Gateway number - 07375

Urgent Treatment Centres – FAQs to support implementation

How will urgent treatment centres link with the rest of the urgent and emergency care system?

A key enabler for transformation of urgent and emergency care (UEC) has been the establishment of twenty three UEC networks across the four regions of England. These networks are responsible for describing and creating agreed effective clinical pathways of care, and work across traditional boundaries to ensure that all patients are managed, that mutual trust is developed in the system, and that no clinical decision is made in isolation.

The effective provision of comprehensive and responsive primary and community care services, to ensure a timely same day response to all urgent care needs, is a fundamental principle of the NHS England Urgent and Emergency Care Review. In order to achieve a comprehensive and enduring shift in urgent care provision from hospitals to the community, primary care and community-based facilities must be developed and reconfigured to meet the vast majority of patient needs. The development of UEC networks will only have impact if the range of primary and community services available is simultaneously expanded through a unified and coordinated approach in general practice, community care, NHS111, ambulance services, community pharmacies, mental health services, urgent primary care and urgent treatment centres (UTCs).

UTCs should have shared written clinical governance arrangements with the rest of the local Urgent and Emergency Care system.

How do urgent treatment centres fit into the vision for general practice as set out in the GP Forward View?

The General Practice Forward View set out a multi-billion plan designed to promote sustainability in general practice, improve patient care and access, and invest in new ways of providing primary care, including delivering at scale. This aims to lay the foundations for general practice providers to move to a model of more integrated services such as Multispecialty Community Providers (MCPs) or Primary and Acute Care systems (PACs).

Clinical commissioning groups (CCGs) are already beginning to commission extra capacity to ensure that, by March 2019, everyone has more convenient and improved access to GP services including sufficient pre-bookable and same day appointments at evenings and weekends to meet locally determined demand alongside effective access to other primary care and general practice services such as urgent care.

Improving GP access generally means providing additional hours of GP and other primary care practitioners' time and increasing the ways in which appointments are delivered so that patients have enhanced and more convenient access to primary care. The typical features of improved GP access are:

- Appointments being available after 6.30pm during the week and on Saturdays and Sundays.
- Telephone and/or online consultations being available in additional to traditional face-to-face consultations.
- Local collaboration between groups of practices, whereby they pool staff, facilities and other resources in order to provide longer hours and more innovative consultation methods.
- Many local areas establish 'hub' practices and also offer central booking facilities for appointments.
- Collaborative working with other parts of the local healthcare system (e.g. physiotherapists, A&E departments, community nursing teams and pharmacists) to offer patients the most appropriate care first time round.

There is an opportunity for commissioners to secure genuine integrated care for all patient needs outside of a hospital setting. This can be achieved by bringing together general practice routine and urgent care services, aligning NHS 111 with direct booking into existing urgent care settings, newly formed access hubs or co-locating Integrated Urgent Care Clinical Assessment Services (formerly known as "GP out of hours" services) with other elements of urgent care provision, ensuring interoperable IT systems across all stakeholders.

Commissioners should align their thinking for UTCs with the seven core requirements for improving and extending access, as set out in the NHS Planning Guidance 2017-19. These include ensuring GP access is effectively connected to other system services, enabling patients to receive the right care from the right professional in the right place, including access from and to other primary care and general practice services such as urgent care.

The guidance also set out that commissioners should secure a minimum of 30 minutes per 1000 population, rising to 45 minutes per 1000 population. Commissioning such a service that meets this and other core requirements could include utilising the UTC as an integral part of the service delivery model which can contribute towards the GP access commitment by using UTCs to provide some routine pre-bookable and same day appointments as part of a hub and spoke model. There are already many GP access hubs across the country and some of these may meet the requirements to become a UTC, whilst others will not and may need upgrading. CCGs could plan a hybrid model whereas some of the routine access appointments could be delivered in UTCs to maximise resources and estates.

How can commissioners maximise opportunities to integrate wider primary care with urgent treatment centres?

The principles below will support commissioners to commission an integrated urgent care offer, whilst following proper procurement processes. There are many opportunities to integrate wider primary care with urgent care, to rationalise the service offer, reduce duplication and flex the workforce to provide urgent and primary care services which meet the needs of the local population.

1. The main route to UTC services should be through an efficient NHS 111 service, which in time will include 111 online.

2. Co-location of the clinical advice hub for NHS 111 services with a UTC or A&E should be encouraged where practical to do so and where the trade off with patient convenience is justifiable.

3. Build on established services by commissioning UTC specifications (e.g. pre-bookable appointments, extended opening) from existing WiCs, MIUs, UCCs. This will mean sites are already known to patients for urgent care, multi-disciplinary teams are already recruited, and systems are in place, e.g. governance, IT, Care Quality Commission (CQC) approvals, etc.

4. Create additional services to achieve equitable coverage for patients in the local area depending on the population's health needs, access, travel times, and the best use of staff and estates capacity.

5. Create opportunities for closer working through creation of multi-disciplinary teams working across services, e.g. OOHs GPs, pharmacy, dental, nurse, mental health therapist, open access physiotherapy, etc.

6. Use opportunities to rationalise the current workforce and estates for example:

    - Commissioning a single GP call back service across OOHs GPs and GPs supporting NHS 111.

    - Sitting clinicians supporting NHS 111 clinical assessment services (including face to face appointments) and GP access hubs at a UTC (or, where appropriate, A&E), so staff can be flexed across services (calls, face-to-face, visiting) in a community setting.

    - Greater co-location will offer better service efficiency and reduced duplication of provision, but may be less convenient to patients. Local commissioners will need to consider patient flows and determine what is desirable and achievable within available finances.

7. Commissioners should note that the core requirement to commission a minimum additional 30 minutes consultation capacity per 1,000 population

could be partially fulfilled by providing routine pre-bookable and same day appointments through a UTC.

What do you mean by co-location with GP and clinical assessment services?

UTCs are community and primary care facilities that provide access to urgent care for a local population. There will often be advantages from co-locating UTC with other primary and community services such as GP access hubs, out of hospital services such as falls teams or the clinical assessment service that provides clinical advice to NHS 111 and 999 ambulance services.

Delivering at scale and better integration between primary care and urgent care is one of seven core requirements set out in planning guidance that CCGs must secure as part of agreeing a contract to deliver services.

What does "GP-led" mean - does this mean only general practices can provide the urgent treatment centre service?

No, services could be provided by acute trusts, community trusts, third sector providers, private sector or GP practices/super practices/networks / federations – commissioners will need to consider a contract for an integrated service that meets local requirements. GPs should have a clinical leadership role, clearly positioning UTCs as primary and community services, supported by a multi-disciplinary workforce. Where services are co-located with an A&E, it may be sensible for leadership to be shared with an ED consultant, reflecting the opportunity to work effectively between acute and primary care over one site and offer opportunities for streaming to services at the front door of ED.

Does GP-led mean a GP will need to be on site at all times?

No, we understand that it will not always be desirable or practical to have a GP on site at all times. Commissioners will want to consider local demand, be realistic about local supply of workforce, and ensure there is sufficient capacity to meet patient requirements, including bookable appointments with GPs and other clinicians.

Co-location of UTCs with other services, whether that be the clinical assessment service that supports NHS 111 (including face to face service) and ambulance services, GP home visiting service or GP access hub will increase the availability of having a GP on-site and fully utilised. Where commissioners secure an integrated model including access hubs and UTCs, face to face appointments with a GP should also be available across the area the service is contracted to cover. This could be provided in one or more access hub or in part through the UTC.

Does GP-led mean that services co-located with emergency departments can't have leadership from an ED consultant?

No, it's entirely sensible for co-located services to have clinical leadership from an ED consultant. We recognise this is likely to be the model in place already, particularly where front door streaming has been introduced. It is still important that joint clinical governance arrangements are put in place that demonstrate shared clinical leadership from both ED and general practice, reflecting the opportunity to work effectively between acute and primary care over one site.

What will happen to patients requiring urgent care outside of the UTC opening hours?

Patients phoning NHS 111 will be given appropriate advice depending on the nature of the complaint and availability of alternative services. This may mean attendance at A&E, booking an appointment with their GP the next day, booking an appointment at the UTC, booking an appointment at a GP access hub, offering self-care advice, etc. Clear signage should be offered to patients who walk up outside of closing hours advising them to phone NHS 111 (or 999 in an emergency).

What specific services should be on offer?

The standards set out a minimum expectation of service offer; the exact range of services on offer and opening hours will be dependent upon local need. Commissioners will need to consider the local health needs assessment, the availability of alternative services and any geographical restrictions in determining the exact specification. An urban facility may have call for a dedicated mental health crisis team on site, or a drug and alcohol liaison service; whereas a rural service may find it beneficial to be co-located with a district nursing service. There is no one-size fits all solution and commissioners will need to tailor provision accordingly, acknowledging some services may be available to patients at other sites such as GP access hubs offering additional GP appointments.

To address variation, regions may wish to set additional requirements (e.g. the London Quality Standards) to ensure a consistent approach across a geographic area.

Where do mental health services fit in?

Mental health should be considered a fundamental part of urgent care services, and pathways should be in place to support those in crisis. Depending on local needs assessment, this may mean liaison mental health services or access to community-based crisis services, as well as signposting to other services such as places of safety, safe havens and sanctuaries, etc. To support appropriate referral from NHS 111, all mental health services should be part of an updated Directory of Service (DoS).

How will patients get an appointment?

Patients should be encouraged to contact the Integrated Urgent Care service via NHS 111 to access urgent treatment services. A range of clinical professionals such as paramedics, nurses with specialist experience, mental health professionals, pharmacists, dental professionals and doctors will be available to speak to callers who require it, and when a patient needs to see a GP, or needs an appointment at a UTC, a mental health crisis service or other service, this should be booked directly for them (where locally commissioned). UTCs are expected to offer directly booked appointments, direct from NHS 111, from the ambulance service or from their GP practice.

Equally, patients should be able to walk in and get to see a clinician. Access time standards for booked appointments and walk-in patients are given and will all contribute to the local waiting times standard.

UTCs should be described to patients and the public in a nationally consistent way to avoid any public confusion about the services available and how they should access them. Communications guidance and assets will be provided to support local activity.

What ongoing referral pathways could you expect to see from urgent treatment centres?

Referrals from UTCs will be dependent on the condition of the patient. Patients could be referred to emergency departments, ambulatory emergency care services, specialist services, GPs, primary and community services or discharged with treatment or a follow up appointment booked at an appropriate location. Commissioners should work with local services to set up effective and efficient onwards referral pathways.

What IT systems will need to be in place?

UTCs will be expected to have a clinical workflow system with some specific ability including but not limited to:

- The ability to send and receive patient transfers and referrals.
- The ability to share appointment availability and receive direct appointment bookings from other Integrated Urgent Care services (including NHS 111).
- The ability to access key patient information, such as the Summary Care Record, other local care records, care / crisis plans, and key patient flags.
- The ability to offer electronic prescriptions via the NHS Electronic Prescription Service.

Clinical workflow systems are expected to make use of nationally-defined interoperability standards where they are available, and to use other locally-available solutions where not. Plans should be in place to adopt national standards once established in the future.

NHS Digital regional delivery teams will support with the planning and roll out of technical solutions where needed.

Should urgent treatment centres include access to community pharmacy?

It may make sense to have a co-located pharmacy; this would be a commissioner decision based on local need. There may be benefit in having a pharmacist as part of the multi-disciplinary team. Commissioners may want to consider holding simple medication on side such as analgesics, antibiotics, antivirals, steroids, inhalers, etc. UTCs should be able to signpost to local pharmacies where there is no facility on site.

If x-ray facilities are not available on site, what does having clear access protocols in place look like?

Where X-rays are not offered on site or are not available on-site at all times, access protocols may include:

- Access via co-located service – e.g. elsewhere on a hospital site

- Mobile unit offering set hours (recorded in Directory of Services)

- Direct referral to x-ray on an alternative site (not via A&E) – e.g. on an appointment basis. Patient may then conclude treatment at referring site if necessary

Clear protocols must be in place to manage clinical risk if patient referred off site. Where a patient is referred off site, they should not have to 'start again' in a new setting; they should be given a booked slot or direct referral to the appropriate facility and not have to go through further triage at ED.

What sort of health practitioners would you expect to see working in an urgent treatment centre?

Commissioners will want to consider a multi-disciplinary team according to local need. This could include GPs, nurse practitioners, paramedics, district nurses, paediatric or geriatric specialists, mental health practitioners, social care, physiotherapist, community mental health, etc. All UTCs should provide appropriate supervision for training purposes including both educational and clinical supervision.

Where does social care fit?

Commissioners, including local authorities, will want to consider the opportunity for social care involvement in the UTC.

How will patients understand what's on offer at different services?

It is the function of the system to guide the patient to the correct level of care and to provide clarity as to which services are provided where, along with the pathways to access these services reliably 24/7. NHS111 should be that guiding service for most urgent care needs. Wherever a patient enters the system they will have consistent access to all services and will, if necessary, be referred on through a process of direct booking whenever possible.

Locally, commissioners will want to consider communication approaches regarding NHS 111, UTCs and other primary and community facilities, including extended GP access. Services should be clearly signposted when searched through NHS Choices and on practice or CCG websites.

What sort of patients would be suitable for referral to a UTC?

Examples of the types of patients suitable for a UTC include:

- Strains and sprains
- Suspected broken limbs
- Minor head injuries
- Cuts and grazes
- Bites and stings
- Minor scalds and burns
- Ear and throat infections
- Skin infections and rashes
- Eye problems
- Coughs and colds
- Feverish illness in adults
- Feverish illness in children
- Abdominal pain
- Vomiting and diarrhoea
- Emergency contraception

In 2015 you shared draft guidance for commissioners regarding urgent and emergency care networks, urgent care centres, emergency centres and emergency centres with specialist services. What's different about this guidance?

This document focuses on the primary and community urgent care provision through UTCs only; we are not currently offering guidance on facilities within A&E departments. Specific changes regarding the guidance are outlined below:

- An obvious change is in the name; patient and public feedback indicates that 'urgent treatment' is better understood than 'urgent care' which has connotations with longer term or social care.

- To firmly position UTCs as part of primary and community care we now recommend that the services are GP led; we previously did not indicate who should take leadership.
- We now recommend a minimum opening time of 12 hours; previously we indicated 16 hours. This was in response to received feedback regarding demand and workforce availability; local services should not feel constrained to only open 12 hours if demand indicates longer would be appropriate; the Directory of Service should be accurately maintained.
- We have offered greater clarity on access to services via booked appointments through NHS 111; this reflects the evolving operating model of Integrated Urgent Care, although direct booking was always an aim.
- We have offered greater guidance on the range of diagnostics that should be considered.
- We are offering greater specificity on what is required to deliver digital interoperability.

Locally there are services that will not be able to justify opening 12 hours a day or offering the full range of services due to patient throughput for example; however there are exceptional reasons (e.g. rurality) to maintain the service offer. What options are there?

We recognise that there will be exceptions, although we stress that designation as UTC for limited services offers should be considered exceptional. An appeals process will be developed with NHS England and NHS Improvement regional teams that will allow localities to make their case. To ensure patients have a clear understanding of the service offer expected at an UTC anywhere in the country, these exceptions will not be commonly granted.

There may be opportunities for a limited offer to form part of an alternative community service, or to provide an enhanced offer within, e.g. a GP access hub. All services should be clearly identified within an updated and maintained Directory of Service to enable effective referral from NHS 111 and 999 services.

What support will be offered to establish a baseline of existing service provision?

Building upon the stocktake of services undertaken last year, regional teams will be expected to support a local assessment for each facility against key elements of the UTC specification, including, supported by NHS Digital, 'digital capability' i.e. ability to directly book appointments, offer e-prescribing and readiness for the new Emergency Care Data Set (ECDS).

What are the next steps?

Local areas will need to review current provision against the standards and make a plan for each facility, subject to local consultation. This should take into account local

needs assessment and the provision of other services. NHS England and NHS Improvement will support this process as required, although decisions should be made locally.

Can you provide examples of where this model works effectively?

Examples will be drawn up and made available on the NHS England website.

Do you expect the name of the service to change on 1st December?

The current range of names in use is confusing for patients, and we do expect all services to adopt the urgent treatment centre terminology; however we also recognise that this needs to take place in a managed way as part of a communications plan, and that without this we actually risk more confusion. As such, we are focusing on services achieving the standards of an urgent treatment centre and ensuring a consistent patient offer, and ask that plans are put in place to adopt the new names in a managed way, which will not confuse patients.