representative body, the National Association for Patient Participation (NAPP), about urgent care services. They believe that patients are often not confident enough to know which service to choose and when. This lack of certainty leads to people turning to their GP, and then to emergency (A&E) departments. NAPP felt that the bodies involved in commissioning and delivering urgent care services should play a greater role in producing clearer information and advice about the best ways to access these services and under what circumstances they should be used. They believed this would help to manage demand across the system, as well as increasing patient satisfaction.

There was a similar theme in our conversations with Age UK. They believe we're trying to overcome 50 years of social programming (that is, people going to A&E by default) with these new services, but people will always think of A&E as being first in the pecking order so it's only natural that people are drawn towards it. Age UK also told us that the availability of urgent care services very much depends on what is in a local area, particularly in rural regions, and depends on the money available to commissioners. Age UK believes that part of the planning and commissioning process should take into account people with long-term or end of life care needs, and provide further information for older people on what to do, where to go and when.

When talking with Mind, we heard that people with mental health problems may be accessing urgent care services such as NHS 111 because appropriate crisis care services are not available. If somebody calls NHS 111 about their mental health, they are often only advised to see their GP the next day or go to the emergency department, meaning that people are not getting the timely appropriate care they need. Clearly, this has system-wide implications. Currently, access to appropriate services is difficult for many people with a mental health problem, meaning their options are to 'wait until you're in crisis' or 'wait for a GP appointment'.

Mind also told us about their engagement work with young Black men. This found that these young men were less likely to access GP services as a result of a distrust of formal statutory services, which is due to stigma, cultural barriers, and discrimination. They also found a reluctance to discuss psychological distress and seek help. But conversely, this group was more likely to access urgent care, including A&E.

Integration

Better integration of urgent care services can balance demand across the health care system. Integration is a vital part of the future model of primary urgent care as NHS 111 and GP out-of-hours services are combined with other community provision, such as dentistry, mental health and pharmacy services. However, where many different providers are working together on the same contract, all too often there can be governance gaps between the services, placing patients at risk as they move from one to the other. This can also be an issue where a service is sub-contracted.

Access to GP notes

There is an inherently higher risk associated with urgent care services than with daytime general practice, as a high percentage of patients present with acute illnesses such as sepsis. A high proportion of those using the services are also often more vulnerable, including those receiving end of life care.

Urgent care is short and episodic, and is most effective when services have access to people's medical records – as a minimum, through the summary care record or local care record sharing services. It is also more effective for both clinicians and patients to have access to a person's primary care records from daytime general practice, and information about their mental health and end of life care plans during 111 consultations. However, although information from the summary care record should be available, it is often difficult for clinicians to access.

After using an urgent care service, information about the patient has traditionally been communicated back to their GP electronically and incorporated in their primary care record. Increasingly the most innovative local health economies are moving towards a more multi-agency approach using online clinical systems that can record, share and use real-time patient information to provide better, more efficient integrated care.

Voluntary sector perspective

Age UK believes that passing information about patients between services is a key issue, and that it is vital to ensure that more services share the summary care record, particularly in relation to medicines management. They say that older people can approach urgent care services with symptoms linked to other underlying problems that can go unnoticed (for example, frailty, under-nutrition or sepsis). Access to the summary care record can be crucial in having a more detailed understanding of their health and needs.

Developments in the sector

NHS England's Next steps on the Five Year Forward View plan sets out a number of improvements to address challenges and we have already started to see some of these changes take place across the country.

The NHS 111 Clinical Assessment Service (CAS) ensures that only patients who genuinely need to use an emergency department or ambulance are advised to do so. This means that rather than assessing and directing patients to another service, NHS 111 is aiming to become a 'consult and complete' service providing clinical contact to more calls. When a patient is identified as needing a category 3 (urgent) or category 4 (less urgent) ambulance, they will now speak to a clinician within 30 minutes to determine whether their care can be managed in alternative settings.¹⁰ This deals with a patient's problem at first contact, shortening the patient journey and ensuring they get the right treatment or advice first time. By 2019, NHS 111 also aims to be able to book people into urgent face-to-face appointments with their usual primary care provider or alternatively at their usual surgery.

Enhanced triage is starting to have a positive impact on pressure in other parts of the system. For example, by the end of March 2018, over half of the callers to NHS 111 were offered a telephone consultation with a health or care professional. And in March and April 2018, 39% of calls with an initial category 3 or 4 ambulance disposition were downgraded to a lower acuity after review by a clinician, equating to almost 65,000 calls. Calls from care homes are also prioritised to avoid patients repeatedly being admitted to hospital unnecessarily.

There are also plans to increase the core hours of GPs so that, by March 2019, everyone in England will be able to get an evening or weekend appointment, facilitated by the new GP contract agreement. In many areas this is being provided through extended hours hubs, where GPs come together to provide a service.

NHS England intends to roll out new urgent treatment centres to bring fast and effective urgent care closer to home. It aims to end the current mix of minor injuries units and walk-in centres, and instead offer a uniform model of urgent treatment centres that offer a standardised high level of care and access to services that patients will be able to understand.

The use of pharmacists in delivering urgent and emergency care can give patients faster access to advice from a health professional in a variety of healthcare settings. It can also reduce waiting times in other parts of the local health community, particularly general practice, which allows senior clinicians to treat patients with more serious conditions. With additional training, pharmacists can provide urgent care under medical supervision as part of a multi-disciplinary team.¹¹

As part of the Next Steps on the Five Year Forward View¹², a joint programme of work between NHS England and Health Education England (the [Integrated Urgent Care Workforce Development Programme](#)) has designed a career structure to ensure the right skills, knowledge, competencies and behaviours, and that staff are trained and supported. This is supported by guidance that outlines the governance to support the Integrated Urgent Care and NHS 111 workforce.¹³

Underpinning these changes is better integration between services so that demand is balanced across the healthcare system and the system can be more responsive to its local population. This involves improving seven key areas of change across: ambulance, hospital, transfer from hospital to community or home, urgent treatment centres, GP, NHS 111 clinical support and 111 online services.

Sustainability and transformation partnerships are supporting new approaches to improve the coordination of urgent and emergency care services and reduce the pressure on emergency departments. These are leading on the development of new care models that will act as the blueprints for the NHS moving forward.¹⁴

The views of patients are a measure of success: NHS England reports that in the NHS 111 patient experience survey for October 2016 to September 2017, 16% of respondents said they would have called for an ambulance and 28% would have gone to the emergency department if NHS 111 was not available.¹⁵ From the actual 12.1 million calls triaged over that year, it suggests that 0.4 million callers were directed away from the ambulance services and a further 2.3 million were directed away from emergency departments. The survey also shows that 87% were very or fairly satisfied with the way NHS 111 handled the whole process.

Regulation of urgent care

CQC began registering providers of NHS GP out-of-hours services in 2012. Before this, there had been a number of high-profile failures in both the arrangements for how care was commissioned and how it was delivered to patients. This prompted the 2010 ministerial review into out-of-hours providers, led by Professor Steve Field and Professor David Colin-Thomé. It concluded that the quality of GP out-of-hours services varied unacceptably, and led to a number of recommendations.¹⁶

In January 2014, CQC began testing a new comprehensive and clinician-led approach to inspecting GP out-of-hours providers. This was then rolled out for all urgent care services from October 2014. We inspect GP out-of-hours services using an adapted approach to general practice inspections, which does not look at the separate population groups for these services.

We have developed a regulatory approach that is flexible but robust, to take account of different service delivery models and types of organisation that provide the service. Where providers deliver different types of services across more than one sector, we coordinate our inspections to be more efficient and to simplify the process. For example, if an urgent care service is provided directly by an NHS trust, we will inspect it as part of the core service of urgent and emergency care, using our inspection approach for NHS trusts; whereas an urgent care centre or walk-in centre that is provided by a separate organisation that is not part of a hospital trust will be inspected by CQC's Primary Medical Services Directorate.

In our inspections, although we take into account performance against the specified service model that has been commissioned nationally or locally, and regardless of which approach we use, the focus of our inspections across all services is on the quality and safety of care for patients, based on the things that matter to people. We do this by asking whether services are safe, effective, caring, responsive and well-led.

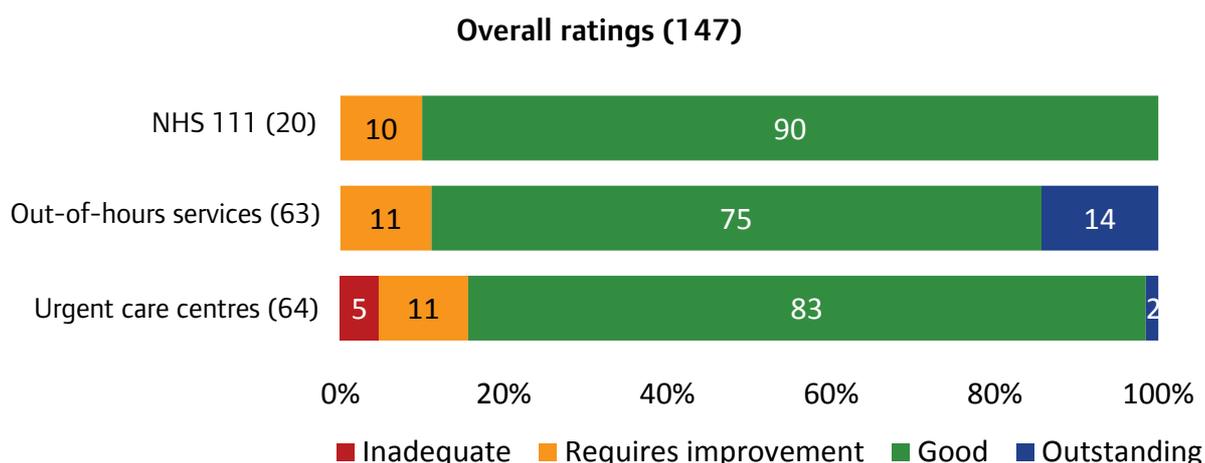
Findings from inspections

After inspecting an urgent care service, we give a rating for the quality of care at the location for each of our five key questions: is a service safe, effective, caring, responsive and well-led, as well as an overall rating for the service. We rate the quality of care as either outstanding, good, requires improvement or inadequate.

Figure 1 is a snapshot of the most recent ratings for registered providers as at 31 March 2018. It does not show every single overall rating for all urgent care services since inspections started, as many organisations have de-registered during the programme and are no longer active. This could be through non-renewal of a contract (either voluntarily or as a result of poor performance). In the same way, when one provider de-registers, another new or existing provider will take up that contract, and may not yet have been inspected. The ratings include those for first comprehensive inspections and focused follow-up inspections and show a national picture for England across the overall ratings, and the ratings for each of our five key questions.

Figure 2 on the next page shows the ratings that were available at 31 December 2016. At this time, far fewer providers (32) had been inspected and rated, so it is not a direct comparison between providers.

Figure 1: Overall ratings by service type at 31 March 2018



Source: CQC ratings data extracted 3 April 2018. Figures in brackets are the numbers of active rated locations, figures in the chart are percentages of rated locations.

Notes: For locations that provide more than one of these types of services, all relevant ratings are included. Therefore, the number of ratings does not equate to the number of locations providing urgent care services.

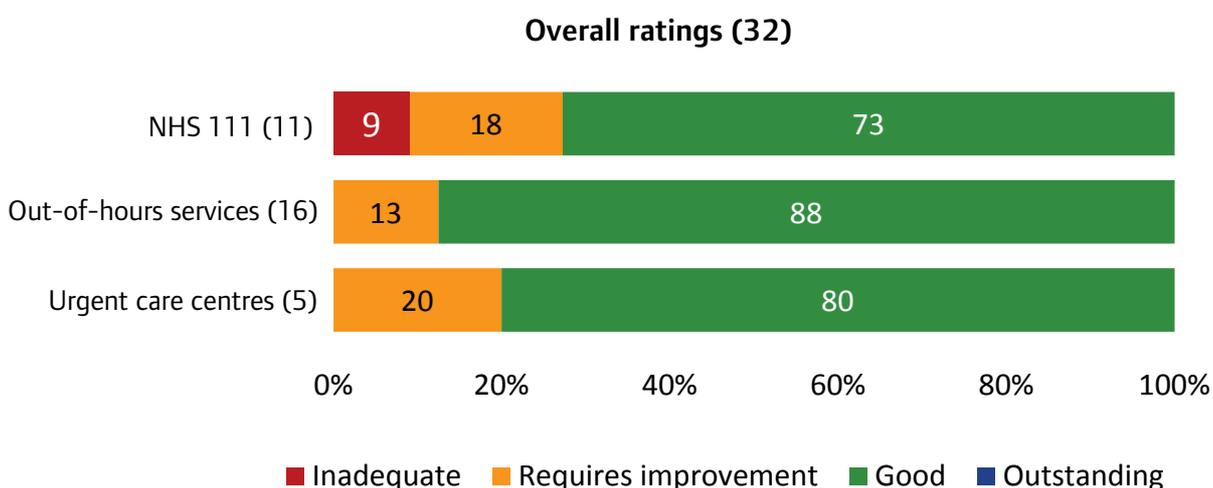
NHS111 services were identified from a review of location inspection reports for providers that were identified from NHS England’s Minimum Data Set.

All other urgent care ratings are based on locations with CQC’s PMS primary inspection category only. All ratings for locations in the P3 (out-of-hours) and P6 (urgent care services and mobile doctors) primary inspection categories have been reviewed. Ratings have also been included for some services in the P5 (remote clinical advice) and P7 (independent consulting doctors) primary inspection categories where we identified that the inspection was focused on urgent care.

Urgent care services under an acute or community NHS trust are not included, unless the related location has a PMS primary inspection category.

The ratings included for a location may not be the location’s most recent ratings – for example, London Ambulance Service is the NHS111 provider for South East London. London Ambulance Service Headquarters was most recently rated as requires improvement in June 2017, but the NHS 111 service was rated as good in January 2017.

Figure 2: Overall ratings by service type at 31 December 2016



Source: CQC ratings data (extracted 3 April 2018). Figures in brackets are the numbers of active rated locations, figures in the chart are percentages of rated locations.

Characteristics of services rated as good and outstanding

Our inspections identified certain common characteristics in these providers, despite the different types of services and different arrangements to deliver them.

Effective communication with staff

Services rated as good and outstanding had developed processes to communicate effectively with staff, despite the workforce being dispersed across different areas and locations. They provided appropriate clinical supervision and support for their staff. For example, NHS 111 providers enabled call handlers to get clinical advice quickly, often using methods that were simple but effective, such as the call handlers holding up signs to attract the clinicians' attention.

These providers shared learning from significant events, audits and complaints effectively across the team. They had identified effective ways to communicate these with their staff, such as newsletters and screen-saver alerts, and were able to demonstrate to inspectors that they used them regularly.

We saw effective two-way communication between frontline staff and managers, with staff telling us that managers were approachable and supportive.

In NHS 111 services, our inspections found that the best providers had paid close attention to communication between call-handlers and clinicians, ensuring that call-handlers could access clinical guidance quickly and consistently. Effective providers had well-established systems for monitoring the quality of their performance and for supporting call-handlers or clinicians if there were concerns about quality.

Cumbria Health on Call (ChoC)

(Rated as outstanding overall, April 2017)

ChoC provides urgent care services spread across Cumbria, which includes a very large rural area. Its out-of-hours services were the first to be rated as outstanding in April 2017. The service had completed a pilot for telehealth appointments, which had reduced the average waiting time for a consultation with a clinician from 146 minutes to 32 minutes. Telehealth appointments offered the option of using specialist medical cameras at a local base to enable a doctor to assess patients, rather than patients driving long distances to a hospital or a doctor driving to their home. It also worked closely with North West Ambulance Service to ensure that in 93% of cases requiring ambulance attendance, the patient avoided admission to hospital.

The inspection report noted, “The leadership, management and governance assured the delivery of high-quality care, and supported learning and innovation throughout the organisation. Leaders had an inspiring shared purpose and motivated staff to succeed. Staff told us the executive team were highly approachable, and that this had a positive effect on staff morale. Governance and strategy were proactive and innovative. The provider had been proactive in addressing the specific recruitment difficulties faced by the service in this geographical area. As a result of a collaborative recruitment drive, six new salaried GPs had been employed. This, in turn, improved capacity to meet demand and safety, as reliance on agency staff was sometimes as low as 5% of shifts per week.

“The provider used innovative approaches to gather feedback from people who used services and the public. They had commissioned Healthwatch Cumbria to conduct a survey, which gathered the views of 1,676 patients. They also used the website ‘I Want Great Care’ (www.iwantgreatcare.org) to gather feedback from patients. The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear and proactive approach to seeking out and embedding new ways of providing care and treatment, and we saw multiple examples of this during the inspection, such as the telehealth pilot, the pharmacy triage pilot, and working with the ambulance service to reduce demand.”

Initial assessment of patients

Providers of urgent care centres rated as good and outstanding ensured that they gave a timely initial assessment to patients, typically either using a health care assistant working with clinical supervision from a nurse or GP, or by training reception staff to use an assessment system validated as safe for (trained) non-clinicians to use, such as NHS Pathways.

Being responsive to the population

Providers were able to demonstrate to inspectors that they responded to their local population, which included engaging with their patients and tailoring their services to their population’s needs.

They used all feedback constructively, including feedback from significant events, complaints and surveys. By analysing this information, they could identify any trends and take action to address problems. Furthermore, providers of care at locations rated as good and outstanding were able to demonstrate how they used feedback from patients to improve services.

Providers of outstanding urgent care were also proactive in developing a clear understanding of the health and social care needs of particular populations such as people receiving end of life care or those with chronic illness.

New Waves Integrated Care (Boscombe & Springbourne Health Centre)

(Rated as outstanding overall, April 2017)

The Boscombe and Springbourne Health Centre in Bournemouth is managed by New Waves Integrated Care. The inspection report for the urgent care centre noted that the service reviewed the needs of its local population and engaged with NHS England and the clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients' individual needs and preferences were central to the planning and delivery of the service.

The service worked with the local community police support unit and Boscombe Forum, a local community group, to understand the population's specific needs, such as isolation and poverty, and to design services to meet these needs. The service did not discourage patients who frequently attended the service and who might be able to have their needs addressed elsewhere, for example by a pharmacist or their own GP. The service felt it was important to have an 'open door' policy to meet the needs of the patients in the area they served. For example, patients without a fixed abode or with a learning disability were always seen by the service.

The service ensured information leaflets were available in community venues including a local addiction centre and shelter for the homeless. In addition, GPs who worked at the centre encouraged attendance through their outreach work at these venues. Patients were informed of the wait time to see GPs and could leave and re-attend the service at an allocated time if this was more convenient to them.

Recruiting staff

To tackle the difficulty in recruiting GPs to work in this sector, we are seeing organisations turning to a multidisciplinary model. This has been beneficial for patients and provided safe and effective care where it was embedded with appropriate clinical supervision and a clear understanding of the competencies of the individuals in the service, with any changes to patient pathways ensuring that patients are seen by the most appropriate professional in a timely way.

Cooperating with the wider health and social care system

The urgent and emergency care sector as a whole is becoming more integrated with other providers, for example with contracts split between organisations, one of whom may deliver the out-of-hours component and another the 111 service, but with the expectation that both services work together. Urgent care providers rated as good and outstanding were able to demonstrate effective joint working with other providers, even where there was no formal integration by way of contracts. These providers demonstrated a proactive approach to working with other providers at operational level.

Governance

The best organisations have a well-developed and independent system of audit, and use innovative tools to monitor the quality of care.

We also saw good examples of peer review and external audit – many of the providers that were members of Urgent Health UK (a membership organisation for social enterprise urgent care providers) were rated as good or outstanding and they submitted themselves to an external audit and committed to peer review of serious incidents. This included auditing call handling and clinical supervision, which led to regular quality improvement activity. It is important for urgent care providers to embed a culture of learning from incidents, particularly with a dispersed and sessional workforce.

Hillingdon Urgent Care Centre

(Rated as good overall and outstanding for the effective key question, May 2017)

Hillingdon Urgent Care Centre serves Uxbridge and the surrounding areas of North West London. The service is co-located with the A&E department at Hillingdon hospital in Uxbridge. The inspection report noted that the staff team was committed to working collaboratively with hospital and community-based colleagues and services (including the A&E department, specialties and safeguarding teams and primary care practices) to ensure patients received appropriately coordinated care. The service proactively shared learning from incidents and audits with stakeholders and was persistent in seeking coordinated solutions where appropriate.

The urgent care centre staff recognised that some patients attended with exacerbations of longer term conditions that were not best met in an urgent care setting and could readily be treated in general practice. Some patients who attended the centre were not registered with a GP. The centre aimed to direct these patients to services able to provide ongoing advice and treatment which would better meet their needs over the longer term.

The centre had found it difficult to meet its targets to redirect patients to alternative primary and community health care services when appropriate. This had triggered the recruitment (through a voluntary organisation) of a team of 'health connectors' who were trained to help people register with a GP, access primary care appointments and community services, and direct patients to more appropriate services, such as advising on when to use NHS 111. It had reduced the number of patients who attended the centre frequently. The urgent care centre was building on this work by developing better links with general practices.

The team also signposted suitable patients to local health-related workshops and courses, such as 'healthy heart' and 'living with diabetes' workshops and first aid training for parents.

Care UK – East of England

(Rated as good overall and outstanding for the well-led key question, May 2017)

Care UK – East of England out-of-hours service provides out-of-hours primary care services for Suffolk. The inspection report noted: "There were clear lines of accountability within the service. The provider's leadership structure was set up in such a way that there was local leadership accountable for delivering the out-of-hours service. The local leadership team were supported and overseen by a national leadership team who in turn were overseen by board level management."

"There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice employed a dedicated GP education lead to support clinicians and GP registrars. The provider had created an in-house learning mobile app for staff to use on their phones and hand-held tablet devices. This had led to a high uptake of training courses for all staff within the organisation."

"The leadership team had been engaged in projects to ensure a focus on high-quality and performance. They were proactive in ensuring effective working relationships with other stakeholders and regularly met with the commissioning groups and other health and social care providers. The aim was to ensure they were working together effectively to respond to local health inequalities and ensure services were accountable and supported by strong governance processes."

Fox Talbot House (Medvivo)

(Rated as outstanding overall, April 2017)

Fox Talbot House is the registered location for services provided by Medvivo Group Limited for a population across Wiltshire. The out-of-hours services are provided from six sites. The inspection report noted that the provider worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example the provider worked in partnership with the ambulance service to deliver a Lift and Assist service, in order to support patients who had fallen, had not sustained an injury but were unable to get up independently. We saw that 90% of the calls for the Lift and Assist service over a six month period were managed by their responders with no other involvement required.

There were innovative approaches to providing integrated patient-centred care. For example, the provider delivered an Urgent Care @ Home service, which had been jointly commissioned by NHS Wiltshire CCG and Wiltshire County Council. The service ensured an integrated rapid health and social care response for people in a health or social care crisis in their own home. Patients were actively supported for up to 72 hours whilst ongoing support was arranged in order to avoid inappropriate admissions and expedite hospital discharges. Since its commencement three years ago, the service had supported more than 2,000 patients to remain at home or to return home from hospital as soon as possible.

The provider recognised the need to increase the resilience of the GP out-of-hours cover and this had been achieved by employing and using paramedics to carry out a portion of appropriate domiciliary visits on behalf of the clinical team, therefore enabling a higher number of visits to be made. A trial period of five days over Christmas 2015 demonstrated improved patient outcomes from the increased clinical resource, which had led to more efficient and effective home visits during busy periods. A decision has been made for this service to operate over future bank holidays.

Care UK Surrey

(Rated as good overall and outstanding for the well-led key question, October 2017)

The NHS 111 service serves approximately 3.5 million people in Kent, Medway, Surrey and Sussex, generating a call volume in 2016/17 of more than 1.1 million calls. CQC's inspection report noted a well-developed leadership structure that had supported innovative practice and new systems to be developed and embedded across the service – for example, the diamond pod training structure where staff had instant access to supervisory help on the floor, allowing new staff to be nurtured and valued without pressure of call targets, with more experienced staff able to give their time appropriately.

There were initiatives to increase safety and welfare in the call centre for staff and patients, such as bright orange cards that could be used by call handlers to easily signal that immediate help was required. There was also a focus on continuously improving working relationships within the management team at South East Coast Ambulance Service (the contract holder for the NHS 111 service) and the wider health and care service.

The Care UK management team was striving to find more efficient and responsive ways of sharing and using knowledge from the acute and primary health providers, social care providers and voluntary agencies in order to improve service to patients and the working environment for all staff.

Characteristics of services rated as inadequate and requires improvement

Initial assessment of patients

Providers of GP out-of-hours and NHS 111 services have to meet nationally-mandated targets for assessing patients. National standards require patients in urgent care centres to receive a clinical assessment, including observations where appropriate, within 15 minutes, though some commissioners have set local targets. Some urgent care centres only see patients who have already been assessed by NHS 111 and/or an emergency department clinician (if they are co-located).

The two safety concerns that we most consistently identified in urgent care services rated as requires improvement and inadequate were:

- Failing to perform a reliable and timely initial assessment of patients to identify those needing urgent care. This primarily affected services providing face-to-face assessments, such as primary care centres run by GP out-of-hours services and urgent care centres.
- Failing to deliver prompt definitive care to these patients, once identified. We found this happened primarily in GP out-of-hours services, especially the home visiting element. A number of providers were delivering on target home visits that were assessed as being of routine urgency, but failing to meet their target for the smaller number of patients who had been assessed as needing an urgent home visit.

Where urgent care centres see walk-in patients who have not already been assessed, we found that some services needed to have a more reliable form of initial assessment if the patient has to wait more than 15 minutes for a definitive clinical assessment. This is because patients attending urgent care centres are more likely to have a medical condition that needs urgent attention than those attending a GP practice.

Poor leadership

In all services that CQC regulates, we have found that good leadership is key to providing safe and effective care. The quality of leadership is reflected across the whole service and poor performance has a knock-on effect, for example on staff turnover and recruitment. The dispersed nature of the urgent care workforce and large geographical areas covered creates a particular challenge for leaders. Where a provider holds multiple contracts, services can support each other through a national triage hub, bringing economies of scale and opportunities for home working.

However, there is often a wide range in the quality of services across the country delivered by the same provider – often as a result of a disconnect between management and oversight at national and local level. In addition, being a small part of a large organisation can also create a sense of isolation, with a marked gap between central management and front line staff and a failure to apply learning from one part of the organisation to another.

Urgent care organisations work well when they have strong local leadership, especially clinical leadership, but if the central overall organisation is unresponsive and unsupportive, this can inhibit good local work. As a result, even within the same parent provider, the quality of the service offered in different parts of the country can be inconsistent if the provider doesn't have the mechanisms to share and disseminate best practice.

When looking at the well-led key question, we saw that NHS 111 services rated as requires improvement or inadequate had a blame culture when things went wrong, focusing on the call handlers rather than the whole system. Call handlers are non-clinical and their training lasts for six weeks. This means they can't always pick up on the nuances of an unwell patient and sometimes choose the wrong question set. Blaming them is convenient but usually inappropriate.

Weak systems and formal processes

We found that urgent care services rated as requires improvement and inadequate were unable to provide evidence to demonstrate that their processes were sufficiently robust to meet the demands of providing urgent care. Although a provider may have policies and systems in place, if the formal processes are not clearly defined and embedded, we found that issues such as failing to identify all incidents will not ensure that learning and outcomes are effectively shared to prevent the same thing happening again.

Governance

Services are required to perform an audit of 1% of cases, but we found variability across the sector as to whether they do this, and whether they take action on the basis of poor performance. Too often in services rated as requires improvement and inadequate, the attitude that “it’s better to have a bad doctor than no doctor” leads to a toleration of poor performance.

In some providers, there were no robust processes for managing safeguarding referrals or for passing on safeguarding concerns to a patient’s registered GP if it wasn’t appropriate to make an immediate referral to safeguarding services.

Recruitment, staffing and workforce planning

The ability to recruit was a recurring theme and key area of concern throughout all of our inspections of urgent care services.

This was particularly evident in some NHS 111 services, where we saw low levels of staff for both call handlers and clinical advisors. The impact of this was a failure to consistently meet KPIs for call answering, call abandonment, call transfer and clinical call-backs. It also resulted in an inability to fill rotas, more staff sickness and higher staff turnover.

We found that almost all urgent care providers experience some difficulties in filling rotas. They need to be able to demonstrate reliable processes for minimising risk and maximising efficiency when there aren’t enough staff; those rated as requires improvement and inadequate could not mitigate these risks.

In some cases, this was because the staff who made operational decisions were insufficiently empowered by central management. For example, one provider that operated seven days a week did not allow local managers to arrange locum cover if there was unplanned staff absence, but the manager who was permitted to make this decision did not work at weekends.

The high rates of self-employed clinical staff in urgent care services cause particular challenges. Although some services carefully monitor demand and map their staff resources accordingly, other services do not deal with the Saturday morning peak in demand, leading to backlogs and delays that can persist throughout the weekend.

We found that, in several instances, nursing and paramedic staff had been recruited to fill gaps in the GP rota and asked to work outside their competencies, with managers not having an adequate understanding of the competencies of these staff. In addition, services were not providing adequate supervision and support or adjusting pathways if clinicians did not have competencies or up-to-date skills and knowledge.

This leads both to risk to patients, and also to long delays for groups such as children under one year and patients with a mental health condition, who these professional groups are not always able to manage.

We found on one inspection that there was the potential risk during the overnight period where children could go for long periods without an assessment while the doctor on duty was making home visits.

The following example shows how inefficient staffing has an adverse effect on safe care for patients.

Example from inspection report of an urgent care centre rated as inadequate overall and requires improvement for being responsive

“After receiving concerns about the provider, our subsequent inspection verified that demand had exceeded staff capacity at the service, which had affected all services provided on varied dates over the weekends. This had led to breaches in service level agreed time limits which meant patients were being re-triaged by clinical staff. Examination of records confirmed a number of occasions when there were delays in seeing patients. This included children and other vulnerable patients.

We also verified the concerns highlighted for a particular Saturday. These involved delays of up to 10 hours, patients being diverted to hospital and home visits being passed through to the next day with no recorded clear rationale as to why this had occurred. Following the review of the findings, we found there was insufficient home visiting capacity built into staff rotas for the population size.”

Poor communication

We found a number of providers had inadequate systems to communicate with their clinicians and had not developed a process to address the challenges of a dispersed workforce. For example, some relied on face-to-face meetings, which few of their clinicians were able to attend, while others did not hold governance meetings at a local level to discuss issues, or there were no regular local staff team meetings that included all staff.

We found a lack of information to show that services were consistently disseminating learning to staff and embedding this in their policy and processes. Similarly, there were ineffective systems to act on alerts issued by the Medicines and Healthcare products Regulatory Agency about medicines and to ensure that NICE guidelines and updates were received and acted on in a timely way.

Poor medicines management

Many urgent care services hold a stock of emergency medications for when local pharmacies are closed. Our inspections have found varying standards of stocking, monitoring and availability of drugs. In some out-of-hours organisations, access to controlled drugs has been a particular issue, limiting their availability to patients receiving palliative care who experience distressing symptoms. To reduce paperwork, some providers store drugs centrally, but then have no one available to collect them and take them to the patient.

Impact of commissioning arrangements on services

A number of NHS 111 providers told us that lack of sufficient funding from commissioners was a key inhibitor to delivering a high-quality service. This was combined with local variations to the national commissioning standards, with differing service specifications and funding between CCGs, which prevented them from achieving economies of scale in how they delivered the service.

We had no doubt that the complex commissioning arrangements (as well as providers sub-contracting to other providers) had an impact on the quality of service delivered. Furthermore, we recognised that as the provider landscape is continually changing as contracts are re-procured, it leads to further disruption when incumbents fail to win the tender because of the inevitable period of transition and 'bedding in' of services.

Another area that we identified is the limits placed on services by some commissioners. Often, providers wish to adapt their services to local needs, for example sending a nurse rather than a doctor to verify deaths, or moving to a more multidisciplinary model to support staffing; but they are prevented from doing so because of contractual restrictions on the services they provide.

Next steps

CQC's regulation has shown that urgent primary care services have been able to improve and, overall, the quality is good. However, if the integrated urgent care sector is to achieve NHS England's ambition, it must be adequately resourced, with contracts realistically priced, and commissioners prepared to support but also to take action where providers are not meeting the specifications of their contracts. Too often when presented with a poor CQC report, the commissioners are already aware of problems, but have failed to address them through contractual levers.

Moving forward, it is imperative that funding is adjusted to reflect the true costs of running these services, and that commissioning decisions take into account the impact and benefits of effective urgent primary care services on the wider local healthcare system – not just the cost of the service.

Alongside this, providers themselves need to give careful attention to how they manage staffing issues. This means mapping capacity more effectively to demand and, when integrating multidisciplinary staff, considering their knowledge, skills and competencies, adjusting patient pathways where necessary and providing adequate clinical supervision. We know that staff work in a difficult and stressful environment and providers need to give greater consideration to their support and wellbeing. Effective two-way communication needs to be prioritised, and learning incorporated throughout large organisations. Where this happens, staff turnover and absence is reduced and patients receive a higher quality service. Recruitment and retention has improved where NHS 111 organisations have moved to an integrated clinical assessment unit model with call advisors and other clinicians supported by a GP.

Based on what we learned from our inspections, we tailored our [approach to inspecting urgent care providers](#) to the type of provider, and the maximum intervals for re-inspecting services will now depend on the rating and the level of risk that we determine from our monitoring activity.

Our regulatory approach will reflect the changes in the urgent and emergency care sector in both the primary medical and acute sector, as well as the internal changes happening within providers. We will continue to work with our national partners, for example NHS England, and with providers, to ensure that our approach is the right one so we can regulate urgent care effectively.

To inform our wider strategy on integrated care, care pathways and place-based care, we carried out two [pilot reviews](#) of the quality of urgent and emergency care services across two local health and care systems. These looked at how services including NHS 111, GP out-of-hours, GP practices, ambulance services, A&E departments and care homes

supported people with urgent and emergency care needs, and how well they worked together for the benefit of the local population.

Our recent report on rising pressure in emergency departments recognises that the challenges facing urgent and emergency care services are a symptom of a much wider capacity problem across the whole health and social care system, and that an integrated approach is vital to meeting them.¹⁷

Integration and whether services meet the needs of the local population are central to what we have looked at in our reviews of local systems of health and adult social care for older people. These reviews allow us to look at how care is provided for whole population groups and areas, as opposed to inspecting individual services. Although we regulate urgent care services in isolation from the way they operate in local systems, we know they play an important role in any local system as an alternative to the emergency department and to provide a better outcome for people. The reviews have enabled us to understand the challenges of local health and care organisations in working together to meet the needs of individual people. We will publish the conclusions of the reviews in July 2018.

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Published June 2018

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How to contact us

Call us on > 03000 616161

Email us at > enquiries@cqc.org.uk

Look at our website > www.cqc.org.uk

Write to us at >

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA



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