NHS South West Clinical Senate

Clinical Senate Council Meeting

South West Clinical Senate Council: Urgent Treatment Centres Recommendations
Thursday 29th November 2018

Question
Given the geography of the South West and the need to ensure equitable access, what are the essential clinical characteristics for networked delivery of Urgent Treatment Centres (UTCs)?

As part of your deliberations please consider the following:

- Clinical responsibility for pathway/s
- Skill mix, distribution and training of workforce
- Essential diagnostics and networks thereof

Overview

The South West Clinical Senate considered the above question in response to a request from the NHSE Urgent Care Team around how urgent care services in the South West can best be delivered in response to the guidance laid out in the national document 'Urgent Treatment Centres – Principles and Standards', published in July 2017 https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf and against the delivery deadline of December 2019. The focus on UTCs forms one strand of the Urgent and Emergency Care Transformation Programme under the Five Year Forward View.

The focus of these Principles and Standards is on delivering services with a consistent offer and where the varied array of nomenclature (UCC, UTC, MIU etc.) which is confusing to patients is removed and that all urgent care services become more integrated with the wider primary care offer, with UTCs at the core and with the overall aim of reducing A&E attendances.

The key elements that need to be delivered by a UTC are;

- Open 12 hours a day, 7 days a week
- GP led
- Provision of simple diagnostics including x-ray
- Directly bookable appointments via NHS 111 and GPs (as well as walk in provision/receiving ambulances)

The guidance recognises that it will be necessary for local interpretation of the principles and standards to match local need and variation. The key issues within the South West that need to be taken into consideration are:

- Rurality against number of UTCs across South West
- Strong existing MIU offer.
- Large number of existing sites for urgent care delivery (MIUs, Community Hospitals)

File path:

- Impact on GP and Radiology workforce to deliver the enhanced services to move from MIU to UTC provision.
- Access to diagnostics as a key barrier.
- Interdependencies with wider STP programmes of change for acute and community services that are underway to differing extents across the South West.

The South West Clinical Senate Council explored the policy, evidence and best practice context in the South West and brought together regional urgent care programme leaders to inform development of the following recommendations in response to the above question and to help clarify what is needed in the South West System.

It should also be noted that the NHS Long Term Plan has been published with a section on urgent care, since the council and development of these recommendations.
https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/2-the-nhs-will-reduce-pressure-on-emergency-hospital-services/

The agenda, pre-reading and presentations from the session can be found here; www.swsenate.nhs.uk

Recommendations

The South West Clinical Senate Council heard evidence around the opportunities for out of hospital care, use of hub and spoke models, clinical governance around patient responsibility and the importance of signposting as well as access to shared digital patient records.

A number of STPs are already developing UTCs in line with the core standards above. Directly bookable appointments (which were felt to better manage flow) and near patient testing are already being set up or existing models enhanced but potential challenges were highlighted in delivering widespread GP led provision and enhanced diagnostics beyond the current MIU offer.

There was consensus that developing UTCs should be about enhancing and adding consistency to the existing provision but not about opening another door to services. It was clear that one size doesn't fit all and the use of networked UTCs in the future may help manage the predicted growth in demand. However, it is essential that any modified offers are ones that the public can easily understand.

1. **Delivering 'GP Led Provision'**
    a. UTCs should focus on the competency and skill mix of staff to deliver safe services above all else. There is a distinction between GP led and GP provided that should be noted. UTCs could have a GP lead but with services provided by a mixed model of competent clinical staff to include GPs, Consultant Nurses and junior doctors on rotation. This would both offer opportunities to the wider workforce and mitigate against the impact on the GP workforce.

    b. Strong Clinical Leadership of UTCs will be essential in maximising the potential for UTCs to be part of a community integrated service that supports people in their own homes, avoiding unnecessary hospital admissions.

c. UTCs should work collaboratively and have clear clinical links with community and GP services that deliver extended access as well care planning and holistic assessment of complex patients. By working together, the GP resource will be appropriately used and patients will be supported to access the urgent care service that best meets their needs.

2. Mixed Network Models that include both UTCs and MIUs

a. All UTCs should establish a minimum offering consistent with the national standards and focusing on safety as a priority with the option to build on those minimum standards over time.

b. Given the rurality of the South West it is unlikely that a UTC will be easily accessible by all populations. Models where a UTC is networked with successful MIUs should be explored.

c. Consistency of terminology is important, in part due to the impact of tourism on the area and in turn, the large number of patients accessing the urgent care services who come from outside the South West. Where systems network other facilities with UTCs there should be clear signposting and both the public and staff should be kept well informed about the urgent care offer and how services can be accessed so that capacity is appropriately used.

d. Where UTCs are co-located with Emergency Departments there must be clear signposting and operational processes to ensure patients intended for UTCs do not end up in EDs. A separate entrance to the UTC should be considered.

3. Single Clinical Governance Framework

a. There should be a single clinical governance framework for the whole system or pathway of urgent care, embracing services in the community, and in hospitals. This will facilitate a shared approach to risk management, common protocols and common training. The framework should then lead to contractual frameworks and employment models that support collaboration rather than frustrate it.

b. The single clinical governance framework for each networked UTC model should make clear at each point of a pathway, where responsibility lies for the patient, the treatment protocol and the service offer.

c. UTCs and MIUs should have remote access to medical advice and the governance structures to support this when no doctor is on site. This will support risk assessment and clinical decision making.

4. One System Workforce

a. An urgent care workforce strategy should be developed at a system level (one STP or more) to help facilitate the creation of an integrated workforce with the benefits of common training framework and consistency in approach with the opportunity for rotations.

b. Leadership of these new models of care should provide exciting opportunities for aspirant clinical leaders.

5. **Diagnostics to Maximise the Benefit of Networked UTCs**
    a. Minimum standards for the provision of appropriate diagnostic and near patient testing equipment (along with staffing and reporting arrangements 12/7) are essential.

    b. Flexible approaches to skills development should be explored, for instance training other members of the team to perform simple radiography to mitigate against specialist staff shortages.

    c. Diagnostics and regional replacement programmes for machines should be procured for the system as a whole (one STP or more) rather than for the individual UTC facility.

6. **Access**
    a. Access to digital patient records will be key to integration of services.

    b. NHS 111 (and SWAST) need to have clear information in its directory of service to correctly refer and signpost patients. This includes last entry times to a service.

    c. Moving to directly bookable appointments being available at all UTCs in addition to the walk-in should be explored. Systems need to be mindful however of the tensions in mixed models where patients who have been waiting may perceive that others are “queue jumping”.

The above recommendations are for STPs with facilitation from NHSE around common standards and frameworks.