NHS England

Urgent Treatment Centres – Principles and Standards

July 2017

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**06861**
Document Purpose	Guidance
Document Name	Urgent Treatment Centres – Principles and Standards
Author	NHS England
Publication Date	July 2017
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs , NHS England Regional Directors, Emergency Care Leads, NHS Trust CEs
Additional Circulation List	NHS England Directors of Commissioning Operations
Description	This document sets out the principles and standards which Sustainability and Transformation Partnerships and local commissioners should achieve when establishing Urgent Treatment Centres as part of their local integrated urgent and emergency care system.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Urgent and Emergency Care Review Team NHS England Quarry House Leeds LS2 7UE england.urgentcarereview@nhs.net

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Urgent Treatment Centres

Principles and Standards

Version number: 1.0

First published: 13 July 2017

Prepared by: NHS England

Classification: OFFICIAL

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact england.urgentcarereview@nhs.net

What change are we looking to see?

1. The *"Next Steps on the NHS Five Year Forward View (5YFV)"* was published on 31 March 2017. This plan explains how the 5YFV's goals will be implemented over the next two years. Urgent and Emergency Care (UEC) is one of the NHS' main national service improvement priorities, with focus on improving national A&E performance whilst making access to services clearer for patients.

2. One element of the UEC section of the FYFV is *"Roll-out of standardised new 'Urgent Treatment Centres'".* This document sets out the standards that we want to see implemented by Sustainability and Transformation Partnerships and local commissioners.

3. From the outset of our review of urgent treatment services in the NHS[1], our patients and the public told us of the confusing mix of walk-in centres, minor injuries units and urgent care centres, in addition to numerous GP health centres and surgeries offering varied levels of core and extended service. Within and between these services, there is a confusing variation in opening times, in the types of staff present and what diagnostics may be available.

4. To end this confusion, we have set out a core set of standards for urgent treatment centres (UTC) to establish as much commonality as possible. By December 2019 patients and the public will:
    a. 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.
    b. 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.
    c. 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.
    d. 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.

5. We expect reduced attendance at, and conveyance to, A&E as a result of this standardisation and simplified access, as well as improved patient convenience as patients will no longer feel the need to travel and queue at A&E. Attendances at urgent treatment centres will count towards the four hour access and waiting times standard.

[1] NHS England (2013) Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report

6. In addition, commissioners will wish to consider if, and how, clinicians working in urgent treatment centres can also provide wider clinical assessment services to patients calling NHS 111.

Alignment with primary care and other urgent care services

7. It is the function of the system to:
    a. guide the patient to the correct level of care and treatment.
    b. provide clarity as to which services are provided where, along with providing pathways to access these services reliably 24/7.

    NHS 111 should be that guiding service for most urgent care needs, in addition to provision of treatment through the clinical assessment service.

8. Wherever a patient contacts the healthcare system they will have consistent access to all services and will, if necessary, be referred on to necessary services through a process of direct booking whenever possible. Urgent treatment centres will operate as part of a networked model of urgent care, with referral pathways into emergency departments and specialist services as required. Commissioners should make sure that all services form part of ambulance services referral pathways as an alternative to conveyance to A&E where appropriate.

9. The General Practice Forward View set out a plan for investment of a further £2.4 billion a year by 2020/21, designed to promote sustainability in general practice, improve patient care and access, and invest in new ways of providing primary care. CCGs are already beginning to commission extra capacity to ensure that, by March 2019, everyone has 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.

10. There is an opportunity for commissioning of a genuine integrated urgent care service, aligning NHS 111, urgent treatment centres, GP out-of-hours and routine and urgent GP appointments with face to face urgent care. Commissioners should align thinking for urgent treatment centres with the core requirements for extended access[2], as well as opportunities with the clinical assessment service that supports NHS 111. 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.

What are we asking of STPs and local commissioners?

11. There will inevitably be variation in what each urgent treatment centre may provide as the needs will be different for different populations and geographies. But in the future, all facilities must have in common the offer of booked urgent appointments, accessed through NHS111, General Practice

[2] Set out in the NHS Planning Guidance 2017-19.

and the ambulance service. Commissioners will need to consider local activity, demand management, and patient flow and throughput in the final specification of commissioned services. This will ensure that patients are directed to the most convenient service available that can provide the treatment they need, that there is consistency of access and that investment is targeted to meet demand.

12. We know that there will be some exceptions where there will be justification for offering a service that does not meet these standards, most likely in more rural or sparsely populated areas. These exceptions should be agreed on a case by case basis working with NHS England and NHS Improvement regional teams.

13. Commissioners, supported by NHS England, should review current provision, impact and local health needs assessments against the below standards and make a plan for each existing facility, alongside current provision and plans for extended GP access, subject to local consultation and following proper procurement process where appropriate. We know that many services will already offer, or be close to offering, this level of service, and others will need local investment to meet the standards. Other services, that will not meet the new standards, may become an alternative new community service; this may be a GP access hub.

Principles and standards for Urgent Treatment Centres

Principles

1) 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 will usually 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).

Co-location with other services

2) Co-location with, and strong links to, other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector will also be beneficial in providing an effective and integrated service. There are advantages if they can be co-located alongside hospital A&E departments to allow the most efficient flow of patients to the service that best serves their need but this will be determined by geographic distribution of urgent care sites and patient flows.

Standards for Urgent Treatment Centres

3) Urgent treatment centres must conform to the following minimum standards. STPs and commissioners may also choose to build upon or add to these, according to their requirements.

(1) Urgent treatment centres should be open for at least 12 hours a day seven days a week, including bank holidays, to maximise their ability to receive streamed patients who would otherwise attend an A&E department. Typically this will be an 8-8 service, but commissioners will wish to tailor to local requirements based on locally determined demand.

(2) Urgent treatment centres should provide both pre-booked same day and "walk-in" appointments, however patients and the public should be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.

(3) Urgent treatment centres, and NHS 111, should support patients to self-care and use community pharmacy whenever it is appropriate to do so. Urgent treatment centres should promote and record the numbers of patients offered self-care management and patient education.

(4) The urgent treatment centre should ensure that there is an effective and consistent approach to primary prioritisation of "walk-in" and pre-booked appointments, and the allocation of pre-booked routine and same day appointment slots.

(5) For patients who require an appointment in the urgent treatment centre this should be booked by a single phone call to NHS 111; locally patients should be encouraged to use NHS 111 as the primary route to access an appointment at an urgent treatment centre.

(6) Patients who "walk-in" to an urgent treatment centre should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary.

(7) Following clinical assessment, patients will be given an appointment slot, which will not be more than two hours after the time of arrival.

(8) Patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time.

(9) Protocols should be in place to manage critically ill and injured adults and children 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'[3]*, 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'.

(10) An appropriately trained multidisciplinary clinical workforce will be deployed whenever the urgent treatment centre is open. The urgent treatment centre will usually be a GP-led service, which is under the clinical leadership of a GP. There will be an option for bookable appointments with a GP or other members of the multi-disciplinary team. Where the centre is co-located with an emergency department there may be justification for joint clinical leadership from an ED consultant.

(11) The scope of practice in urgent treatment centres must include minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries.

(12) All urgent treatment centres should have access to investigations including swabs, pregnancy tests and urine dipstick and culture. Near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes should be available. Electrocardiograms (ECG) should be available, and in some urgent treatment centres near-patient troponin testing could also be considered.

(13) Bedside diagnostics and plain x-ray facilities, particularly of the chest and limbs, are desirable and considerably increase the assessment capability of an urgent treatment centre, particularly where not co-located with A&E. Where facilities are not available on site, clear access protocols should be in place. Commissioners will need to consider patient throughput in their cost benefit analysis where capital investment will be required.

(14) All urgent treatment centres should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (e-prescribing should be in place in all sites by June 2019).

(15) All urgent treatment centres should be able to provide emergency contraception, where requested.

(16) All urgent treatment centres must have direct access to local mental health advice and services, such as through the on-site provision of 'core' liaison mental health services where services are co-located with acute trusts or links to community-based crisis services.

(17) All urgent treatment centres should have arrangements in place for staff to access an up-to-date electronic patient care record; this may be a summary care record or local equivalent. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient's

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

best interests in an emergency situation where the patient lacks capacity to consent.

(18) There must be the ability for other services (such as NHS 111) to electronically book appointments at the urgent treatment centre directly, and relevant flags or crisis data should be made available for patients.

(19) A patient's registered GP should always be notified about the clinical outcome of a patient's encounter with an urgent treatment centre via a Post Event Message (PEM), accompanied by a real-time update of the electronic patient care record locally. For children the episode of care should also be communicated to their health visitor or school nurse, where known, within two working days.

(20) Where available, systems interoperability should make use of nationally-defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMED-CT) and nationally-defined record structures.

(21) Urgent treatment centres should make capacity and waiting time data available to the local health economy in as close to real-time as is possible for the purposes of system-wide capacity management; relevant real-time capacity information should also be made available for use across Integrated Urgent Care nationally.

(22) Urgent treatment centres should refer to and align with the Integrated Urgent Care Technical Standards to ensure effective service and technical interoperability.

(23) Urgent treatment centres should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.

(24) Where appropriate, patients attending an urgent treatment centre should be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).

(25) All urgent treatment centres should collect contemporaneous quantitative and qualitative data, including patient experience. From October 2018 all urgent treatment centres must return the data items specified in the Emergency Care Data Set (ECDS). Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.

(26) All healthcare practitioners working in urgent treatment centres should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.

(27) All urgent treatment centres to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.