NHS
Halton
Clinical Commissioning Group

Service Specification

For the

Halton Urgent Treatment Centres (previously known as Urgent Care Centres)

As Primary Care Networks continue to be developed in Halton and Integrated Urgent Care services are being developed across Cheshire & Merseyside, there may be a need to refine the service specification for the new UTC to be in line with any new recommendations and developments. Halton CCG reserves the right to make necessary changes during the procurement process and subsequently in discussion with the preferred provider.

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0.3	7th September 2018	Dr Sangeetha Steevart	Amendments re clinical model.
0.4	15th September 2018	Nicky Ambrose-Miney	Updates to model
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0.11	26th June 2019	Di Armstrong	Updates to section 4.4 (Consultation, Communications & Engagement)
0.12	3rd October 2019	Nicky Ambrose-Miney	Updates to throughout following clarification questions received during 1st procurement.

1. Introduction

The Halton Urgent Care Centres are a highly accessible community-based facility providing care for a large population area. The UCC has been in operation since 2013 and is located within the two towns of Halton, Widnes and Runcorn. The UCC currently operates 15 hours per day, 365 days per year.

In 2017-18, some 80,000 patients were treated at the UCCs, approximately 60,000 of those were Halton residents and a further 20,000 were from neighbouring boroughs.

Within Halton and Cheshire & Merseyside, the vision is to create an urgent and emergency care system (one system multiple facilities) that is capable of delivering equitable access to the right care, first time for the majority of patients through a networked model with services provided along robust pathways 24/7. As this model develops, and the national guidance and local context around Urgent Treatment Centres (UTCs) there will be a need to refine the service specification for the Halton UTC. Halton CCG reserves the right to make necessary changes during the procurement process and subsequently in discussion with the preferred provider.

Halton CCG continues to implement the whole systems integrated programme which covers Cheshire & Merseyside and is also actively working with commissioners and providers to consider what accountable care partnership/s could look like. The provider of the UTC would be expected to participate in the discussions to develop this model of care and consider how they could operate within this. Alignment to this vision of healthcare delivery is critical for Halton CCG.

Urgent Treatment Centres form an important access point on the urgent care network with key interdependencies with general practice, NHS 111, North West Ambulance Service (NWAS), the Intermediate Care Services, social services , GP Out of Hours service (GP OOH), GP extended hours hubs and hospital Emergency Departments.

It is important that Halton UTC is fully integrated with every other part of the local health community and that it operates as part of the overall evolving urgent and emergency care strategy for the local health economy. Pathways from NHS 111, GP OOH and NWAS are of key importance as are referral routes on to GP extended hours and community and other services. The Halton UTC provider(s) will be expected to be a full and active participant in the Urgent Care Operational Group, A&E Operational and Delivery Board and other committees and board as appropriate.

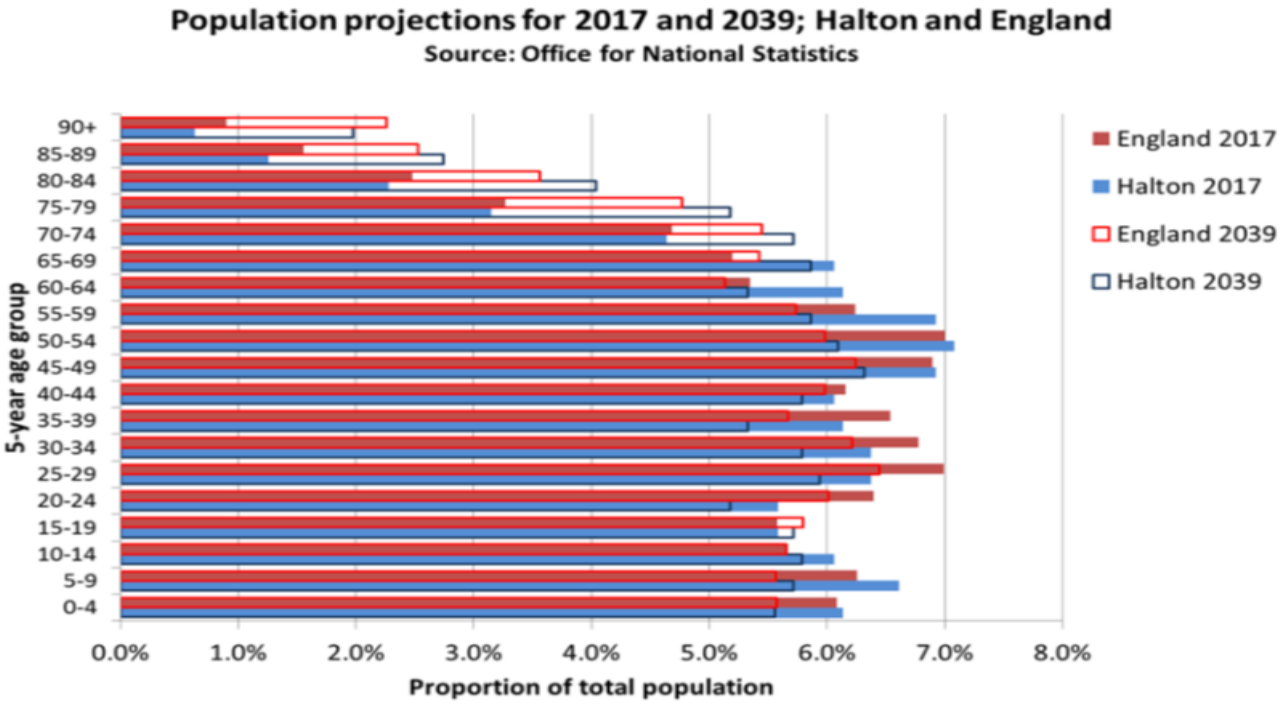
2. Background

Halton is a district in the county of Cheshire in North West England, with borough status and administered by a unitary authority. Since 2014 it has been a member of the Liverpool City Region Combined Authority. The borough consists of the towns of Runcorn and Widnes and the civil parishes of Hale, Daresbury, Moore, Preston Brook, Halebank and Sandymoor. The district borders Merseyside, Warrington and Cheshire West and Chester. The borough straddles the River Mersey – the area to the north (including Widnes) is historically part of Lancashire, that to the south (including Runcorn) part of Cheshire.

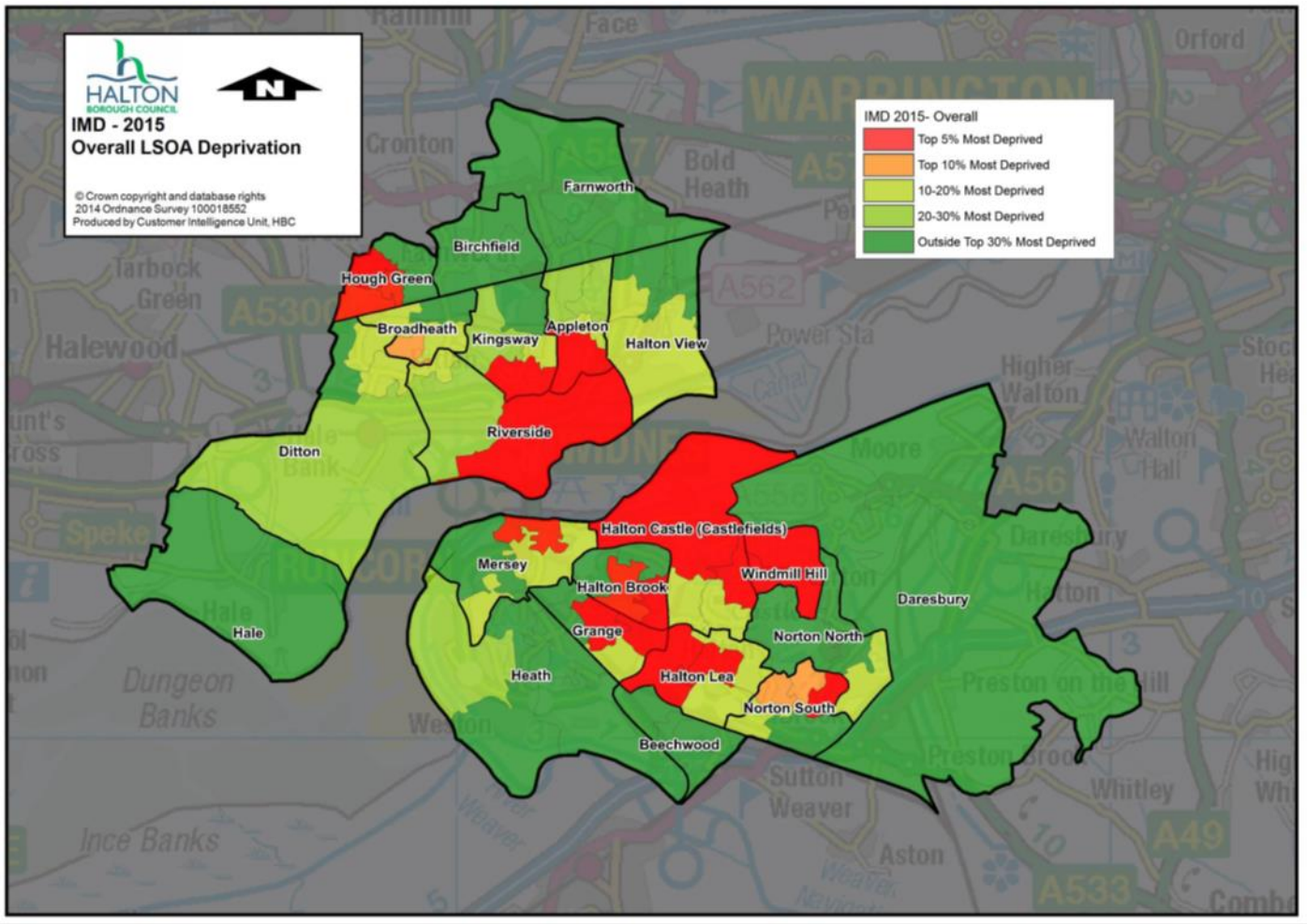
Halton is an industrial and logistics hub with noticeably higher than average levels of employment in manufacturing (particularly of chemicals and advanced manufacturing); energy; wholesale and retail; and transport and storage compared to the average for England. The wages of employees in Halton are slightly higher than the average for England and significantly higher than the average for the North West and the Liverpool City Region

Based on the Office for National Statistics (ONS), the Halton population in 2017 is 127,595. Population growth across all ages remains flat which is consistent with the projected growth of neighbouring CCGs as demonstrated in the chart below.

The age breakdown of Halton's population is expected to change over the next two decades. The proportion of people over the age of 74 is expected to swell and the proportion of children and people of working age is expected to contract. This is the case nationally also but is predicted to be emphasised more so locally. As of 2016 12.0% of Halton's population are aged 70 and above, whereas, in 2039 Halton's projected population aged over 70 will represent almost a fifth (19.6%) of the entire population of the area.



The borough of Halton has a varied demography. Halton has 21 of its 79 small areas (LSOAs) that fall within the top 10% most deprived nationally. This is around 26% of its population.
In terms of Health Deprivation and disability, Halton is ranked 13th most deprived out of 326 Local Authorities, with 37 small areas falling in the top 10% most deprived nationally for Health Deprivation and Disability. A pictorial map represents the Borough on the next page.



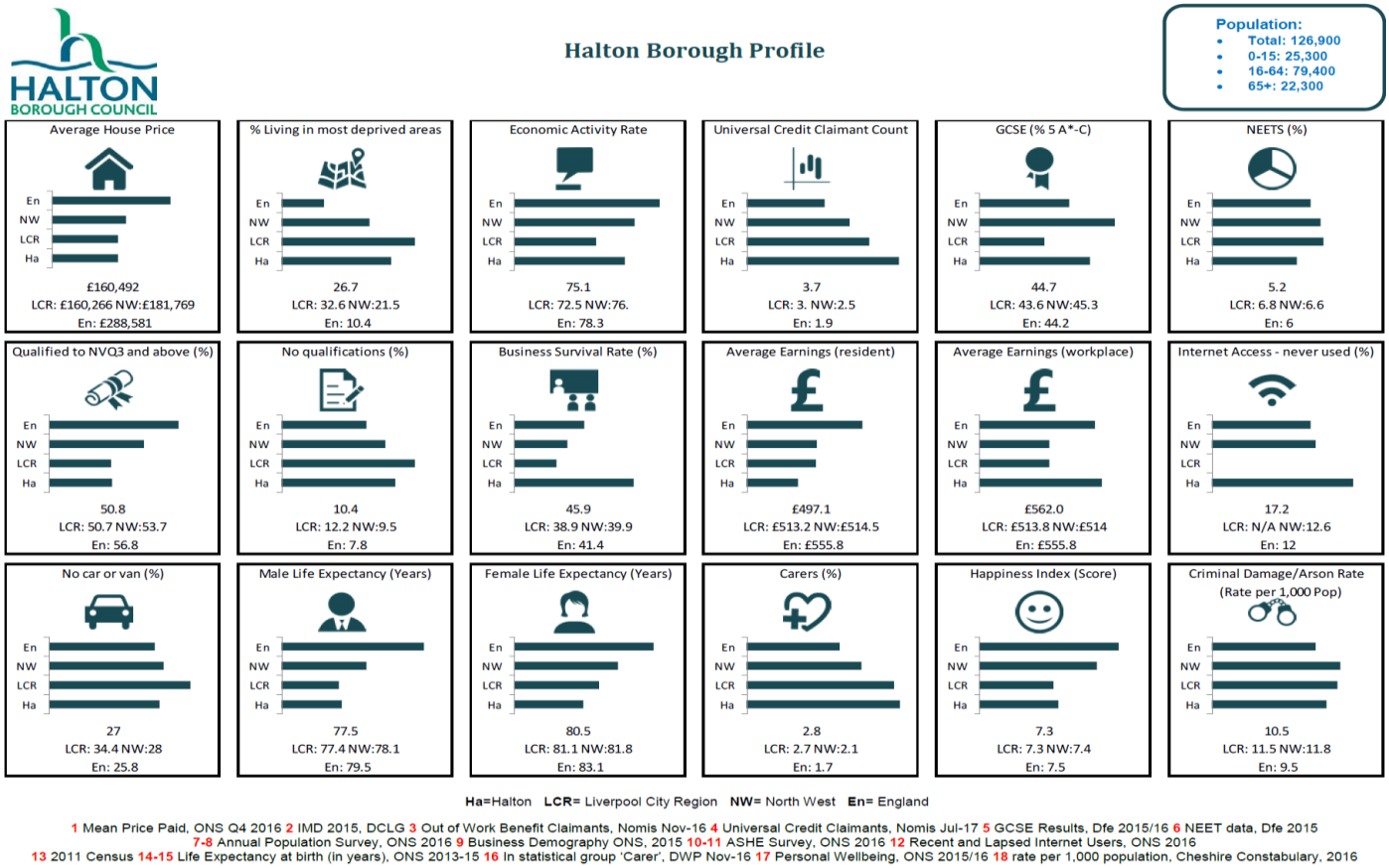
The table below shows the breakdown of population for Runcorn and Widnes towns in Halton, by age and sex based on 2017 borough ward data. The data source is from the JSNA and is available via the website. https://www4.halton.gov.uk/Pages/health/JSNA.aspx

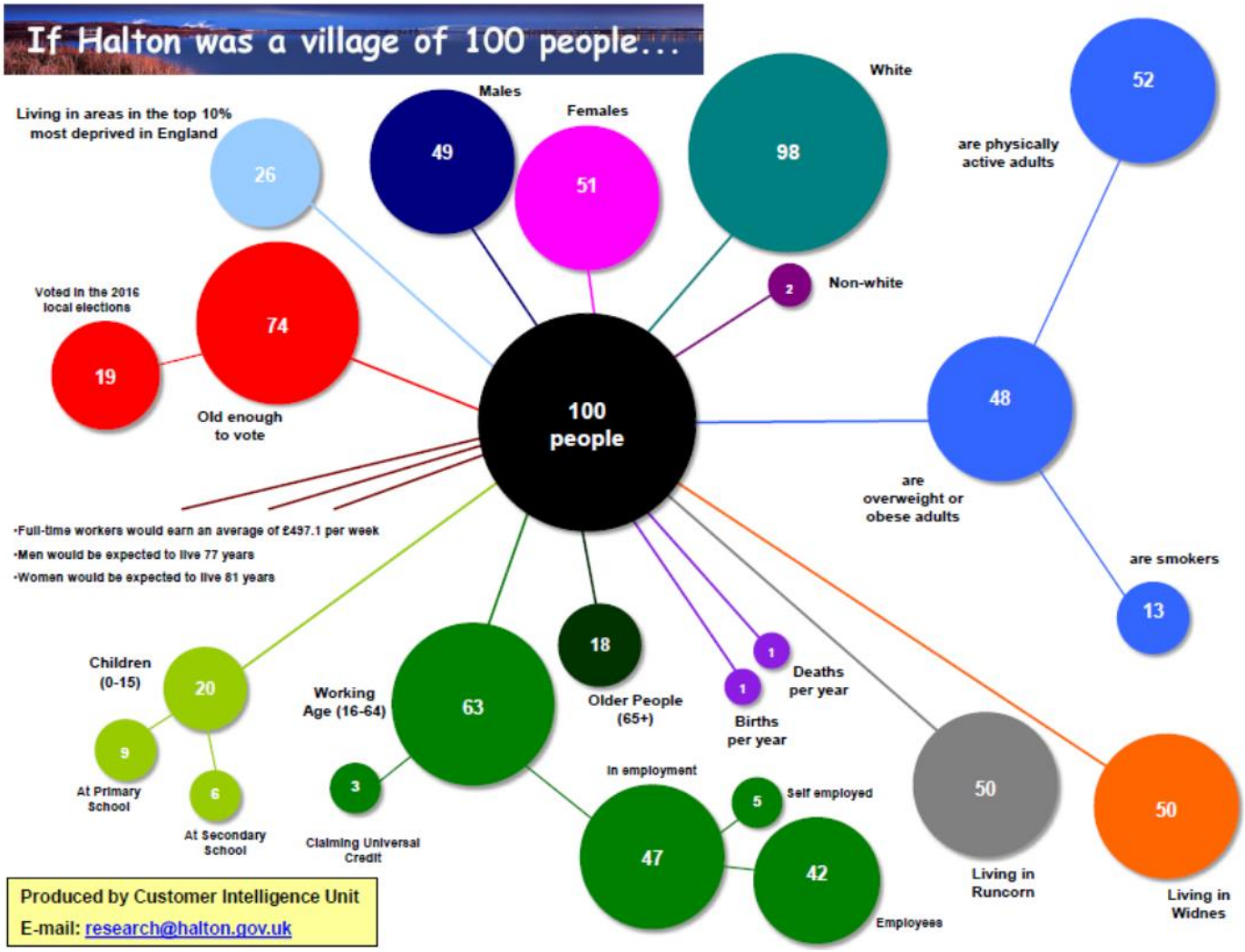
	Runcorn	Widnes	Total
Age 0-4			
Male	2000	1990	**3,990**
Female	1920	1900	**3,820**
Age 5-18			
Male	5840	5410	**11,250**
Female	5580	5250	**10,830**
Age 19-64			
Male	17,850	18,580	**36,430**
Female	19,190	19,320	**38,510**
Age 65-80			
Male	4,520	4,320	**8,840**
Female	4,780	4,620	**9,400**
Age 81-100			
Male	930	1,160	**2,090**
Female	1,400	1,730	**3,130**
Total	**64,010**	**64,280**	**128,290**

Inequalities in Life Expectancy

Life expectancy in Halton is lower than life expectancy in the North West which is in turn lower than life expectancy across England. The reduced life expectancy in the Riverside ward of Widnes means that females living there can expect to live 5.0 years fewer than the general Halton population and males can expect to live 5.8 years fewer.
The inequalities are emphasised by the Beechwood ward; Riverside's counterpoint in life expectancy. Females living in Beechwood can expect to live for 9.8 years longer than the general female population of Halton; males in Beechwood have a 4.4 year greater life expectancy.

Halton is within Liverpool City Region and the below pictorial shows key demographics of the population compared to Liverpool City Region, Northwest and National data. Appendix 1 at the end of the specification, provides a snap shot and easy read pictorial of Runcorn and Widnes health outcomes compared to the England average for 2017 as detailed in the JSNA.





The above diagram shows the population breakdown if Halton was a village of a 100 people. The diagram clearly articulates the demographics spilt by age, sex, ethnic minority, employment, lifestyle, births and deaths.

Further information regarding Halton can be found from the following hyperlinks:

Joint Strategic Needs Assessment:
https://www4.halton.gov.uk/Pages/health/JSNA.aspx

Joint Strategic Needs Assessment Summary:
https://www3.halton.gov.uk/Pages/health/JSNA/JSNASummary.pdf

3. National Context

The NHS Five Year Forward View (5YFV) explains the health services in England for people of all ages with physical and mental health problems, and sets out the new models of care needed to deliver this. The 5YFV highlights that the traditional divide between primary care, community services, and hospitals is increasingly a barrier to the personalised and coordinated health services required for patients. The management of long-term conditions is now a central task for the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single unconnected 'episodes' of care.

The FYFV sets out a clear programme of change to better connect care across organisational boundaries for these patients, including;

- Delivering care through a system approach using networks of care not just single organisations
- Increasing the focus on out-of-hospital care
- Integrating services around the patient, ensuring health, mental health and social care services (housing) are co-ordinated, supporting carers (of all ages)
- Continually evaluate new models of care and develop them to provide the best
- experience for patients and best value for money

The inclusion of community services is fundamental in delivering this programme of change and provider(s) will deliver against the objectives set out above whilst continually working alongside partners to evolve the model in accordance with the strategic direction of NHS Halton CCG and Halton Local Authority.

3.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing people from dying prematurely**	
OUTCOME 1	People are assessed, provided with advice and/or treatment and discharged from the service within the specified timeframe by appropriately skilled and qualified staff leading to an appropriate clinical outcome	✓
OUTCOME 2	People who use the Urgent Treatment Centre have access to the right care, in the right, place, by those with the right skills, the first time	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	
OUTCOME 3	People with long-term conditions are treated in-line with their care records and wishes and are provided with the most appropriate treatment for their needs first time	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
OUTCOME 4	People receive a holistic and personalized service which responds to their immediate need in a timely fashion and also arranges for any follow-up care and support required within a single episode of care	✓
Domain 4	**Ensuring people have a positive experience of care**	
OUTCOME 5	People have access to a service 24/7 which supports them in effectively navigating the urgent and emergency care system	✓
OUTCOME 6	People's perceived urgent care need is dealt with in a personalised way that takes into account their holistic need	✓
OUTCOME 7	People are provided with information and options for self-care and are supported to manage an acute or long-term physical or mental condition	✓

OUTCOME 8	People received improved patient care, experience and outcome by ensuring the early input of the most appropriate senior clinician when required.	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	
OUTCOME 9	The service is accessible and provides the same quality of care to all patients who access the service.	✓
OUTCOME 10	People who use the service have their care needs responded to within a single episode of care which minimises the need for handovers and retriaging between services.	✓

3.2 One Halton Context

The Health and Social Care Act 2012 placed a statutory duty on the NHS and local authorities to promote and enable integrated care, further reinforced by the Care Act 2014. A raft of policy initiatives and incentives have been implemented to support greater integration and partnerships including the Better Care Fund, a national pioneer programme and, most recently, actions to support the vision for the NHS in England described in the Five Year Forward View. The new care models proposed in the Five Year Forward View are particularly aimed at overcoming barriers between hospital and community services. They are aligned with the wider policy direction of organising care in the community around the needs of service users, shifting the focus from episodic and acute care to whole life care, expanding preventative support that encourages "self-care", independence and wellbeing.

In 2014/15 Halton as a borough started its journey towards an integrated model of care with a shared vison across health and social care.

3.2.1 One Halton Strategic Vision

To improve the general health and wellbeing of the people of Halton, working together to provide the right level of treatment close to home, so that everyone in the borough can live longer, healthier and happier lives.

Our values are based on strong partnerships; Collaboration (engagement & participation), System leadership (values based approach) Strong relationships, shared goals and an agreed set of outcomes.
Ultimate responsibility for the implementation of One Halton lies with the Halton Health & Wellbeing Board, however, in order to deliver our vision and priorities we need everyone who lives and works in Halton to take an active role. We are passionate about improving the health and wellbeing of people living in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in achieving this goal.

The One Halton Health and Wellbeing Strategy set the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on "self-care" prevention and early intervention. It does not replace existing strategies, commissioning plans and programmes, but influences them.

A governance structure for One Halton oversees the development and delivery of our priorities. Specific groups are responsible for the development of an action plan setting out what all

stakeholders will do to deliver the outcomes we want. A life course approach is used and ensure each action plan includes action to maximise "self-care" prevention and early intervention, provide high quality treatment and care based on need close to home where this is possible and supports people in both the short and long term.

The key design principles and objectives of One Halton are:

1) Manage demand for services by promoting self-care independence and prevention.
2) Enable health and social care integration wherever possible and appropriate.
3) Design services around users and not organisations.
4) Incentivise providers to work together to meet the needs of the whole person.
5) Treat people in their home and community for as long as it is possible and appropriate.

The Halton UTC provider (s) will be expected to be a full and active participant in driving the vision and change within the One Halton agenda towards delivering integrated care partnerships.

4. Vision for Urgent & Emergency Care Services

The redesign of Urgent and Emergency (UEC) care services in Halton is an objective for 2018/19 and beyond. It is recognised that the current service model needs to be reconfigured to integrate with primary care and offer same day service for the population. It is necessary to reposition the current UEC across the Borough to deliver high quality, cost effective care to Halton residents:

- To ensure right care, in the right place, first time.
- To align and reduce the duplication of unscheduled care services, improve accessibility and the overall patient experience
- To ensure that diagnostic provision can be provided and where possible at a single site to reduce wasting resources and manage the workforce effectively.
- To manage patients effectively, reducing unnecessary steps and clinical risk
- To ensure that access to services is coordinated, avoiding the need for patients to navigate a complex and confusing system
- IT systems should be aligned to the community GP system ie EMIS and have access to the local community pathways. This should enable uniformity of the service delivery in the community
- For all services to be technically linked and/or inter and intra operable to an IT infrastructure that facilitates the sharing of patient records, referrals and booking of appointments, including GP practice appointments as part of a whole integrated system
- To create an integrated unscheduled care service that is coordinated between Primary, Planned, Urgent, Intermediate, Mental Health, Learning Disability, Social Care, Community and Paediatric care services and other parts of the local healthcare system
- To promote health and wellbeing
- To promote and support the delivery of self-care where appropriate
- To deliver appropriate referrals, information, advice and sign posting about other support available.

It is imperative that innovate approaches are used to deliver online integration in the future and will make it easier for the public to access urgent health advice and care. This will increasingly be in a way that offers a personalised and convenient service that is responsive to people's health care needs when:

- They need medical help fast, but it is not a 999 emergency
- They do not know whom to contact for medical help
- They think they may need to go to A&E or another NHS urgent care service
- They need to make an appointment with an urgent care service

- They require health information or reassurance about how to care for themselves or what to do next

Where online triage facilities are made available for local patients the provider should have the ability to book appointments into the UTC or from UTC to GP practices, primary care hubs, OOH service.

4.1 Principles

Urgent treatment centres (UTCs) are community and primary care facilities providing access to urgent care for a local population. They encompass current Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as "Type 3 and Type 4 A&E Departments".
Urgent treatment centres are to be led by general practitioners, and are ideally co-located with primary care facilities, including GP extended hours / GP Access Hubs or Integrated Urgent Care Clinical Assessment Services (formerly known as "GP out of hours" services).

A core set of standards for urgent treatment centres (UTC) to establish as much commonality as possible to ensure patients and the public will:

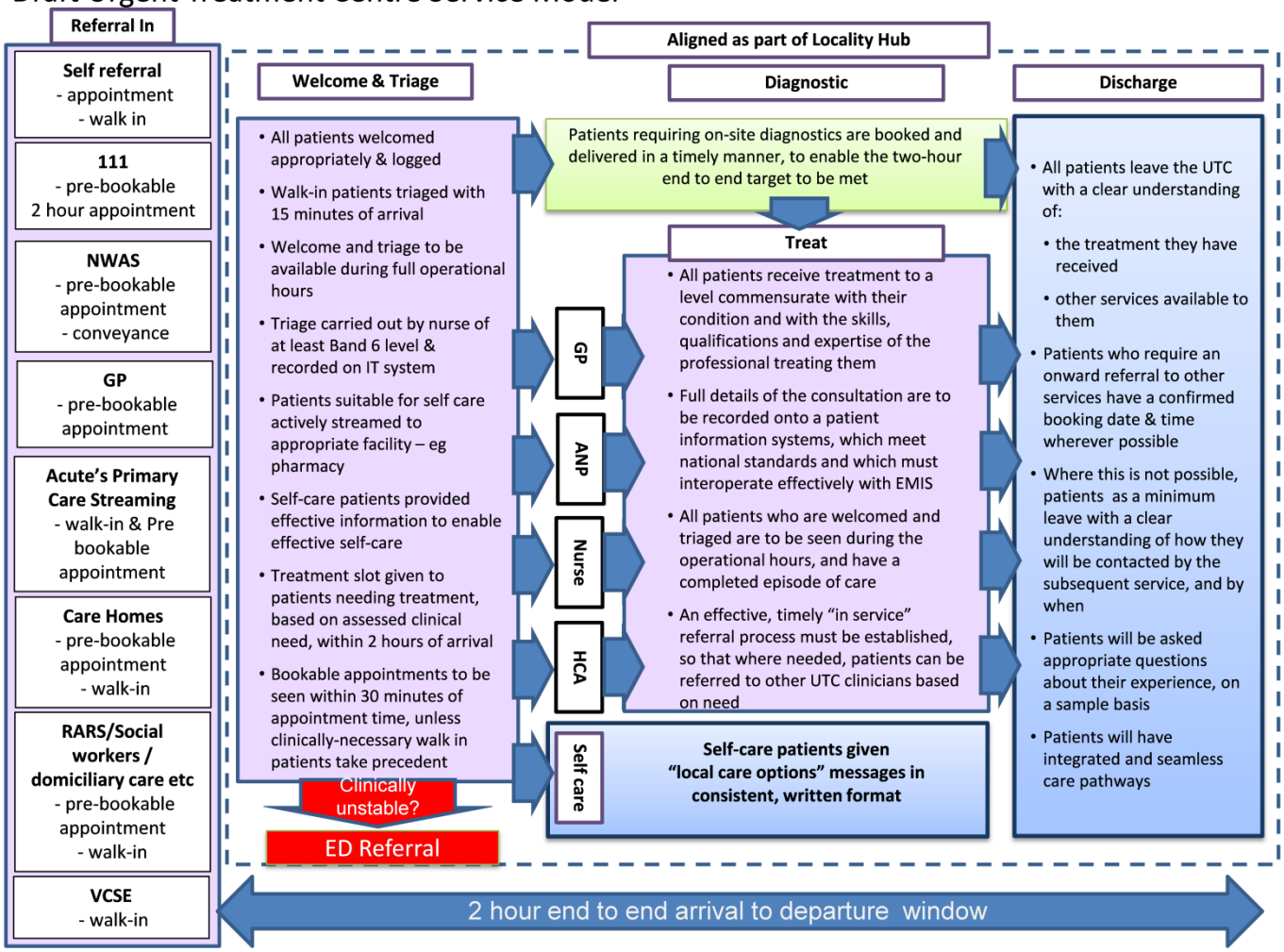
1. Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
2. Have a consistent route to access urgent appointments offered within 4hrs and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.
3. Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.
4. Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.

The local provider will have to ensure that the new service meets all the requirements of the Urgent Treatment standards: Principles and standards (July 2017) available on https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards

4.2 Proposed model

The local Urgent Treatment Centre model ensures that this facility is integrated into local primary and community care hubs and delivers same day urgent needs to the population ensuring a consult and complete episode of care is provided, as opposed to see and refer. The below diagram describes the local process and expectations of a patients journey.

Draft Urgent Treatment Centre Service Model



4.3 Service Aims and Intended Outcomes

The UTC will be both an open-access and a referred-in service, operating on the principle that all patients should receive a consistent and rigorous assessment of the urgency of their need and an appropriate and prompt response.

The aims and intended service outcomes are:

- The service model will be based upon the need to provide improved patient access to urgent, unplanned care, while ensuring that the patient's ongoing healthcare needs are met in the most appropriate setting within primary and community care. This may involve facilitating a small cohort of patients back into services to meet their long term complex needs.

- The UTC will integrate and develop the distinctive culture and approach of a primary care service and be integral to support the development of primary care networks. The UTC will operate with experienced primary care clinicians and practitioners working alongside emergency care clinicians and practitioners undertaking assessments and seeing and treating patients.

- The UTC will not constitute a further access point for routine NHS care in the health economy e.g. management of long term conditions, medication reviews, etc. ; neither will it allow duplication of existing commissioned services or by primary medical services contractors: patients attending with long term complex primary care needs will be appropriately and actively navigated back into core primary/community services.

- The UTC should ensure patients receive a consistent and rigorous assessment of the urgency of their needs and an appropriate and prompt response, including but not limiting to prompt engagement with the Local Authority with regard to safeguarding concerns for children and adults. UTC must be able to provide direct pre-booking of appointments from NHS 111, NWAS and patients' clinicians.

4.4 Consultation, Communications and Patient Engagement

NHS Halton CCG conducted a series of pre-consultation and public consultation activities and events (during August 2018 to March 2019).

Pre-consultation activity ensured the local population were aware of the new model of urgent care. It also provided an opportunity for the local population to get involved in the development of a localised UTC model, share their initial views on the proposals to reduce opening hours, which then fed into the formal public consultation process and provide the CCG with sufficient evidence and information to ensure the new model is fit for purpose and meets the needs of the population.

The outcome of the formal 8 week public consultation (via online/paper-based surveys and engagement events) confirmed that 52.09% of respondents agreed or agreed somewhat to the reduction in hours for the new UTC model.

Other notable key themes included:

- 77.3% of respondents were in favour of a mental health offer within the new model of urgent care
- Waiting times for initial triage and from triage to treatment are too long. Experiences were shared of 45 minute wait times for triage and a 4 hour wait for subsequent treatment
- Workforce. Respondents voiced concern about the lack of GP provision available and some believed that a GP was only available (currently) for 2 hours a day
- Signage and car parking at current sites were seen as an issue. Respondents advised road signage and car parking facilities needed improving in the new UTC model
- Comfort was also highlighted as a concern. Patients asked whether free water dispensers could be made available in the UTC waiting areas, as well as more comfortable seating and a separate area for children or those at risk of infection
- Customer care. Respondents advised that nursing and reception staff (on occasions) lacked empathy, compassion and could be quite dismissive regarding the patients presenting condition.
- When respondents presented with one or more family members requiring treatment, they advised the approach could be more joined up i.e. Parent being seen and treated at the same time as the child – reducing anxiety levels and wait times.

4.5 Future Service Developments

NHS Halton CCG is committed to improving services to patients and responding to the changing landscape of the NHS and the needs of population, these are aligned with the strategy of the One Halton and Cheshire & Merseyside STP.

The CCG and One Halton programme is currently working to redesign the model of same day urgent care and Urgent Integrated care. The provider will work with the CCG to accommodate service development changes and improvements.

The provider will be required to be receptive and adaptable to change and to manage the change process quickly and efficiently to deliver future services and drive financial efficiency within the current financial

envelope. The future services should contribute and provide seamless integrated same day urgent care for the population of Halton.

Future anticipated changes could include:

- Use of local response car to transport patients to the UTC to reduce pressure on ambulance services and support patient education.
- Local front door online triage tool such as EConsult.
- Use of Information technology within centres to promote public health messages and accessible services within the borough.
- The use of a wider and varied clinical and professional skill mix
- The implementation of alternative operational and clinical pathways
- Contribution to the management of long term conditions.
- Further development of Virtual Wards and Intermediate Care Step up/down beds
- Further development of community based provision i.e respiratory, COPD.

The future model of care will be a whole systems integrated care approach to the delivery of healthcare across the locality with integrated and close working links to NHS 111, other Urgent Treatment Centres, Out of Hours services, Clinical hubs, community, intermediate, primary and secondary care services with pathways to mental health services to form a functionally integrated, effective and networked model.

5. The UTC Service Model

5.1 General

The Halton UTC will be open 8am – 9pm 7 days a week, 365 days per year.

5.2 Key functions

The main elements of the service will include:

- Triage, on line and clinical triage
- Observation of UTC patients who are awaiting treatment to identify any deterioration
- Treatment, including medications provided directly or prescribed and discharge
- Support self care and patient education.

The UTC consists of the following main functions:

- Reception
- Triage
- Assessment and treatment including prescribing of appropriate medication.
- Associated diagnostic tests/investigations
- Discharge, including necessary communications to the patient's registered GP
- Provision of self-care and wellbeing advice and information
- Helping patients with registration with a local GP if required
- Onward referral only if clinically required (e.g. Assessment units, speciality services within Acute)

5.3 Patients

The age range of the patients, attending the UTC will be from 0-100, these include:

- Patients who self-present or are bought by another (such as peer) will include patients with minor illness/ailment and/or injury and will be triaged as appropriate.
- Patients who have contacted the 111 service and been advised to attend with or without an appointment time.

- Patients who are transported/transferred by the North West Ambulance Service using the agreed Appropriate Care Pathway (ACP) protocol for patient management/disposition e.g. UTC
- Vulnerable patients in a crises e.g elderly patients becoming confused due to a UTI requiring antibiotics
- Patients from care/nursing homes

6. Scope of Clinical Services

6.1 General

The scope of the UTC will include both minor illnesses and minor injuries. The UTC will assess and treat patients who have a minor illness or injury that require same day urgent care treatment by a Health Care professional in the community.
The UTC will include open access patients and may include scheduled or appointed patients (e.g. via 111 or local booking system) with an urgent need. UTC patients are either:

- Patients with minor injury or illness or
- Patients with a problem that may need further investigation but who are not regarded as requiring ED services

6.2 Conditions suitable for the UTC

Patients suitable for the UTC are those who satisfy the following criteria:

- Must be mobile and fully conscious
- Must not need to lie on a trolley (other than for examination or short treatment)
- Do not need investigation outside the agreed diagnostic menu
- Do not need (or are not expected to need) hospital admission
- Do not require regular observations
- Non-complex fractures without manipulation
- Exclude certain treatments such as manipulations (except digits), peripheral lines, urethral catheterisation
- May require a specialist opinion without further investigation or admission

6.3 Clinical Exclusions (adults)

The UTC will not assess and treat patients who are traditionally referred to as “majors” patients. Major patients will be seen in an Acute and are those who are clinically unstable in one or more respects. This means that the patient has one or more of the following symptoms:

- haemodynamically unstable and/or arrhythmia or significant risk of this
- significant trauma
- fluctuating level of consciousness
- breathing unsafe or abnormal (compared with patient’s normal breathing)
- acute severe abdominal pain
- suspected stroke (as per local stroke pathway)
- non traumatic chest pain for high risk groups
- acute severe headache
- suspected injury preventing ambulation above knee
- overdose with risk of compromising circulation, consciousness level or breathing
- Patients who are presenting with a condition who have been referred by a GP - when their clinical condition warrants their presence in an ED.

Patients with the following conditions will go to an ED and not the UTC:

- Self-harm (adults) or any self-harm (children)

- Severe withdrawal, delirium tremens and withdrawal seizures (as these are very likely to require medical admission).

6.5 Clinical Exclusions (children)

A triage protocol will be agreed between the UTC and hospital paediatric team based on the following guidelines for conditions that are not suitable for the UTC. This protocol will have been agreed by the Joint Clinical Governance Group.

Basic principles

- Clinical assessment as not suitable for UTC – redirected immediately to an ED
- Markedly abnormal baseline signs – redirected immediately to an ED

Additional condition-specific guidelines for children (exclusions)

- Complex fracture of upper and lower limbs and likely to require manipulation
- Procedure requiring sedation
- Overdose / intoxicated and not able to mobilise
- Deliberate self-harm
- Fever with oncology
- Sickle cell crisis
- Multiple pathologies deemed to be complex

A protocol shall be in place to ensure direct referral and transfer of care of children, as appropriate. Triaging of children within urgent care will be conducted using a common approach to assessment and common standards. The protocol underpinning this immediate assessment/triaging decision will have been agreed by the Joint Clinical Governance Group and by the Clinical Lead.

6.6 Mental Health

Most of the patients with the following problems would be expected to be seen by the UTC, unless their clinical state dictates otherwise. Patients with the following conditions will be triaged directly to the ED:

- Overdose
- Other significant self-harm (adults) or any self-harm (children)
- Severe withdrawal, delirium tremens and withdrawal seizures (as these are very likely to require medical admission).
- People expressing suicidal intentions

A robust model for community mental health provision is still in development and the CCG would expect the provider(s) of the UTC to work with commissioners in developing a robust mental health crisis offer and ensure patients have access to urgent and same day services.

6.7 Major Incidents

Providers of the UTC service will ensure that staff involved in the delivery of the service are aware of the Major Incident Policy and Procedures. The UTC will be expected to be flexible in the event of a major incident and potentially see and treat patients who would under normal circumstances be seen and treated in the ED. This will enable the ED to be cleared to take patients involved in the major incident.

7 Arrival, Triaging and Registration

7.1 General

As a part of the arrival and triage process, the following activities will take place:

- Patients' basic demographic data will be recorded immediately on arrival at the UTC. For Children & young people recording school and Looked After status.
- Patients will be registered on UTC clinical records system
- The Provider must agree a process for urgent escalation of concerns raised by the commissioners of the service.

7.2 The Role of the Triaging Clinician

The Provider will be expected to develop a cohort of staff to undertake this role based on an agreed minimum competency framework. The Provider will take full management responsibility for the clinical triaging phase of the patient journey and will provide a clinically appropriate workforce to meet the required demand. This will include gaining consent taking into account Fraser Competency. All clinical staff will be trained in line with intercollegiate competency framework for Children and Adult Safeguarding.

Clinicians with suitable competencies may include GPs, Emergency Care Consultants, Medical Practitioners with ED experience, Primary Care Nurses, Emergency Nurse Practitioners and other suitably qualified clinicians to meet case-mix demands. The UTC provider(s) will need to put in place mechanisms so that a Clinical Lead will assume management responsibility for all clinical staff. All staff will be assessed against a suitable competency framework owned by the Provider and approved by the Joint Clinical Governance Group.

The triaging clinician has the responsibility for ensuring the safe and effective direction of patients to the most appropriate clinician.

7.3 Patients presenting at UTC with Emergencies

Patients self-presenting at UTC with emergencies that require them to need care in an ED will be identified immediately by the triaging clinician. Protocols shall be in place to ensure direct referral and transfer of care, as appropriate.

Triaging within urgent care will be conducted using a common approach to assessment and common standards, irrespective of the triaging clinician.

7.4 Unregistered patients

Patients attending the UTC who are not registered with a GP will be managed by the UTC according to the same criteria as a registered patient. In addition, they will be supported by staff in the UTC to register with a local practice of their choice, within their home address practice catchment area. By linking and liaising with the relevant GP practice the UTC staff will support patients with registration.
For children and young people not registered with a GP, consider safeguarding issues, such as sexual exploitation or trafficking etc.
If the patient chooses a local practice as part of this process and the practice is open, the UTC will contact the practice and arrange a convenient appointment for completion of the patient's preliminary health checks necessary for registration. UTC reception staff will assist patients in completing the required GMS1 form in readiness for registering with the practice. The UTC will electronically forward details of any diagnosis and treatment administered at the UTC to the practice. All outcomes will be recorded in the patient's notes / records.

If the patient does not wish to choose a practice while at the UTC, or if the practice of their choice is not open, UTC staff will supply the patient with hard copy information about practices in their area and a copy of their attendance summary for presentation to the GP.
Unregistered patients from outside Halton will be asked to contact the Registration Department in their local area. Hard copy information about this process should be available for neighbouring boroughs.

7.5 Communication of episode to the patient's GP

The UTC will pass the patient's details, information of the care provided by the UTC and any further information (for example, the need for the GP to follow up with the patient) in electronic format by 8am the next day.

The summary of the episode of care should include:

- The patient's demographic details and NHS number
- The patient's presenting condition and diagnosis
- Details of any diagnostics conducted and, where possible, their results.
- Any treatment provided and full details of any medicines prescribed in the UTC and/or to take home with them, including details of any follow up needed for these medicine.
- Details of any referral made to specialist services to address the patient's immediate needs
- Any recommendations made to the patient for services to which they might self-refer
- Any recommendations about appropriate services (including social care services) that the GP might wish to refer the patient for their ongoing needs
- Safety netting advice issued to the patient
- Patients will be provided with a printed summary of their episode of care that summarises their presenting condition, diagnosis and the advice/treatment provided. Patients should also be given appropriate printed materials relating to their specific condition.

The IT system used by the UTC provider(s) will be inter-operable with national NHS systems (e.g. Summary Care Record), GP (EMIS Web) and Trust systems (Acute, Community and Mental Health Trusts) in order to facilitate effective information sharing (including care plans) and to avoid the need to re-enter patient data at any point in the patient's journey through the service. Inter-operability will also allow UTC to identify any vulnerable children or adults who may have been "red flagged" by other services. This will also be same for other vulnerable groups such as learning disabilities or Autism.

7.6 Management of Waiting Times

Waiting times will be managed as part of the triaging clinician function. The triaging clinician will work in partnership with all parties to ensure compliance with targets and will escalate within procedures as appropriate. Patients will be informed on arrival of the expected waiting time.
Patients who self-present will be clinically assessed and triaged within 15 minutes of arrival (the standard for paediatric patients is 15 minutes). For Children & young people who present alone or with a peer, assessment must take into account safeguarding and Fraser Competency.

Patients transferred from the NWAS Ambulance Service will be handed over to UTC staff for clinical assessment and triaging within 15 minutes of the ambulance arriving at the UTC.

Patients accessing the service via 111 will present their reference number to the UTC staff and will be seen according to their appointment time or within 30 mins of their appointment time.

In some cases, a diagnostic test or investigation will be required. Where a diagnostic test or examination is requested the test must be ordered and patient seen with the results within 2 hours.

8 Care Delivery

8.1 Minor illness / injury

Patients identified by the triaging clinician will be registered on the UTC clinical IT system by the reception staff and be seen by an appropriate clinician.
All patients will be seen in order of arrival unless the triaging clinician or consulting clinician feels they should be seen more urgently.
All adult, children and young people will wait in the main waiting room.

8.2 Paediatric care delivery

The Provider must deliver appropriate and responsive care to all children in accordance with the requirements set out in Section 11. This must be in accordance with the standards set out in the Children Act 2004, National Service Framework for Children

Children suitable to be seen in the UTC will be seen by a suitably qualified clinician.

The Provider shall be responsible for ensuring that their staff:

- Have relevant professional registration, indemnity and have an up to date enhanced Disclosure and Vetting (DBS) checks.
- All staff caring for children shall have appropriate paediatric experience, including core paediatric competencies
- Know who to contact for advice on child safeguarding matters at all times
- Are compliant with their safeguarding duties and responsibilities under Section 11 and all staff have up to date Child Safeguarding training, in line with the intercollegiate competency framework for Child Safeguarding.

For children and young people it is expected that the episode of care will be communicated to their health visitor or school nurse (and the Halton LAC team for Halton LAC children and young people, where known to be LAC) no later than 8am on the second working day following the child or young person's episode of care. There is an expectation to communicate with the Liaison Health Visitor and to take part in any relevant child protection meetings.

8.3 Streaming to / from UTC

As part of the development of integrated care provision, an internal transfer process will be developed to ensure that patients receive care from the most appropriate clinician. Following clinical triaging in the UTC any patient found to require more complex urgent care will be referred directly to an ED or Paediatric ED as necessary within a 60 minute timeframe.

Conversely, if a patient arrives at an ED and is able to be treated in the UTC, the patient will be directed to the UTC. A 'Patient Transfer' protocol for establishing the appropriate transfer of patients between services will be agreed between the Provider and Acute Trusts prior to service commencement and where possible the patient will be given an appointment slot. This protocol will support services in delivering the 4-hour standard, and will not put either the UTC or the ED at Acute Trusts in a detrimental position to be able to treat a patient safely and appropriately.

As part of this protocol, patients transferring from the UTC to the ED should have their arrival time noted and verbally communicated to the ED staff. The 4-hour waiting time standard will commence from the patients arrival to the UTC and NOT from the time of their transfer; e.g. patient arrives at UTC at 0900, is transferred to ED at 1000, treatment and discharge to be completed by 1300 (4 hours from 0900).

As part of this process the patient's details will be transferred from the UTC clinical system to the Acute Trusts IT system (or vice versa) by staff without the need for the patient to reregister:

- Patient details to be transferred between Provider and Trust IT systems
- Provider and Trusts must ensure safeguarding and information governance measures are taken to protect patient information and have policies and processes in place to ensure the correct transfer of details from one IT system to the other.
- Patient information will be tracked for data collection and future planning purposes. The utilisation of this pathway will be subject to regular audit by the Joint Clinical Governance Group.

The internal transfer protocols and processes must delineate where accountability sits at each stage of the transfer and must delineate where responsibility and accountability will sit i.e. with UTC or ED for any waiting time breaches. Any waiting time breaches seen as the responsibility of the UTC must be reviewed and analysed to determine remedial actions.

9. Access to Diagnostics and Investigations

9.1 General

UTC will arrange access to diagnostic tests and investigations. These diagnostic tests and investigations will be available to the UTC on the same day, and within two hour period which will allow the result of the diagnostic/ investigation to inform a treatment decision before the patient returns home. The results of any tests requested from the UTC will be made available to the patient's own GP.

All diagnostic tests will be available for both adults and children attending the UTC, where applicable. Diagnostic tests will be available to clinicians for UTC patients as described in the table below. The principle is that the only diagnostics to be carried out are those that are necessary to assist in acute management of the patient and complete the episode of urgent care.

Only clinicians who are competent to interpret results of tests should request tests and this should be documented in the procedures manual competence section.
All tests are to be requested using the electronic order communication system, and the UTC provider(s) must ensure staff are appropriately trained and that IT systems have connectivity with the acute system.

All appropriate consent (Fraser Competence) and chaperone policies must be adhered to as well as health and safety requirements regarding the handling and transport of body fluids.

9.2 Menu of Available Diagnostic Tests

There is the option for UTC provider(s) to undertake Point of Care Testing if required and is necessary depending upon clinical need. Point of care testing can include the following:

Point of Care tests (Near Patient test)	Blood sugar Troponin CRP – in agreement with the commissioner. INR Potassium Urine dipstix Pregnancy urine test ECG Doppler Ultrasound BP Pulse oximetry

The following is a proposed set of diagnostic tests which the UTC should have access to:

Haematology:	Full Blood Count (FBC) Erythrocyte Sedimentation Rate (ESR) C-reactive protein (CRP) Serum HCG D-Dimer Clotting studies
Biochemistry:	Urea and electrolytes (U&E) Blood Glucose Liver Function Tests (LFTs) Thyroid Function Test (TFT) Amylase Pregnancy Test
Microbiology:	Urine Stool Throat, wound swabs etc.
Radiology:	Plain film for limbs and chest
Ophthalmology:	Slit lamp

9.3 Appropriate use of diagnostics

To ensure effective use of resources the UTC provider(s) should conduct a quarterly audit of requests for diagnostic tests and present the findings to the Joint Clinical Governance Group and to the commissioners. Urgent patients presenting to the UTC may require access to diagnostics where this would assist the clinician in a decision regarding either the patient's immediate treatment or for a decision or requirement for admission.

9.4 Interpretation and Reporting

The UTC is expected to interpret all diagnostics and investigations it requests, except for those which it requests as part of an onward referral to a specialist clinic. This applies to Radiology as well as Pathology. For Radiology, the UTC is required to develop a process through which X-rays can be subject to a medical interpretation, as part of the episode of care. There is expectation that current SLA's with acute providers, with regards to diagnostics, will be reviewed and ensure fit for purpose in the new model.

Measures must include having an abnormal results review process in place. The interpretation of all plain films by UTC staff must be clearly recorded on the patient's care record in the UTC. The provider must implement a system whereby all films reported are checked against the UTC clinician's interpretation and any differences in interpretation likely to affect the patient's treatment or outcome must be reported to the patient's own GP.

10 Discharging Patients from the UTC

10.1 General

Patients will be discharged at the end of their episode of care. It remains the requesting clinician's responsibility to ensure that all abnormal diagnostic results are followed up and actioned appropriately. Care should be taken when discharging unaccompanied children, other vulnerable (eg Young Offenders (YOS, LAC where known) children and other vulnerable people depending on the time of day.
A discharge summary is to be offered to the patient by the clinician responsible for their treatment. This is a summary record of the patient's visit to the UTC outlining what happened to them.

There are also other staff groups who may need to be informed for example:

- Community matrons
- Ambulance clinical support desk
- Discharge support team
- Rapid Response Team
- Adult Psychiatric Liaison Service
- Social services
- Paediatric Liaison Nurses
- Health Visitors
- School Nurses
- LAC Team
- District Nurses
- Probation Service
- Independent Domestic Violence Advocate
- Police
- Mental Health Team
- Learning Disability Team
- Care Homes (with Consent)

It is the responsibility of the appropriate UTC professional to ensure the information is passed to the appropriate service within 24 hours of the episode of care.

The provider will issue discharge summaries to the patient and send electronically to the GP practice providing relevant clinical and treatment information, medicine administered or prescribed and any necessary follow-up care within the agreed timeframe.

Many UTC patients will be seen, treated and discharged from the UTC with no specific coordination of or access to community support services. However, a significant proportion of UTC patients will need to be assessed to ensure they can be safely returned to their usual community setting with the appropriate community support (or a temporary alternative such as an intermediate care facility). These patients may need input from the Rapid Access Rehabilitation Service (RARS) and therefore a patient pathway between UTC and the RARS Team will be established by the UTC provider(s).

10.2 Follow up care

If further follow-up care is required, the UTC should transfer the patient appropriately, for example, back to their GP, care at home or other intermediate care services, and will need to agree processes for this to happen.

The UTC will need to establish referral mechanisms for patients requiring community physiotherapy as a part of their on-going care, should this be considered to be appropriate.

The UTC provider(s) will also be responsible for arranging any patient transport deemed necessary at the time of their discharge.

The Provider will work collaboratively with any new services relevant to Halton patients which are established during the contract duration.

10.3 Referrals for first Outpatient Appointments

With the exceptions below, clinicians in the UTC will NOT refer patients for first outpatient appointments.

Exceptions are:

- Suspected cancer (the patient needs to know that this is an urgent 2 week wait appointment)
- Referral to the Rapid Access Chest Pain clinic
- Referral to Early Pregnancy Assessment Unit
- Referral to Fracture Clinic
- Ophthalmology out-patient clinic

Referral guidelines and protocols regarding referral to these services will be drawn up and adhered to. The UTC provider(s) will be expected to agree direct referral pathways to additional specialist services and clinics including specialist gynaecology services and genito-urinary medicine.
Where an admission is required this will be made directly to the specialty concerned. Patients will not be referred back to an ED for diagnostics or admission.

11 Medicines Management

11.1 Medicines management services required in the UTC

The UTC provider will be responsible for providing the following:

- A supply of stock medicines for use or administration as part of immediate treatment or assessment. This stock will need to be comprehensive and align with the clinical pathways agreed for the UTC. The stock formulary and any future changes to it will need to be agreed with the commissioner as well as via the UTC clinical governance processes.
- A supply of pre-labelled stock medicines for supply under a Patient Group Direction (PGD) in line with the Pan Mersey Area Prescribing Committee (APC) formulary, recommendations and guidelines. The PGDs will need to be agreed with the commissioner and must be aligned with the clinical pathways agreed for the UTC.
- Access to FP10 prescriptions for use by medical and non-medical prescribers where clinically appropriate, including the use of EPS where available. The Provider will be expected to adhere to the APC formulary, recommendations and guidelines as agreed by NHS Halton CCG. This is available via the APC website. A budget is currently available for the current UCC aligned to primary care for prescribing costs.

11.2 Formulary

NHS Halton CCG is part of the Pan Mersey Area Prescribing Committee (APC). All prescribing within the locally should be in line with the Pan Mersey APC formulary, guidance and recommendations as agreed by the CCG. Any deviation from this formulary must be agreed by the commissioner in advance.
Prescribing of antibiotics is likely to be a common intervention within the UTC and as such it is essential that the Provider adheres to the Pan Mersey APC antimicrobial guidance to support effective antimicrobial stewardship and reduce antimicrobial resistance.

11.3 Clinical governance

The Provider is responsible for clinical governance and compliance with applicable national legislation and guidance for all aspects of medicines management, including prescribing and supply.
Providers must engage and participate in any prescribing audits when deemed necessary by the CCG. It will be expected that the provider will carry out a full antibiotic audit twice a year working as agreed with CCG medicines management team and will be able to demonstrate activities that support good antimicrobial stewardship. .

The UTC provider must ensure compliance with all legal, clinical and governance procedures regarding the use of PGDs.

Any incidents related to medicines and prescribing, including use of PGDs, must be investigated by the UTC provider, with outcomes reported following the provider and commissioner reporting processes along with shared learning as a result of the investigations.

Supply of Medication
The Provider is expected to have a mechanism available through which a full course of medicines can be supplied or administered where clinically appropriate.
The Provider should also implement a mechanism for reporting all medicines prescribed and provided as part of the UTC service to the CCG on an annual basis.

Although not routinely recommended the UTC can issue repeat prescriptions, where this is deemed appropriate as determined by clinical assessment.

Medicines policies
The provider is expected to have in place a full set of policies and protocols relating to safe use of medicines and safe management of controlled drugs within the UTC. These policies must be audited on a regular basis to support adherence to legislation and best practice.

12 Arrangements for Adult & Paediatric Care

12.1 General

Protocols should be in place to manage critically ill and injured children and adults who arrive at an urgent treatment centre unexpectedly. These will usually rely on support from the ambulance service for transport to the correct facility. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance *'Quality standards for cardiopulmonary resuscitation practice and training*[1], should be immediately available. At least one member of staff trained in adult and paediatric resuscitation present in the urgent treatment centre at all times. This should all be part of an approach of 'design for the usual, and plan for the unusual'.

13. Arrangements for Paediatric Care

13.1 Service design – an integrated unscheduled care system

The Provider shall ensure that the arrangements for paediatric care comply with recommendations of Services for Children in Emergency Departments[2] and the National Service Framework for Children, Young People and Maternity Services[3].

All front-line staff delivering unscheduled care to children must be competent in the basic skills required for safe practice, in whichever setting they work.
The UTC provider(s) must work with the commissioning organisation to provide safe, unscheduled care for children taking local needs into account.
In order to smooth the interface between organisations, commissioners and providers should encourage shared or rotational posts, or regular secondments to the acute unit.
Notification of the child's attendance at the UTC should be made in a timely way to their primary care team.
The UTC should prevent unnecessary hospital admissions by being aware of alternative options, and developing care pathways for common conditions with community and paediatric colleagues.

13.2 Child and family-friendly care

The UTC must accommodate the needs of children and accompanying families as far as is reasonably possible.
The UTC should regularly seek comments from children, young people and separately their carers to improve services and facilities. Information for children and young people must be suitable for their age and developmental stage to enable and encourage self-care.
Children and young people up to the age of 25 years, with a learning disability or with complex needs and or with Education, Health and Care Plan who are transitioning into adult services will need be considered.

13.3 Initial assessment of children

All children attending the UTC are to be visually assessed by Reception staff within 15 minutes of arrival to identify an unresponsive (or in a confused state) or critically ill child and alert a clinician. Protocols should be in place to guide reception staff in the UTC.

A brief clinical assessment, including heart rate, respiratory rate and temperature, by an appropriately trained nurse or doctor will occur within 15 minutes of arrival (the Initial Assessment) if it is not possible for a full clinical assessment to be conducted in this time period. A system of prioritisation for full assessment should be in place if the waiting time for a full clinical assessment exceeds 15 minutes.

The Initial Assessment should include an assessment of the requirement for analgesia using an appropriate pain score and, if required, the UTC should ensure that treatment of pain is delivered within 20 minutes of such Initial Assessment. The Initial Assessment shall include consideration of whether there are any child protection concerns and whether checks should be made as to whether a child protection plan is in place. All records should be kept safely and be made available when required.

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[2] Royal College of Paediatrics and Child Health (2007) Services for Children in Emergency Departments: Report of the Intercollegiate Committee for Services for Children in Emergency Departments

2 National Service Framework for Children, Young People and Maternity Services, Department of Health, September 2004

3 https://www.resus.org.uk/quality-standards/acute-care-equipment-and-drug-lists/#_blank

Registration details completed in respect of each child seen at the UTC shall include specific additional information (e.g. name and relationship of accompanying adult, who can legally give consent to treatment, school, health visitor, LAC, where known, social worker). Details of any child's visit to the UTC should be sent to the health visitor or social worker regardless of the reason for the visit.

13.4 Treating the sick child

All UTC staff will be trained in paediatric basic life support. At least one member of the UTC team should have training in advanced paediatric life support (APLS) and the UTC should establish and monitor guidelines and protocols to ensure the safe transfer of any child from the UTC to an ED at the hospital. The UTC provider(s) will have a named paediatrician with designated responsibility for UTC liaison including safeguarding children.

Systems must be in place to ensure safe discharge of children, including advice to families on when and where to access further care if necessary.
All unscheduled care attendances by children shall be notified to that child's primary care team: the GP and the health visitor or school nurse and where known the LAC teams.

13.5 Staffing and training issues

All UTC staff shall be trained in recognising serious illness in children. All clinical staff caring for sick and injured children shall have the same basic competencies in caring for children as they do for adults e.g. recognition of serious illness, basic life support, pain assessment, and identification of vulnerable patients. All clinicians should have the same competencies - Nurses caring for sick and injured children in the UTC shall have at least basic competence in both emergency nursing skills and in the care of children. Nurses caring for children in the UTC shall be competent in:

- Communicating with children and their families
- The assessment and recognition of the sick child
- Basic life support skills
- Recognition of vulnerable children , the ability to identify when safeguarding procedures are necessary, and the ability to implement the ED child protection policy
- Pain assessment and management
- Prescribing and administration of medication by appropriately trained Nurse Prescribers
- The current legal and ethical issues pertaining to children, including consent and confidentiality issues

Minimum competencies in relation to caring for children and young people have been defined by Skills for Health[4], the Department for Education and Skills[5], the RCN[6], and the Faculty of Emergency Nursing (FEN)[7] and the UTC must ensure that all relevant staff meet the requirements set out in this guidance.

Where emergency nurse practitioners (ENPs) work autonomously to see and treat children in the UTC, the UTC must ensure that the nurses have received specific education in the anatomical, physiological and psychological differences of children.

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4 Skills for Health, www.skillsforhealth.org.uk
5 Department for Education and Skills 2004 Common core of skills and knowledge for the Children's Workforce
6 Royal College of Nursing 2012 Core competencies for nursing children and young people
7 Faculty of Emergency Nursing Competency Framework

They must also have specific training in history-taking, examination skills and diagnostic reasoning in children, including interpretation of investigations. When nurses prescribe medication for children, they shall have the necessary knowledge of paediatric pharmacology.

The UTC shall have an RN (Children) lead nurse responsible for the care of children and a lead nurse responsible for safeguarding children. All clinical staff fulfilling these roles shall liaise closely with their counterparts at the EDs at the hospitals for the purpose of ensuring that there are consistent processes across both the UTC and EDs at the hospitals.

The UTC shall agree with an Acute Trust the availability of an paediatric consultant whose remit includes paediatric emergency medicine. Access by UTC staff to this consultant must be agreed as and when may be required to provide clinical supervision, or the UTC must otherwise employ its own consultant with sub-specialty training in paediatric emergency medicine.

13.6 Safeguarding Children in the UTC

The UTC will provide quarterly reports using the Safeguarding Children Health Outcome Framework (SHOF), to the CCG as part of their Contract Quality monitoring process. UTC will also be required to complete self-assessment audits in line with the local Safeguarding Assurance Framework.
Evidence of compliance with the above will be included in the Annual Report to the CCG Outcome 7, Regulation 11 of the Health and Social Care Act 2008 & 2012 (Regulated Activities) Regulations 2009).

Access to safeguarding advice must be made available to UTC staff from a paediatrician and social services 24-hours a day. The UTC must ensure that there is direct or indirect access in place to the list of children with child protection plans (engagement with CP-IS). This system will give access to children and unborn with CP Plans and Looked After Children (LAC). UTC should have a paediatric liaison Health Visitor and School Nurse Professional. Systems must be in place to identify children who attend frequently.

13.7 Information systems and data analysis

The information systems at the UTC will enable a child's attendance at the UTC to be notified automatically to their primary health care team (both the GP and health visitor or school nurse and LAC, where relevant and known). The UTC must ensure that surveillance of local patterns of injury is possible.
Further guidance may be found in Standards for Children in Emergency Care Settings.[8]

14 Staffing

14.1 General

The establishment of the UTC provides a significant opportunity to develop and enhance the skills and competence of health care professionals across the local health economy.

The planned establishment must recognise the need for a strong primary care and emergency care presence in all assessment, diagnosis and treatment roles. It is anticipated that the band/role mix may change and include a wider range of practitioners with varying competencies as the UTC becomes established and protocols implemented and reviewed. It is expected that clinical staff will rotate through primary care hubs and UTCs and ensure training, workforce and skill mix to create a resilient and stable workforce for Halton.

[8]Royal College of Paediatrics and Child Health 2012 Standards for Children in Emergency Care Settings

The clinical model recognises that outside of rota planning there will still be peaks and troughs of activity within the UTC.

Drawing on recommendations made by the College of Emergency Medicine[9] commissioners are defining the minimum competencies for UTC staff as follows:

Area	**Competence**
Standard Clinical Competencies	All staff should have the ability to carry out basic life support for adults Minimum staff education and competency requirements for all clinical staff working in the UTC include: • Recognition of serious illness • Intermediate life support training • Pain assessment • History taking, examination, formulation of a diagnosis and treatment plan • Prescribing (if a qualified prescriber) or use of Patient Group Directions (PGDs) (if legally allowed to work under a PGD). • Competence in the recognition of acutely ill patients • Identification of vulnerable patients and their multidisciplinary pathways of care (vulnerable patients include, but are not limited to, frail elderly, adolescents and children, people with mental health • issues or learning disabilities) • Level 3 Adult Safeguarding Training for all front line clinical staff. • Level 2 Safeguarding Adult training for all qualified staff • Level 1 Adult Safeguarding training as mandatory at induction for all staff, in line with adult safeguarding intercollegiate competency framework
Minor Injuries Competencies	Clinical staff dealing with minor injuries must possess the practical skills necessary to identify and manage noncomplex soft tissue and bone injuries, for example: • Wound closure • Plaster casting • Assessment of burns
Paediatric competencies	The UTC must have a minimum level of competence, skill and experience for treating adolescents and children including: • Paediatric intermediate life support training • All discharging clinicians/main deliverers of care need to have level 3 child protection training in line with the children's safeguarding intercollegiate competency framework • Recognition of sick children, including Paediatric Early Warning System
Diagnostic Competencies	Clinical staff must be able to assess the need for, and order, diagnostics that the UTC will provide and must be able to interpret results of any tests that they order.

[9] College of Emergency Medicine 2011 Emergency Medicine: the way ahead

14.2 Management of UTC

Management of the UTC will be undertaken by the UTC provider(s). The UTC provider(s) will be solely responsible for the employment of staff, payment of benefits and any disputes arising from employment-related matters.

It is expected that some staff within the current UCC facilities may be affected by TUPE regulations. Commissioners will work with providers to identify which staff may be affected. Providers of the UCC service will be expected to comply with TUPE regulations for transferring staff.

14.3 Clinical leadership

The UTC provider(s) will be expected to develop a model for clinical leadership and clinical governance. As part of this, a local, designated Lead GP/Clinical Director will be appointed by the UTC provider(s).
The designated Lead GP/Clinical Director(s) will take responsibility for the practice of all staff who treat patients autonomously. The Led GP/Clinical Director(s) will also take responsibility for the development, approval and implementation of developed care pathways and protocols working with the Joint Clinical Governance Group to do so.

14.4 Skill mix

As part of the development of an integrated service the UTC provider(s) will work closely with partner organisations to develop an appropriate skill mix of staff to ensure patients are seen and treated.

The UTC should also seek to work closely with commissioners and other partner organisations to realise any potential for collaborative working or innovative staffing models which would enhance patient care. It is expected that the UTC will demonstrate a workforce that can competently deliver either skills in or integration with, providers of:

- Emergency Care
- Primary Care
- Paediatrics
- Obstetrics and Gynaecology
- Mental Health
- Social Care
- Third Sector
- Safeguarding
- Learning Disabilities

14.5 Specialist Input

UTC clinicians should be able to access input from a range of specialists at Acute Trusts, including ED consultants, orthopaedic specialists, paediatric specialists and radiologists. This may require a contractual agreement. Where specialist input has been sought, clinical responsibility for the patient remains with the UTC clinician unless and until the patient is formally transferred to an alternative service.

14.6 Training and Development

The UTC provider(s) is expected to develop the capacity for staff training, including for example, junior clinicians. This applies both to those specialising in primary care, such as GP Registrars, but also to those

specialising in acute medicine. Clinicians are expected to take part in the local clinical teaching as well as A&E teaching to develop clinical competencies within primary / secondary care

All staff working in an UTC must be competent in the basic skills required for safe practice as a first responder in caring for the acutely ill. These competencies include providing immediate life support, paediatric life support and primary survey assessment.

Further guidance on the competencies expected of all staff working in facilities providing unscheduled care is available in the Unscheduled care facilities guidance produced by the College of Emergency Medicine and Emergency Nurse Consultant Association.

Appropriate competency frameworks should be used for staff development and training, but they are not minimum requirements for staff being employed in UTC teams. Relevant competency frameworks include : Guidance and competencies for the provision of services using GPs and practitioners with special interests (GPSIs/PwSIs) – Urgent and Emergency Care

- Competence and Curriculum Framework for the Emergency Care Practitioner
- Advanced Nurse Practitioners – an RCN guide to the advanced nurse practitioner role, competencies and programme accreditation.
- All nurses working in the UTC must adhere to the principle of the Nursing and Midwifery Councils code.
- The College of Emergency Medicine, Emergency Nurse Consultant Association and Faculty of Emergency Nursing (2009) Unscheduled care facilities
- Department of Health (2009) Guidance and competencies for the provision of services using practitioners with special interests (PwSIs) – Urgent and Emergency Care
- Department of Health (2007) Competence and Curriculum Framework for the Emergency Care Practitioner
- Royal College of Nursing (2008) Advanced nurse practitioners – an RCN guide to the advanced nurse practitioner role, competencies and programme accreditation or most up to date versions.
- Nursing and Midwifery Council (2015) The Code: Standards of conduct, performance and ethics for nurses and midwives.
- Prescribing competencies for all prescribers including non-medical prescribers (NMPs)
- Adult and children safeguarding intercollegiate competency frameworks

The National Poisons Information Service (NPIS) is commissioned by Public Health England to support the handling of accidental poisoning and overdose calls in urgent care (http://www.npis.org/index.html). Toxbase is a web based resource provided by NPIS for health care professionals to support clinicians handling suspected incidents of toxic ingestion.

Feedback from NPIS and the Toxbase service indicates that training of clinicians working in urgent care contact centres is essential to support safe decision making and managing patients who can be advised to stay at home or need to attend Emergency Departments for clinical assessment. The Provider(s) shall ensure that clinicians in the Service have undertaken the NPIS Toxbase training and are able to use the tools provided by the NPIS. The eToxbase learning module is a minimum requirement of training for all clinicians supported by additional medicines and Electronic British National Formulary (eBNF) training in the context of therapeutic overdose. Further Information can be found at https://www.toxbase.org/

15 Quality Standards and Clinical Governance

15.1 General

Governance is the mechanism to provide accountability for the way an organisation manages itself. Clinical Governance is a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment

in which clinical excellence will flourish. Clinical governance is therefore an integral part of a provider's overall governance arrangements.

NHS Halton CCG will wish to ensure that the quality of the service to be provided in the UTC is in line with these standards and of a consistently high standard. All professionals will be expected to abide by the guidance of their professional regulatory body. The UTC provider(s) is expected to outline clinical governance mechanisms to be applied when concerns about the quality of the service are raised.
At the time of writing this service specification, the UTC provider(s) will be expected to comply with regulations and standards contained within:

- Health and Social Care Act 2008(Regulated Activities) Regulations 2009,
- Care Quality Commission (Registration)Regulations 2009 ,
- Care Act 2014,
- Counter Terrorism and Security act 2015,
- Mental Capacity Act 2005 including Deprivation of Liberty Safeguards and adherence to the updated Summary Mental Capacity Guidance of March 2017 and The Mental Health Act 2014
- Medicines Act 1968 and any associated amendments
- Misuse of Drugs act 1971 and any associated amendments .

However, for the avoidance of doubt and without prejudice to any other provision in the Agreement, the provider shall deliver the services in accordance with any relevant legislation and standards in force during the terms of the Agreement.

It is required that the provider also ensures that they adopt any guidance or standards that are:

- Issued by the Care Quality Commission, e.g. *Essential Standards of Quality and Safety*
- Issued by the National Institute of Clinical Excellence from time to time
- Issued by any relevant professional body and agreed between the parties
- Connected with the reporting or audit of Serious Incidents
- Included within locally or nationally agreed service specifications, guidance or protocols
- Issued by the DH that cover urgent or emergency care
- Takes into account any guidance issued by Monitor
- Issued by the Pan Mersey Area Prescribing Committee and agreed by NHS Halton CCG

15.2 Integrated Clinical Governance

The UTC provider(s) will be required to have, or adopt, a system of integrated governance, that incorporates key elements of clinical governance and organisational learning, to ensure the safe delivery of services to patients.

The UTC should also be integrated with primary care and secondary care and operate within a common framework of standards and governance therefore ensuring the services primarily respond to the needs of patients. The whole systems approach to the way in which the UTC will integrate will mean that the patient experiences a seamless patient pathway through all urgent care services.

It is recognised that providers delivering urgent care will have discrete transactional systems such as those involving clinical leadership and financial reimbursement, but the vision is that the UTC provider(s) will be able to establish a service where the patient is not aware of moving across transactional or organisational boundaries.

There must be clear tangible commitment to working in this way and therefore, the UTC provider(s) will be expected to put forward clear plans on how integrated clinical governance will work practically across two or more separate provider organisations. These plans will include how operational systems will support the following principles:

- Clear lines of responsibility and accountability both within and between provider organisations
- Clearly defined handovers of care between providers
- A programme of quality improvement activities that transcends organisational boundaries
- Clear policies aimed at managing risk and procedures to identify and remedy poor professional performance

15.3 Joint Clinical Governance Group

A Joint Clinical Governance Group is a mandate and should be in line with the national guidance. This enhances existing clinical governance structures within UTC provider(s). It is proposed that the chair, membership and terms of reference are revised to meet the needs of the UTC provider(s) as described in this service specification.

The Group will include clinicians from the UTC provider(s), Acute Trusts, a paediatrician and the commissioner with associated membership from other providers such as social care and mental health providers, as appropriate.

Terms of reference for the group will include:

- Creation and regular review of the Joint Clinical Policy, including:
    - Assessment guidelines for Clinical Triaging clinicians
    - Staff competency framework
    - Pathways and transfers
    - Reception triage for identifying immediate ED cases
    - Diagnostics – both completion and following up when transferred
    - Staff resilience when increased activity
    - Use of joint spaces
    - Management of complaints when includes more than one provider

 Service audit, including:

- On a case by case basis, the appropriateness of the initial clinical navigation where a patient's treatment is begun in the UTC and subsequently transferred to an ED
- On a case by case basis, the appropriateness of the initial clinical navigation where a patient's treatment is begun in an ED and subsequently transferred to the UTC
- Review of re-directions back to primary care and other community services
- Review of diagnostic tests/investigations
- Review of prescribing and management of medicines within the service including controlled drugs
- At overview level, patient case mixes will be reviewed regularly to assure clinical governance and standards and retain confidence in both services
- On a regular basis, audit against staff competency framework, SUIs, complaints and professional feedback
- Recommendations for service improvement.

Note that the requirements as set out above supplement rather than replace the performance and contract management arrangements between the UTC provider(s) and the commissioner. The terms of reference of the group may be modified as part of the contract management process. It will be the

responsibility of the UTC provider(s) to convene this meeting on a regular basis (frequency to be determined) and ensure that accurate minutes are recorded.

15.4 Patient Involvement

The UTC provider(s) will make arrangements to carry out regular patient experience surveys in relation to the service and will co-operate with such surveys, including surveys of an ED that may be carried out by the Commissioner. In discharging its obligations under this clause the provider shall have regard to any Department of Health guidance relating to patient experience.

The UTC provider(s) will be expected to demonstrate evidence of having used patients' experience of using the service to make improvements to service delivery. Specifically, the service will be required to undertake an annual patient's survey. The results of the survey will be discussed with service users, and evidence of the survey results, recommendations and action plan to implement the recommendations will be submitted to NHS Halton CCG.

15.5 Clinical Risk Management and Legal Protection

The UTC provider(s) will ensure that clinical risk management is an integral part of daily management. The provider will use clinical risk management to improve decision-making and encourage the continued improvement of service delivery and the best use of resources. It will be necessary for a comprehensive risk assessment to be undertaken by the provider to ensure that the patient journey is safe and appropriate.

15.6 Business Continuity and Resilience

The Provider will implement mechanisms for managing risk, including disaster recovery, contingency and business continuity plans. The provider must ensure business continuity plans are available at service level. The provider will keep the CCG informed about detail of the risk management structures and processes that exist, and how they are implemented.

15.7 Accountability

The UTC provider(s) contract will be accountable to the NHS Halton Clinical Commissioning Group as commissioners of this service.
The UTC provider(s) will be responsible for performance, clinical and financial management of the service. Halton CCG expects an open and transparent relationship with the provider in line with the Duty of Candour.

15.8 Incident Reporting

All incidents (both clinical and non-clinical) must be reported. The service will ensure that there are appropriate reporting mechanisms for all incidents and that these reports feed into the relevant monitoring and reporting systems. If an incident meets the NHS England framework for Serious Incidents and Never Events then it will require reporting via STEIS (Serious Incident Management System). The provider will be expected to meet the timeframes for reporting and investigation as per the framework and submit the final investigation report to the CCGs Patient Safety team.
There will also be effective procedures for the management of all Serious Incidents that dovetail existing requirements for reporting and investigating SI's and that safeguarding concerns are considered with each incident report and appropriate referrals made as indicated.

15.9 Safeguarding of Children

The UTC must provide the same level of service as currently provided by A&E to ensure appropriate safeguarding of children and must adhere strictly to current national safeguarding policy.
The provider (s) must have arrangements in place to enable full compliance with the legislation governing safeguarding children (Children Act 1989 & 2004) and guided by the principles embodied in Working together to safeguard children (August 2018). The Provider has a duty of care to ensure that children and young people who use the service(s) are protected from harm or neglect, and must take appropriate action to respond to any concerns about their well-being or allegations of abuse.
This includes:

- Have an established leadership and accountability framework for safeguarding children within the organisation that meets the statutory requirements for safeguarding children. This will include having Board level leads and Named Professionals for Safeguarding Children.
- Have up to date policies and procedures in place for staff to follow in relation to safeguarding children and must be in line with local multi-agency policy and procedure under the local safeguarding children's board (LSCB).
- Have clear systems in place for ensuring that staff are able to recognise children and young people at risk of harm and respond appropriately
- Have arrangements in place to deliver and monitor the training of all staff in relation to safeguarding children in accordance with the Intercollegiate Competency Framework (January 2019).
- Compliance with the Local Safeguarding Children Board and assist with any safeguarding children matters and Serious Case Reviews

Provide quarterly reports as per the North West London Safeguarding Standards and the
NHS Standard service conditions.

15.10 Safeguarding Adults

The provider (s) must have arrangements in place to enable full compliance with the legislation governing safeguarding adults (Care Act 2014). The Provider must ensure that Service Users as well as staff are protected from abuse and improper treatment in accordance with the Law, and must take appropriate action to respond to any allegation of abuse.

This includes:

- Have an established leadership and accountability framework for safeguarding adults within the organisation that meets the statutory requirements for safeguarding adults, Prevent and Mental Capacity Act. This includes having Board Level leads and named professionals in place to cover these aspects of care.
- Have up to date policies and procedures in place for staff to follow in relation to safeguarding. Prevent and Mental Capacity Act (MCA) in line with local multi-agency policy and procedure under the local safeguarding adult board (HSAB).
- Have clear systems in place for ensuring that staff are able to recognise adults at risk and respond appropriately in line with the Adult Safeguarding Procedures (2016) and Care Act 2014.
- Arrange, deliver and monitor the training of staff in relation to safeguarding. Prevent and MCA in line with the Intercollegiate Competency Framework.
- Compliance with the Local Safeguarding Adult Board in safeguarding enquiries and safeguarding adult reviews and other Multi Agency Safeguarding meetings.

Provide quarterly reports as per the safeguarding Standards and the NHS Standard service conditions.

The UTC must ensure that vulnerable adults are safeguarded and must adhere strictly to current national policy, NHS Halton CCG Adult Safeguarding Policy and Local policy and procedures .

It is the responsibility of UTC to ensure that staff are trained in Mental Capacity and Deprivation of Liberty Safeguards. It is expected that all staff accessing patients will considered the mental capacity act and if required will assess a patients mental capacity in relation to specific decisions that is required.

If UTC staff are aware of a patient with a Learning Disability who has died they must report the death on the national reporting system on the following link.
http://www.bristol.ac.uk/sps/leder/notify-a-death/

It is expected that UTC will have a Learning and Disability Mortality Reviewer who will contribute to learning and disability mortality reviews, if required. Further information regarding this can be found at: http://www.bristol.ac.uk/medialibrary/sites/sps/leder/LEDER%20governance%20paper%20v0.8%20Final%20(1)%20(1). Pdf and http://www.bristol.ac.uk/sps/leder/

Key messages from the recent Domestic Homicide Review (DHR) highlighted areas of improvement within the health care setting. Key messages include; professional curiosity is conducted and maintained to ensure that all risks are identified and acted upon. The full report can be accessed below as well as further compliance requirements. Domestic Violence is a category of Abuse under the Care Act 2014.

Information systems should enable the flagging of high risk victims of domestic abuse and that the system is utilised to flag patients of high risk domestic abuse in line with your current policy, and that you read code patients with Domestic Violence in line with your policy.

A Domestic Violence and abuse policy which ensures staff are aware of the issue of domestic violence, how to identify and access perpetrators of domestic violence, local information regarding current pathways and the referral pathway.

You should also have an Adult Safeguarding Policy which is cross referenced to your domestic violence policy and which reflects the information which is in the NHS Halton CCG Adult Safeguarding Policy.

15.11 Complaints

The lead clinician of the UTC should deal with all complaints in line with the provider's complaints policy. The complaints should be given to the most relevant lead to respond to depending on the issue (nursing, medical or admin staff). All complaints should be logged and escalated to the Joint Clinical Governance Group where appropriate with a safeguarding consideration being part of the process.
The volume and content of complaints should be regularly analysed and used to inform internal continuous improvement processes.

15.12 Policies and Procedures

All services will be required to have in place policies and procedures which comply with general legislation and any relevant NHS guidance affecting the service in force throughout the duration of the contract, including:

- The Health and Safety at Work Act 1974 including Needle Stick Management
- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Clinical waste and sharps disposal
- Infection control
- Incident reporting
- Human Rights Act 1998
- Race Relations (Amendment) Act 2000
- Equalities Act 2010
- Disability Discrimination Act 1995

- Information Governance
- NHS Code of Practice on Confidentiality 2003
- Medical records and storage
- Consent to treatment
- Data Protection, GDPR and Freedom of Information
- Discrimination
- Accessible information standard
- Working Time Regulations 1998 (as amended)
- Safer Recruitment
- Mental Capacity Code of Practice
- Deprivation of Liberty Code of Practice
- Mental Health Code of Practice
- NHS England Prevent Training and Competencies Framework
- Learning Disability and Mortality Review Guidance
- The Care Act 2014 Operation Guidance 2017
- Safe management of medicines including ordering, receipt, storage, supply, and disposal;
- Safe management of controlled drugs including implementation of the Shipman recommendations Management and control of secure stationery incorporating recommendations from the Counter Fraud Authority guidance March 2018

The UTC provider(s) will ensure that all policies are reviewed as appropriate and will state the review date clearly.
The provider will carry out pre-employment checks to ensure that all GPs, employed or otherwise engaged to work in the UTC, are registered on the Performers List, in accordance with the National Health Service Performers List Regulations 2013. An enhanced DBS check will be carried out for all staff working in UTC.

Providers are to have in place people management policies such as Disciplinary, Grievance, Capability, Harassment and Bullying at work to ensure there are mechanisms to address performance or conduct issues in the workplace. A recruitment policy must be in place that is in line with the NHS Employment Check Standards. These standards exist to outline the type and level of checks employers must carry out before recruiting staff into NHS positions.

The provider will demonstrate how they are achieving the recommendations set out in *Take Care Now* (2010) issued by the Care Quality Commission.

15.13 Information Systems and Data Analysis

The UTC staff will participate in the national information technology agenda, and engage proactively with local service providers on the strategy and design of local IT systems. It is a mandate that the UTC will have appropriate attendee and participate at the Halton IT group which meets bi-monthly.
A minimum dataset for the information system used by the UTC will be specified and should incorporate the specific needs of children.
The information systems at the UTC will link up with other health information systems such as NHS 111, GP OOH, GP Surgeries, Hubs as a minimum so that data on all local health service contacts are available within the UTC.

16 Supporting Infrastructure

Commissioners are seeking innovation in the introduction of new technologies and ways of working that may enhance the Service over the term of the contracts for the Integrated Urgent Care Service(s) to enrich patient experience which will support the wider urgent care system.
The provision of this service will be significantly dependent on the use of Information Management Technologies in support of integrating information and business processes in support of care delivery. This

innovation aims to place the patient at the centre by making all relevant information on the patient available by appropriate sharing and fast, safe and efficient ways of communication with all clinicians in the local health economy.

The Provider will be expected to demonstrate that its core clinical system and business processes meet the requirements below and that an appropriate and robust IT infrastructure is in place to support this. These should include

- A robust and resilient IT infrastructure
- A fit for purpose core clinical system
- Adequate and secure access to clinical systems
- Electronic Prescribing and use of EPS (where available)
- Clinical Decision Software e.g INR Star
- Full compliance with Information Governance
- Robust Business Continuity and disaster recovery plans and processes

16.1 Information Technology and Information Governance

The provider(s) of UTC will need to ensure the interoperability of their IT systems and core clinical system across each other and across wider IT systems within the local geography. This is particularly applicable to EMIS as the GP system of choice across Halton.

The Provider will need to interface with the application stated following the guidance of the ITK. The UTC should be mindful that under GP system of choice that the GP system landscape can change rapidly and the Integrated Urgent Care Service(s) should be able to integrate with any of the menu of systems as stipulated by HSCIC.

The Provider(s) shall adhere to the national interoperability with locally determined functionalities and standards that are in force at the time of this procurement and future updated standards (National and Local) which may be varied from time to time.
The Provider shall adhere to all NHS standards for Information Governance and be compliant with the Information Governance toolkit, achieving a minimum of level 2. The Provider shall evidence robust plans for maintaining and improving achievement.

16.2 Access to patients records and clinical records

The provider(s) of the UTC(s) must ensure that the patient record is shared with clinicians across organisational boundaries, where appropriate, to support patient care. The main system used across primary care Halton is EMIS. SystmOne and Adastra is also used across the wider Cheshire & Merseyside urgent care provision.

To support this aim all clinicians within the UTC should have access to relevant aspects of a patients' care records, where the Patient has consented to this being available. The provider(s) of UTC will be required to ensure that their system(s) are interoperable with EMIS.

The provider(s) will also need to ensure their system(s) have the interfacing capability to view, retrieve in real time, store and remove notes that were not generated in EMIS. The number of notes this applies to will change during the life of the contract. Access to these records and databases will require a number of systems or gateways including but not limited to:

- Adastra
- Summary Care Record
- Medical Interoperability Gateway (MIG)
- Child Protection Information Sharing (CP-IS) system
- End of life / Co-ordinate my Care (CMC)

- Access Special Patients Notes (SPNs) for Out of Area patients as and when they are made available
- Previous encounters data base
- Mental Health Crisis Plans
- Agreed emergency care / Crisis plans

The Provider will also be required to ensure that all staff login with Smart cards and that their system(s) connect with the NHS Spine.

16.3 Functionality in support of Interoperability expected

- A system for Special Patient Notes must be in place for provider(s) and other providers to receive, upload and manage all notes.
- Ability to share and view agreed data sets from all systems listed above e.g. care plans, patient status alerts
- A system for special patient notes must be in place for provider(s) and other providers to receive upload and manage all notes
- Ability to perform e-prescribing via electronic system and Electronic Prescribing System (EPS)
- Ability to book appointments directly into other local systems
- Ability to send/receive defined and agreed tasks including notifications to/from other local systems and clinicians
- Ability to send text messages from within the system
- Ability to electronically pass on referrals to other local clinicians clinical systems
- Ability to integrate and or interface with the Directory of Services.

16.4 Directory of Services

The Directory of Services (DoS) provides access to service information, which is a critical element of the service. The Provider(s) IT system will need to be able to interrogate the DoS to identify the local service best able to meet the patient's assessed needs and present a list of services to the Health Advisers, Nurses and Clinicians.

The DoS will also help in redirecting any patient into appropriate services in or out of hours to meet patient's requirements. The DoS will clearly indicate the agreed local referral protocols for each service and the message to relay to the patient will indicate the agreed approach to local clinical assessment i.e. whether the local service accepts the type and timescale of the disposition or accepts the type and continues the assessment locally to agree the timescale and setting for any further patient contact (advice, appointment or visit).

All clinicians involved in supporting the Integrated Urgent Care Service(s) will use the mobile DoS to identify the most appropriate service to refer the patient to.

16.5 Applicable National Standards

The UTC in Halton must meet all national standards of service quality including, but not only, those set out in the following policy documents:

- NHS Integrated Urgent Care Commissioning Standards, NHS England, October 2015;
- NHS 111 Interoperability Standards 2.3
- The Interoperability Toolkit (ITK) set of national standards
- National Quality Requirements in the Delivery of Out-Of-Hours Services, DH, July 2006, Gateway ref: 6893;
- DH fact sheet 7: commissioning out-of-hours services, December 2005, Gateway ref:5917;
- Recommendations from Dr David Colin-Thomé and Professor Steve Field report on Out of Hours (2010);

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- National Service Frameworks (NSFs);
- Department of Health Direction on Confidentiality (DH 2000);
- NHS England Serious Incident Framework 2015;
- Data Protection Act 1998;
- General Data Protection Regulation (GPDR) 2016/679
- Freedom of Information Act 2000; and,
- Information Governance standards as set out in National Programme for Information Technology 2006 – 2007
- Out-of-Hours Services A Commissioning Hand book
- NHSE (2015) Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework.
- Care Act 2014

Provider(s) must be compliant to Level 2 for the Information Governance Statement of Complaint (IGSoC) toolkit or above to enable record sharing with other IGSoC compliant organisations without the need for a data/record sharing agreement.

17 Anticipated Service Demand and Associated Required Performance

17.1 General

The following information is provided to assist with identifying staffing requirements for the service. Assumptions included in the estimates are given; however, it should be noted that the anticipated activity levels do not represent a guaranteed level of work for the Provider.
The baseline for both of the UTCs will be 250 treated patients per day.
Potential providers are encouraged to conduct their own research and due diligence with regards to likely demand for the service.

17.2 Demand Management

In keeping with the stated Service Aims, the Provider of the UTC service will be expected to work within care pathway guidelines to implement processes which effectively manage demand in accordance with the defined Scope of Clinical Services to be offered by the UTC.

It is expected that the number of patients attending the UTC will remain consistent and clinically appropriate over time through the following:

- Establishing systems and processes to signpost patients to access local primary care services e.g. local pharmacies and pharmacy services e.g. Minor Ailments Service (Care at the Chemist), Minor Eye Conditions Service, Treatment Rooms, NHS dentist etc. by using the Directory of Service (DoS)
- Reduce the numbers of patients attending the UTC who are not registered with a GP by supporting and facilitating registration with local GP practices to ensure complex/long term conditions are managed appropriately.
- Reduce the numbers of patients who attend the UTC on a regular or frequent basis through close collaboration with other relevant providers, such as Mental Health and Social Services and the Rapid Access Rehabilitation Service to ensure appropriate care plan is in place.
- Encouraging the use of the 111 service.
- Providing information to enable self-care in line with locally and nationally agreed approaches/policies.

18 Performance Measurement and Key Performance Indicators

18.1 General

The UTC provider(s) will have a named Information Lead, a named Quality Lead and a named Clinical Lead. The UTC provider(s) will be responsible for ensuring the data quality of all returns and that any issues are resolved speedily and internally.

18.2 Quality Metrics

The UTC provider(s) will take part in patient experience surveys in accordance with policy. Routine local audit plans will be agreed with commissioners and undertaken on a regular basis. The audit terms of reference will be shared and agreed with the commissioner prior to commencement. The commissioner retains the right to review and agree the audit findings and outcomes and to be updated on the progress against the improvement/implementation plans. Audits involving peer review or the Urgent and Emergency Clinical Audit Toolkit, are examples of the types of audit activity that the commissioner will be expecting the UTC provider(s) to undertake.

The UTC provider(s) will need to pay particular attention to care of children and young people, the elderly and those with special needs and vulnerabilities. The UTC provider(s) will need to demonstrate that they will work with other local healthcare and social care providers to develop care plans for patients who frequently attend regularly.

The Commissioner may wish joint audits to be undertaken to investigate issues or quality areas. This will include agreeing the terms of reference, report findings and outcomes and agreeing and monitoring any performance improvement plans. The commissioner will want to make sure that all patients receive care that is evidence-based and provides a service that is safe and of the highest quality.

Together, the UTC provider(s) and commissioners will agree the reporting format of quality metrics.

18.3 Operational Metrics

The UTC provider(s) will be expected to provide all mandated datasets, which are from time to time amended by the Department of Health and the National Commissioning Board in the format required by each of the requesters. At the time of writing, it is expected that the following data returns will be made on a timely basis:

- Emergency Care Data Set (ECDS)
- Daily Situation Reports

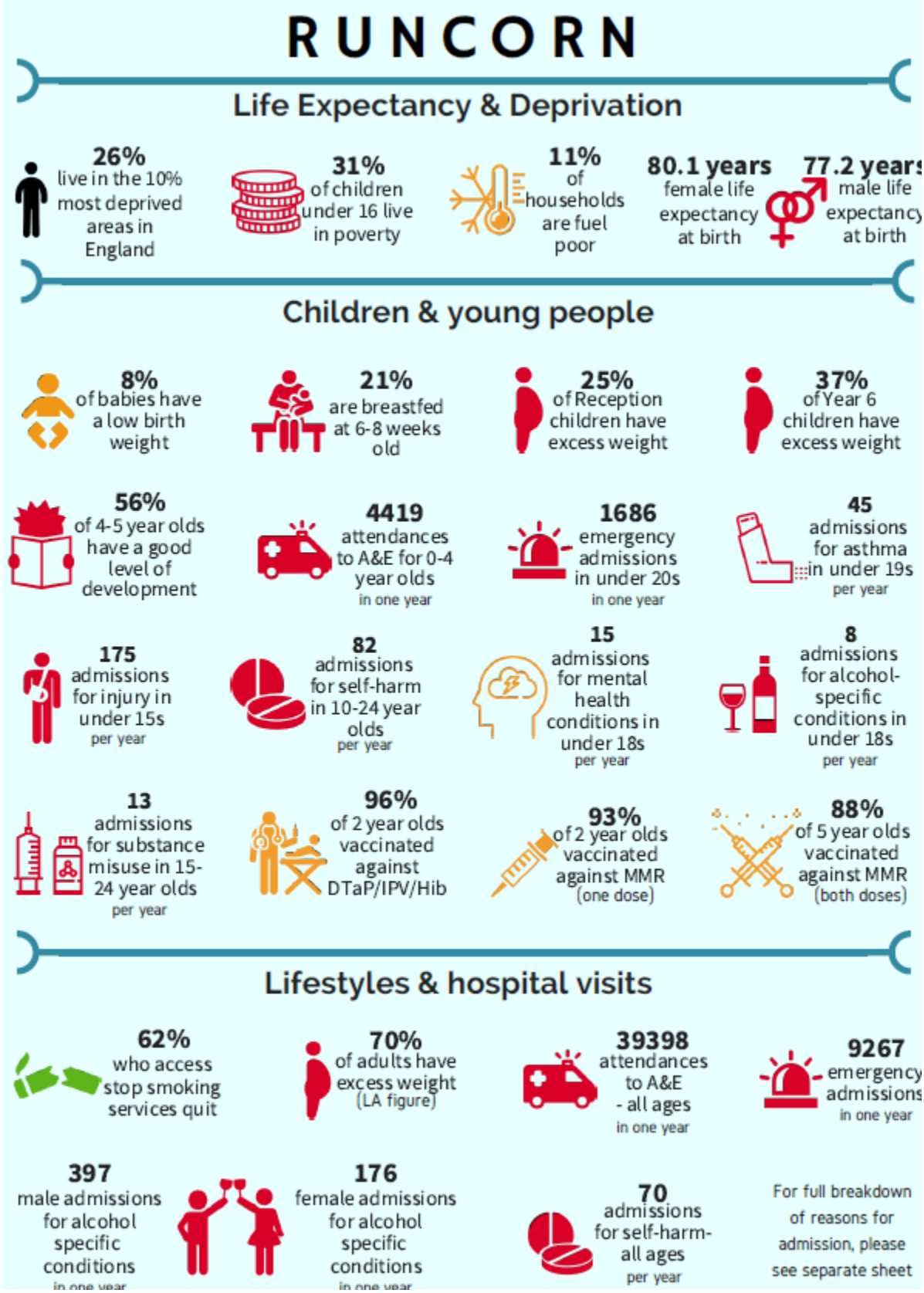
The UTC ECDS will be submitted by the UTC provider(s) according to an agreed timetable. To ensure that the patient journey can be tracked, it is expected that the UTC provider(s) will have the Patient Demographic Service (PDS) in place so that the NHS number is always used as the unique patient identifier. All parts of the patient pathway will be recorded, at a minimum, in accordance with the data dictionary where national codes are provided (www.datadictionary.nhs.uk).

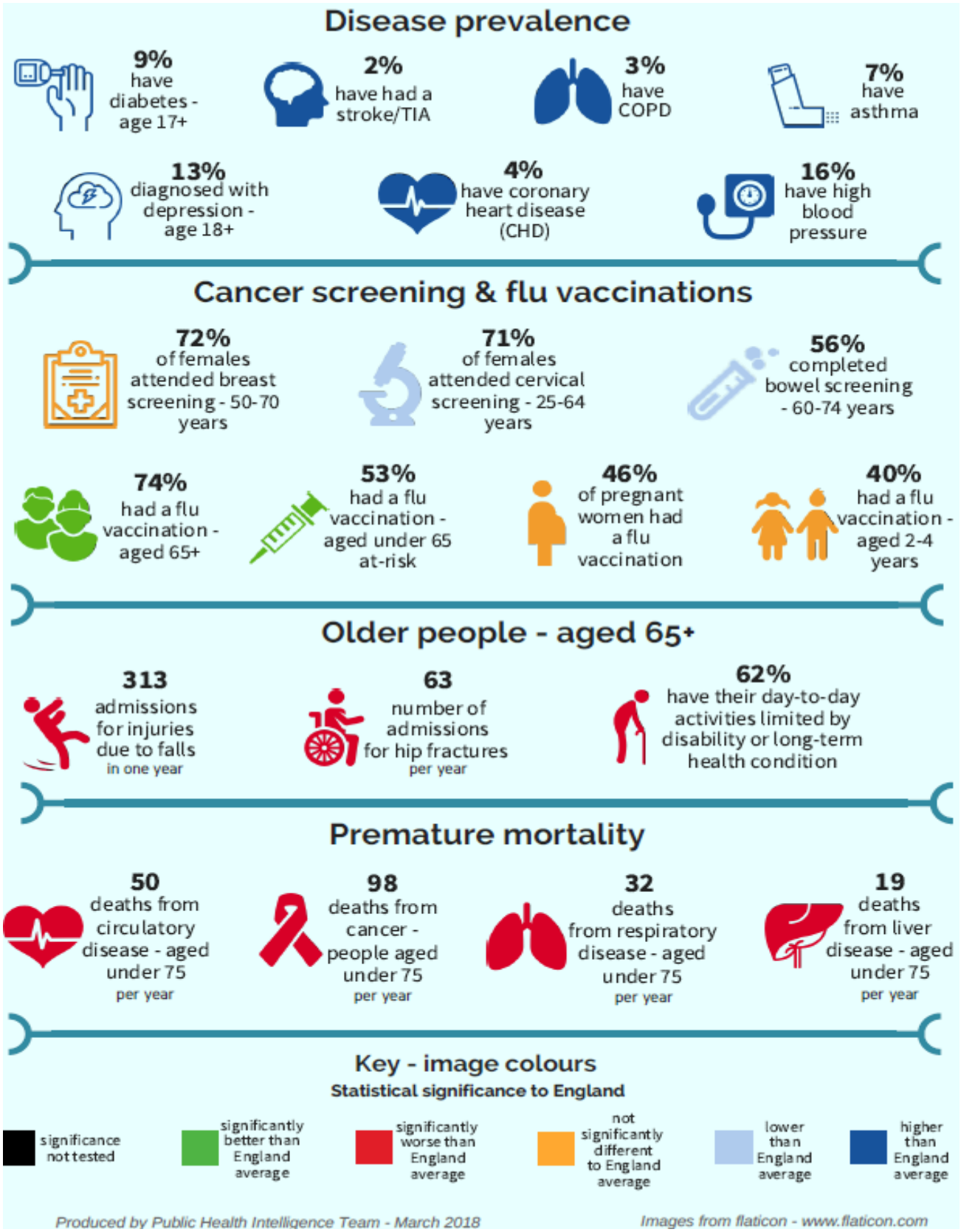
A detailed minimum data set will be finalised and agreed with the UTC provider(s) in advance of service go-live. This will be based on the ECDS current at the time of service go-live, but may include other locally agreed data.

18.4 Key Performance Indicators

The performance and success of the UTC service will be measured against a set of national and local performance indicators. An indicative set of KPIs is set out in the financial outcome based model and can be further developed and agreed with the provider. Where national quality requirements are either amended or rewritten, the UTC provider(s) will be expected to meet these where mandated by NHS England. The outcome KPIs are set out in Appendix 2

Appendix 1


RUNCORN
Life Expectancy & Deprivation
26% live in the 10% most deprived areas in England
31% of children under 16 live in poverty
11% of households are fuel poor
80.1 years female life expectancy at birth
77.2 years male life expectancy at birth
Children & young people
8% of babies have a low birth weight
21% are breastfed at 6-8 weeks old
25% of Reception children have excess weight
37% of Year 6 children have excess weight
56% of 4-5 year olds have a good level of development
4419 attendances to A&E for 0-4 year olds in one year
1686 emergency admissions in under 20s in one year
45 admissions for asthma in under 19s per year
175 admissions for injury in under 15s per year
82 admissions for self-harm in 10-24 year olds per year
15 admissions for mental health conditions in under 18s per year
8 admissions for alcohol-specific conditions in under 18s per year
13 admissions for substance misuse in 15-24 year olds per year
96% of 2 year olds vaccinated against DTaP/IPV/Hib
93% of 2 year olds vaccinated against MMR (one dose)
88% of 5 year olds vaccinated against MMR (both doses)
Lifestyles & hospital visits
62% who access stop smoking services quit
70% of adults have excess weight (LA figure)
39398 attendances to A&E - all ages in one year
9267 emergency admissions in one year
397 male admissions for alcohol specific conditions in one year
176 female admissions for alcohol specific conditions in one year
70 admissions for self-harm- all ages per year
For full breakdown of reasons for admission, please see separate sheet


Disease prevalence
9% have diabetes - age 17+
2% have had a stroke/TIA
3% have COPD
7% have asthma
13% diagnosed with depression - age 18+
4% have coronary heart disease (CHD)
16% have high blood pressure
Cancer screening & flu vaccinations
72% of females attended breast screening - 50-70 years
71% of females attended cervical screening - 25-64 years
56% completed bowel screening - 60-74 years
74% had a flu vaccination - aged 65+
53% had a flu vaccination - aged under 65 at-risk
46% of pregnant women had a flu vaccination
40% had a flu vaccination - aged 2-4 years
Older people - aged 65+
313 admissions for injuries due to falls in one year
63 number of admissions for hip fractures per year
62% have their day-to-day activities limited by disability or long-term health condition
Premature mortality
50 deaths from circulatory disease - aged under 75 per year
98 deaths from cancer - people aged under 75 per year
32 deaths from respiratory disease - aged under 75 per year
19 deaths from liver disease - aged under 75 per year
Key - image colours
Statistical significance to England
significance not tested
significantly better than England average
significantly worse than England average
not significantly different to England average
lower than England average
higher than England average
Produced by Public Health Intelligence Team - March 2018
Images from flaticon - www.flaticon.com

Appendix 1

WIDNES

Life Expectancy & Deprivation

28% live in the 10% most deprived areas in England

21% of children under 16 live in poverty

11% of households are fuel poor

80.9 years female life expectancy at birth

77.4 years male life expectancy at birth

Children & young people

7% of babies have a low birth weight

24% are breastfed at 6-8 weeks old

27% of Reception children have excess weight

38% of Year 6 children have excess weight

62% of 4-5 year olds have a good level of development

7738 attendances to A&E for 0-4 year olds in one year

1591 emergency admissions in under 20s in one year

57 admissions for asthma in under 19s per year

180 admissions for injury in under 15s per year

78 admissions for self-harm in 10-24 year olds per year

10 admissions for mental health conditions in under 18s per year

8 admissions for alcohol-specific conditions in under 18s per year

13 admissions for substance misuse in 15-24 year olds per year

98% of 2 year olds vaccinated against DTaP/IPV/Hib

98% of 2 year olds vaccinated against MMR (one dose)

92% of 5 year olds vaccinated against MMR (both doses)

Lifestyles & hospital visits

51% who access stop smoking services quit

70% of adults have excess weight (LA figure)

53586 attendances to A&E - all ages in one year

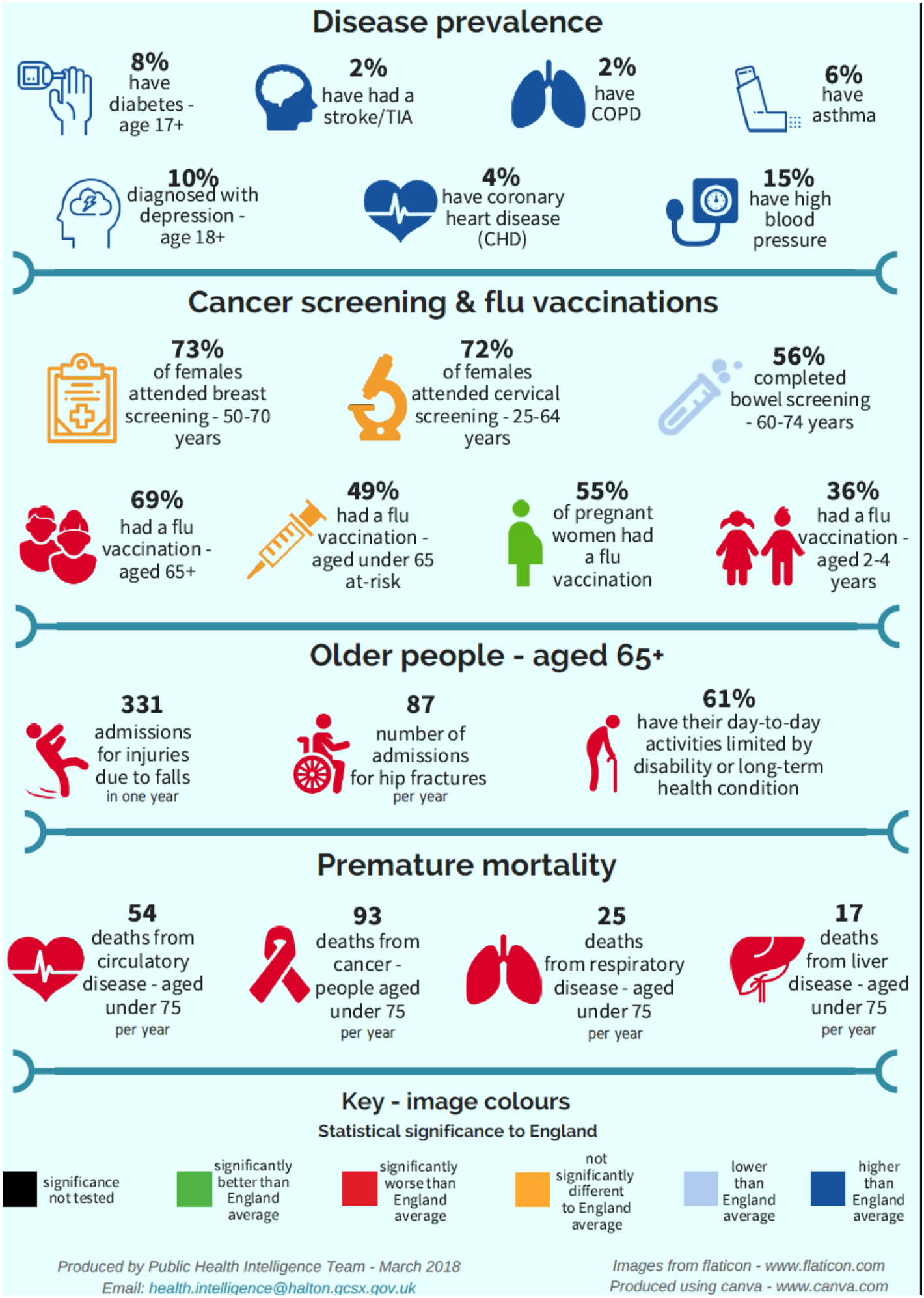
9609 emergency admissions in one year

461 male admissions for alcohol specific conditions in one year

175 female admissions for alcohol specific conditions in one year

70 admissions for self-harm- all ages per year

For full breakdown of reasons for admission, please see separate sheet


Disease prevalence
8% have diabetes - age 17+
2% have had a stroke/TIA
2% have COPD
6% have asthma
10% diagnosed with depression - age 18+
4% have coronary heart disease (CHD)
15% have high blood pressure
Cancer screening & flu vaccinations
73% of females attended breast screening - 50-70 years
72% of females attended cervical screening - 25-64 years
56% completed bowel screening - 60-74 years
69% had a flu vaccination - aged 65+
49% had a flu vaccination - aged under 65 at-risk
55% of pregnant women had a flu vaccination
36% had a flu vaccination - aged 2-4 years
Older people - aged 65+
331 admissions for injuries due to falls in one year
87 number of admissions for hip fractures per year
61% have their day-to-day activities limited by disability or long-term health condition
Premature mortality
54 deaths from circulatory disease - aged under 75 per year
93 deaths from cancer - people aged under 75 per year
25 deaths from respiratory disease - aged under 75 per year
17 deaths from liver disease - aged under 75 per year
Key - image colours
Statistical significance to England
significance not tested
significantly better than England average
significantly worse than England average
not significantly different to England average
lower than England average
higher than England average
Produced by Public Health Intelligence Team - March 2018
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Images from flaticon - www.flaticon.com
Produced using canva - www.canva.com

Appendix 2

No	Outcome Domain	No.	Outcome Goal	Outcome Indicator	Outcome Measure	Incentivise / Monitor / Subjective
1	*Description*		*Description*			
Patients and service users						
1	I received my treatment in the right service in the right place at the right time	1.1	Number/Percentage of Patients attending the UTC who are	1.1.1	>98% Triaged within 15 minutes of attendance at UCC	I
				1.1.2	< 3% Referred onward to A&E	I
				1.1.3	Referred directly to Speciality	S
				1.1.4	>95%cDischarged with appropriate information for care	I
				1.1.5	Discharged with guidance for self-care/management;	M
		1.2	The % of adult patients who had initial clinical triage within 15 minutes	1.2.1	>98% are triaged within 15 minutes	I
		1.3	The % of children who had initial clinical triage within 15 minutes	1.3.1	>98% are triaged within 15 minutes	I
		1.4	The % of non emergency handovers from ambulance service taking less than 15 minutes	1.4.1	> 95% are handed over within 15 minutes of arrival	I

		1.5	The % of patients treated and discharged within 2 hours in accordance with consultant complete model of care	1.5.1	>98% are discharged within 2 hours	I
		1.6	The % of all patients presenting due to a mental health condition receive appropriate treatment and follow the mental care plan in line with Nice guidance	1.6.1	>90% receive appropriate treatment for mental health within agreed treatment plan	I
		1.7	% of people leaving the UTC without being seen	1.7.1	<5% of attendances leave without being seen	I
		1.8	The % of adults over 65 presenting due to a fall receive appropriate treatment and falls assessment takes place in line with Nice guidance	1.8.1	>98% of adults receiving treatment and assessment	I
		1.9	The % of patients with booked appointments to be seen within 30 minutes	1.9.1	>98% of adults re seen within 30 mins of the prebookable appointment time	I
2	I was treated with high quality, safe, evidence based clinical care and by an appropriately qualified, knowledgeable and trained workforce who regularly up date their skills in line with the most up to date practice.	2.1	Comprehensive clinical pathways are developed and signed off via a robust and transparent governance process which must include oversight from senior clinical and medical staff as well as input from the commissioner .	2.1.1	100% The service can provide details of the process in writing and can demonstrate it in progress.	M
		2.2	Clinical pathways are in place, are up to date and accessible to all staff.	2.2.1	100% of agreed pathways are in place and can be evidenced.	M
		2.3	All prescribing within the clinical pathways is in line with the CCG formulary and guidance (Pan Mersey) and where this is not the case there has been discussion	2.3.1	100% of agreed pathways are in line with CCG formulary and guidelines	M

			with the commissioner to agree this deviation and the clinical rationale for it.			
		2.4	The service performs regularly clinical audit of the clinical pathways and of prescribing to ensure adherence and to support learning. Schedule to be agreed with commissioner in Q1 of each year.	2.4.1	100% clinical audits agreed with commissioner and completed within the agreed timescales with a submission of outcomes, actions and learning.	M
		2.5	The service will audit antimicrobial prescribing (both PGD, PSD and FP10) at least annually and will demonstrate actions to evidence good antimicrobial stewardship within the service. To include peer discussion and challenge, data analysis, education and links to the CCG AMR programmes of work. Audits to be agreed with the commissioner in Q1 of each year.	2.5.1	100% Agreement of audits, submission of audit reports and evidence of AMS?AMR activities as detailed.	M
		2.6	The service will demonstrate a robust approach to management of clinical incidents and will positively support a culture of reporting and shared learning.	2.6.1	100% evidence of incident management policy	M
				2.6.2	100% quarterly incident reports detailing themes and trends, actions taken and lessons learnt.	M
		2.7	All Non-medical prescribers within the service undergo regular clinical supervision, have access to a mentor and work within their areas of competence. There will be a robust governance process to	2.7.1	100% NMP policy in place	M

			support the safe and effective uset of this skill mix.			
				2.7.2	100% ATP forms in place, clinical supervision records up to date and all prescribers registered with NHSBSA. Detailed via an annual report.	M
3	I had a positive experience of services and I feel confident in my treatment and the knowledge and understanding to manage my on-going care	2.1	% of patients with overall satisfaction of the service	2.1.1	>90% of responses from survey indicated an overall patient satisfaction of service - satisfactory indication or above	I
		2.2	% of patients who's complaints or issues where followed up in a timely manner	2.2.1	100% of complaints and issues where dealt within inline with complaints policy within contract	I
		2.3	Identification of patients who are high intensity users of UTC's , ensuring they are accessing more appropriate local health and social care services for continued support	2.3.1	Identification of patients who have attended 5 times or more over a 3 month period	I
				2.3.2	Those patients identified are supported with more appropriate wellbeing or care plans to manage conditions	I
		2.4	Identification of patients who would benefit from short term rapid access rehabilitations to avoid unnecessary admission into secondary care.	2.5.1	Identification of patients who would benefit from short term rapid access rehabilitation	I
		2.6		2.6.1	Those patients identified are supported with onward referral into the short term rapid access rehabilitation team	I

4	I expect my treatment outcomes to be shared with relevant health and social care professional in a timely manner and ensure continuation of my care	3.1	Number of patients aged under 18 who's attendance information and treatment outcome is shared with relevant health visitor and school nurse by 8am 2 working days following attendance at the UTC	3.1.1	>98% of children's attendance is reported to the relevant healthcare professional	M
		3.2	% of patients identified with mild to moderate mental health problems are furnished with the relevant information on the local IAPT service as party of the discharge	3.2.1	100% of patients identified with mild to moderate mental health issues are given information on the local IAPT services	I
		3.3	% of patients identified with acute mental health issues are referred for mental health assessment within 60 minutes of attendance at the UTC	3.3.1	>95% of patients with acute mental health are referred for assessment within 60 mins	I
		3.4		3.3.2	100% of patients in mental health crisis are referred to the mental health crisis response team within 60 minutes of attendance at UTC	I
			Number of patients with a known learning disability had a discharge summary sent to the community team for learning disabilities by 8am the 2nd working day following attendance	3.4.2	100% of LD patients have a discharge summary sent to LD community team within 2 working days of attendance at UCT	M
		3.5	Number of patient contacts for children with known child protection plans notified to child protection services within an hour of attendance at the UTC	3.5.1	100% of children with known child protection plan are notified to social services within an hour of attendance at UTC	M

		3.6	Number of patients attending the UTC identified as a vulnerable adults to be notified to the safe guarding adults co-ordinator within an hour of attendance at the UTC	3.6.1	100% of vulnerable adults are notified to the safeguarding co-ordinator within an hour of attendance at the UTS	M
5	I expect my NHS record to be updated correctly and concisely and data is being used appropriately and within guidelines to support service improvement.	5.1	% of patients over 18 asked smoking status and status recorded	5.1.1	>98% of patients are asked their smoking status and this is recorded	M
				5.1.2	>98% of those recorded as a smoker are offered brief intervention and referral opportunity	M
		5.2	% of non registered patients are helped to register with a GP	5.2.1	>98% of non registered Halton patients are helped to register with a local GP	M
		5.3	Ensure all KPI's and outcome measures are recorded within agreed time schedules	5.3.1	100% of measures are reported within agreed timescales as per the contract	I
		5.4	Ensure NHS number of recoded all patients records	5.4.1	100% of patients will have a recorded NHS number	M
		5.5	Total number of serious untoward incidents are reported to STEIS on a monthly basis	5.5.1	0 incidents are reported on a monthly basis	M
		5.6	The maximum number of patient safety incidences per month	5.6.1	Less than 5 incidents per month	M