SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>Service</th>
<th>Commissioner Lead</th>
<th>Provider Lead</th>
<th>Period</th>
<th>Date of Review</th>
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<tbody>
<tr>
<td></td>
<td>Primary Care Urgent Treatment Service</td>
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1. POPULATION NEEDS

1.1 National/local context and evidence base

The CCG triple aim is to:

1. **Improve the health of the people in Oldham**
   By Proactive and Preventative work within GP and Health & Social Care Clusters

2. **Improve the care they receive and their experience of it**
   By simplifying and enhancing access to Primary Care through a Single Point of Access for H&S Care

3. **Deliver the best value for money by using our resources effectively**
   By reducing duplication by sharing information
   With patients being seen By the Right Person, in the Right Place at the Right Time – Every Time.

The vision for primary care led urgent care in Oldham is:

- A single point of entry at a local GP surgery – patients no longer have to 'self-triage' to decide whether to go to their GP, A&E or a walk in service.
- More patients receiving health and social care in their local community setting.
- Extended access to a broad range of health and social care professionals, 7 days per week.
- Single care plans with shared medical records shared between GPs, other health and social care professionals and hospital clinicians.
- A&E clinicians focusing on the critically ill patients who need their care.
- Patients receiving the right care, in the right place, at the right time – every time.

The Primary Care holistic contribution into urgent care resilience and sustainability is a key priority for Oldham Clinical Commissioning Group (CCG).

There is recognition that improvement of the urgent and emergency care system is a major priority, both nationally and across Greater Manchester. The reasons for the strain on the emergency care system are complex. In order to support long term and immediate improvements in timely access to care, connected to new models of care, there is a requirement to fundamentally redesign the current ways of working. This will include changing the culture with regards to access to Urgent Care in the Oldham economy.

Improvement of the urgent and emergency care system is the driver for the national A&E Improvement Plan, which proposes specific, mandated improvement initiatives that all systems must implement in the coming months. Recent guidance received includes

- Next steps on the Five year Forward View March 2017,
These improvements fall into four categories:

1. Demand management: proactive home support and community care packages that reduce ED attendances
2. In hospital flow & processes
3. Enhanced focus on recovery and independence that supports effective discharge.
4. Prevention of re-attendance and readmissions to hospital.

This specification outlines an innovative model for urgent primary care that will be delivered in Oldham.

The Primary Care Urgent Treatment Service (UTS) in Oldham is collectively comprised of:

- Urgent Treatment Service Primary Care Cluster Hubs (UTS Cluster Hubs)
- Urgent Treatment Service A&E Front End Primary Care Streaming (including flow management between services)
- Ambulatory Care Unit

The model itself is twofold:

1) **5 Cluster based UTS Primary Care Hubs:** The service will have explicit connectivity and will complement the Oldham 2M Cluster model as described below:

   In line with the Wider Primary Care at Scale Strategy, Oldham General Practice has been configured into a tiered system of working to enable services to be delivered at the most effective level for the health economy. They are:

   - 1m (micro) = singular level (e.g. a single, stand-alone GP Practice)
   - 2m (meso) = partner level (e.g. groups of geographical & population consistent practices working together)
   - 3m (macro) = federation (whole of Oldham locality) level (e.g. a single contracted unit of organised delivery, comprising of many / all GP Practices)

   This system allows for flexible and population specific service delivery, and ensure that economies of scale can be achieved where appropriate.

   The five Clusters each have a Primary Care Urgent Care Plan, meaning that patients will in the first instance be managed within their own locality through improved risk stratification, care planning and early interventions.

2. **UTS co-located with the A&E at the Royal Oldham Hospital (ROH):** This will be contracted for through a special purpose vehicle, commissioned under the auspices of an aPMS (alternative primary medical service) commercial contract. The model is a holistic care delivery, care management service, managing all Primary Care amenable conditions, demand, throughput control, signposting and discharge planning (including social care liaison). It is an integrated model.

   It is a purpose designed, special primary care practice co-located within the A&E department.
at the Royal Oldham Hospital. It will specialise in ‘primary urgent care’ and will operate as part of an alliance of urgent care providers. It will therefore have integrated pathways and integrated processes.

The urgent care system must be seen within the context of the new care models evolving within and across localities, these will have a direct impact on all four areas of work over time.

1.2 New Models of Care – the GP Clusters

GP practices are be organised into clusters, or groups, of practices so that out of hospital health and social care can be delivered in their local community for patients. Each cluster will take responsibility for the identification and care management of its patients in order to improve patient outcomes, using a risk stratification approach which will identify those who have the greatest need.

Patients will have access to a broad range of clinicians and healthcare professionals from 8am to 8pm, 7 days per week, across the cluster patch with guaranteed access underpinned by innovative ways of working such as on line consultations. Each cluster will have a clinically-led integrated team of health and social care professionals, which will conduct single assessment processes and maintain a single care plan for each patient, ensuring that patients are given the right care by the right person at the right time.

Clusters will be responsible for the identification and care management of all patients with long-term conditions. They will also be responsible for post-discharge community support, early help and prevention, and the oversight of universal services such as health visiting. Clusters will use streamlined, standardised and increasingly sophisticated risk stratification methods to shape their care response to the needs of patients with long-term conditions.

Ultimately the patients of each cluster practice will have a single point of access for appointments, test results and queries although walk in patients will still be supported. Appointments will be offered at the patient’s ‘home practice’ unless there is limited availability there. In such circumstances, patients will be offered appointments in alternative, local, practices within the cluster. Appointments will be managed at cluster level, and a range of consultations will be available including telephone and videoconferencing with nurse practitioners, practice nurses and GPs, face-to-face consultations with a range of health professionals including pharmacists, nurses and other health professionals.

Clusters will direct the deployment of professionals within the integrated health and social care teams, allocating resources to patients in line with agreed, standardised clinical and care pathways. The health and social care teams will act as the multi-disciplinary team for continuing healthcare and end of life care; they will be the principal, day-to-day means of delivering care and providing support, to people with long-term conditions. The cluster’s integrated health and social care teams will include children and young people, adults, people with mental health problems, and with learning disabilities, of all ages. They will include the voluntary and community services available to the locality.

Each cluster will have shared use of available primary care and community service estates, IM&T, including clinical system access (EMIS), and clinical facilities, enabling services to respond flexibly and quickly to changes in demand. Systems will 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.

The broad construct of the Cluster model is:

- Medical hub (single point of entry, triage, crisis and urgent care response, routine primary care, diagnostics co-ordination)
- Logistics unit (information governance, screening programmes and data analysis)
- Community hub (preventative agenda including exercise, diet and alcohol support)
- Prevention Innovations (education, long-term sickness and community resilience)
Successful delivery of these objectives will result in the following outcomes:

- Improved satisfaction level of users of health and care services in the borough
- More users receiving care at or close to home as an overall proportion of care
- Reduction in health inequalities in the borough of Oldham
- Reduced demand for unplanned, emergency and urgent care services across the borough
- Reduced spend by commissioners on health and care services, especially hospital services

1.4 Urgent Treatment Service A&E Front End Primary Care Streaming (UTS A&E Front End)

National guidance ([https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres-principles-standards.pdf](https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres-principles-standards.pdf)) states that the Urgent Treatment Service A&E Front End Primary Care Streaming (nationally known as Urgent Treatment Centres) will be GP-led, open 12 hours a day, every day, and be equipped to diagnose and deal with many of the most common ailments people attend A&E for.

Urgent Treatment Services will ease the pressure on hospitals, leaving other parts of the system free to treat the most serious cases. The Urgent Treatment Service offer will result in decreased attendance at A&E with the opportunity for streaming at the front door. All UTS services will be considered Type 3 / 4 A&E and will contribute to the 4 hour access and waiting times target locally.

These services will be commissioned to provide a genuine integrated urgent care service, aligning with NHS 111, urgent treatment services, GP out-of-hours and routine and urgent GP appointments with face to face urgent care.

The Primary Care Urgent Treatment Service (UTS) in Oldham is collectively comprised of:

- Urgent Treatment Service Primary Care Cluster Hubs (UTS Cluster Hubs)
- Urgent Treatment Service A&E Front End Primary Care Streaming (including flow management between services)
- Ambulatory Care Unit (ACU) provided by Pennine Acute Hospitals Trust

1.5 Urgent Treatment Service Primary Care Cluster Hubs

Cluster Hubs will work to the model described to offer an enhanced level of ‘Out of Hospital’ care to patients. This will ensure that access is readily available and well communicated (i.e. same day access for under 5’s), and patients are effectively managed to reduce and minimise the levels of urgent care and A&E attendances.

Clusters will undertake a simultaneous role to that of the Band 7 Urgent Treatment Service A&E Front End Primary Care Streaming Emergency Nurse Practitioner (ENP) in that as an access point for patients, they will triage and treat or direct patients to the most appropriate part of the system. This will assist patients by being able to be treated in their local community and reduce the need to attend A&E.

The diagram below illustrates the Urgent Care Treatment Service key components:

- Urgent Treatment Service Primary Care Cluster Hubs (UTS Cluster Hubs)
- Urgent Treatment Service A&E Front End Primary Care Streaming (including flow management between services)
- Ambulatory Care Unit
Diagram 1 Urgent Care Treatment service components

Inevitably there will be instances where patients still attend A&E with conditions that can be managed in Primary Care. The Urgent Treatment Service Primary Care Cluster Hub ensures that daily access appointments are made available for patients requiring continued clinical intervention that is not required to be in a hospital setting. The service will cover the following:

- 12 hour opening, 8am – 8pm (cluster not individual practice)
- Pre-bookable and walk in appointments
- Multi-disciplinary teams deployment
- Minor illnesses service
- Access to basic diagnostic services e.g. urine and blood testing
- Issue prescriptions
- Direct access to mental health advice and services
- Signposting to non-healthcare services

2. OUTCOMES
## 2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
</tr>
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<tbody>
<tr>
<td>Outcome:</td>
<td>People are seen in a safe timeframe, by appropriately trained and qualified staff, in the right place, leading to an appropriate clinical outcome</td>
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<thead>
<tr>
<th>Domain 2</th>
<th>Enhancing quality of life for people with long term conditions</th>
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<tbody>
<tr>
<td>Outcome:</td>
<td>There is minimal unwarranted variation in the delivery of care within the (UTS Cluster Hubs)</td>
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<thead>
<tr>
<th>Domain 3</th>
<th>Helping people to recover from episodes of ill health or following injury</th>
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<tbody>
<tr>
<td>Outcome:</td>
<td>GPs with suitable training will be on duty in the out of hours period</td>
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<thead>
<tr>
<th>Domain 4</th>
<th>Ensuring people have a positive experience of care</th>
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<tr>
<td>Outcome:</td>
<td>Patients contacting the UTS A&amp;E Front End or the UTS Cluster Hubs receive timely, comprehensive information regarding their condition including an appropriate management plan</td>
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<tr>
<td>Outcome:</td>
<td>Patients understand their treatment journey</td>
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<tr>
<td>Outcome:</td>
<td>Patients have a high level of satisfaction with the service</td>
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<tr>
<td>Outcome:</td>
<td>People feel that they receive good quality professional care from phone call to resolution</td>
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<tr>
<th>Domain 5</th>
<th>Treating and caring for people in a safe environment and protecting them from avoidable Harm</th>
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<tbody>
<tr>
<td>Outcome:</td>
<td>Patients receive the most appropriate care in the most appropriate setting</td>
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<tr>
<td>Outcome:</td>
<td>The UTS Cluster Hubs must be accessible to all patients who require GP services during the out of hours period</td>
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<tr>
<td>Outcome:</td>
<td>UTS Cluster Hubs facilities are available 365/366 days a year</td>
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<tr>
<td>Outcome:</td>
<td>The UTS Cluster Hub has access to relevant patient information</td>
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<tr>
<td>Outcome:</td>
<td>Relevant organisations have easy access to information about patient contacts with the UTS Cluster Hubs</td>
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<tr>
<td>Outcome:</td>
<td>Information is shared with the GP and named social worker for children known to be subject to a protection plan or looked after by the local authority.</td>
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### 2.2 Local defined outcomes
The Provider will ensure equity of provision across Oldham. Reports will be provided to NHS Oldham CCG demonstrating compliance with all key performance and quality indicators.

### 2.3 Patient Experience
Patients are the first priority for the NHS and as such are at the centre of all service provision. It is a key priority that Oldham residents experience high quality care from all commissioned services and as such, it is imperative that systems are developed to ensure patient experience is captured and used to continuously improve the service.

2.4 **Equality and Diversity**

All health services should be equally accessible by all which includes making reasonable adjustments where appropriate. In terms of reducing inequalities service development should be guided by the needs of the most vulnerable in society. This includes those facing barriers posed by poverty, language, stigma and discrimination.

Providers will be expected to comply with both the General and Specific Public Sector Equality Duties of the Equality Act 2010.

The General Equality Duty has three aims which are:

1. Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the act.
2. Advance equality of opportunity between people who share a protected characteristic and people who do not share it.
3. Foster good relations between people who share a protected characteristic and people who do not share it.

The Specific quality Duty requires that certain public organisations

- Publish information to show they are meeting their responsibilities to employees and service users under the Equality Duty, at least annually
- Set and publish equality objectives at least every four years.

Providers have a duty to support these objectives and to not discriminate in relation to the nine protected characteristics (or indeed other characteristics not specifically listed). Public bodies have a duty to consider the needs of all individuals in their day to day work, in developing policy, in delivering services, and in relation to their own employees which is encapsulated in the NHS Equality Delivery System with its specific patient and staff focused goals and outcomes.

- Better health for all;
- Improved patient access and experience;
- Empowered, engaged and included staff; and
- Inclusive leadership at all levels.

Provider(s) will be expected to record demographic data relating to the protected characteristics which are;

- Age;
- Disability;
- Gender re-assignment;
- Marriage and civil partnership;
- Race including national identity and ethnicity;
- Religion or belief;
- Sex;
- Sexual orientation; and Pregnancy and maternity.

The Provider will be expected to record the characteristics and compare these with local bench marking data to ensure that protected groups are not being excluded from services.
The Provider will have a policy stating how all groups covered by the protected characteristics can access the Service.

3. **SCOPE**

3.1 **Aims and objectives of service**

The aims of the service are to provide a clinically safe and competent primary care led Urgent Treatment Service (UTS) accessible to the local population across the CCG locality. The service is to provide access to unplanned urgent care, working in partnership with the wider urgent care system across primary, community, secondary health and social care.

The service must meet those urgent patient needs that cannot safely be deferred until the patient can access routine primary care services during core hours. The service must work and engage with the CCG and act as a complementary service to the primary care services in and out of hours and maintain treatment protocols.

The service provided should be equitable in terms of access and quality of provision, no matter where it is provided or to whom it is provided.

Patient access should be as simple and straightforward as possible.

A single point of access is to be developed and enhanced via the patient’s own GP telephone number, accessing in hours their own GP or 2m local UTS Cluster Hub which forms part of the UTS in their local community. OOH the patients would be advised to ring NHS 111 as currently, who enable the clinical triage, self-care advice, onward booking to the OOH provider, or in emergencies onward transfer to A&E.

Patients who don’t access Urgent Care via the single point of access and attend A&E will be streamed as appropriate to the UTS A&E Front End streaming component of the UTS.

The UTS is an integral part of the delivery of 24 hour urgent care and as such should work in close partnership with other urgent care stakeholders and the CCG to deliver integrated patient-centred care, making the most appropriate use of resources.

Patients should have access to the most appropriate clinician for all face to face consultations, in the appropriate place in a timely manner, in accordance with assessed clinical priority.

The service delivered should be evidence based and meet all the national quality and clinical governance requirements. Regular monitoring of outcomes should be utilised to ensure continuous improvements are made to the service.

Repetitive information gathering from the patient should be minimised and mechanisms should be in place to ensure timely and efficient flows of information to ensure continuity of care. This is especially important with the NHS 111 Service where all interoperability requirements must be met.

The service should be patient focused and have in place mechanisms to involve patients in their own care and in the future developments of the service.

Services should be provided based on patient need.

Further aims and objectives of the service are:

- To be the first point of access for the public to the emergency / urgent medical service
- To provide a seamless and local patient care pathway
- To be accessible to patients via walk in (self-presentation/GP or other referral) routes
• Following electronic referral from “111” to provide telephone information and advice, including advice about self-care, from suitably qualified clinicians and when necessary direct patients for assessment and treatment during traditional out of hours periods.

• To provide access to care, diagnostics and any subsequent treatment, when needed, delivered by appropriately trained health professionals.

• To provide signposting information for patients regarding access to medical services and other agencies both in and out of hours including how to register with a GP.

• To provide a fully integrated Urgent Care Service as part of the overall strategic direction of the health economy.

• Avoid unnecessary admission to hospital.

• To ensure appropriate referral between services during the traditional out of hours periods.

• Patient information flow between services on referral.

• Provision of information to patients regarding different urgent care services and more appropriate scheduled care services.

• Not to increase pressure on in hours GP services.

• Reduce unnecessary attendances to acute providers of emergency care.

• Not to increase pressure on 999 ambulance services.

• Innovative use of information management and technology.

• Be sustainable in terms of workforce.

• Make best use of and develop the skills of all professional groups.

• Services must be delivered safely and through a learning environment.

• Services must be effective.

• There should be accreditation for training placements for external Clinical Staff.

The links and integration between the above are vital to provide clinical oversight, ensure the maintenance of patient safety and provide a platform from which there is continual clinical quality improvement.

3.2 Service description/care pathway

Care Pathway

The 2 complementary components of the Urgent Treatment Service (UTS) are the UTS Cluster Hubs and the UTS A&E Front End and form an integrated UTS.

The UTS A&E Front End service will provide the following services:

i. Respond to the unscheduled care demand presenting at A&E.

ii. The service should be open for a minimum of 12 hours (currently 11am-11pm) as per national guidance, however a local demand and capacity exercise is being undertaken to understand the local need for the Oldham site.

iii. Provide a Primary Care function that will manage all self-referred unscheduled attendances to ROH.

iv. Commence a definitive clinical consultation within 1 hour of attending for 98% of attendances.

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

vi. Effectively and appropriately referring the very sick and severely injured to the A&E/ACU/hospital specialties.
vii. Provide initial assessment and, where appropriate, effective referral back to, or into existing General Practice, Social Care or other health and social care pathways.

viii. Provide a continuing record of care and notes for unscheduled patients, and providing relevant information to their own GP, Health Visitor and School Nurse where applicable.

ix. Develop research, innovation and a training interface.

x. Demonstrate a “can do” relationship with Commissioners to support sudden unseen needs and changing healthcare demands.

xi. 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.

xii. 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.

xiii. Facilitate pre-bookable appointments via the UTS Cluster Hubs.

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

xv. An appropriately trained multidisciplinary clinical workforce will be deployed whenever the UTS A&E Front End is open. The UTS A&E Front End in Oldham will 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 at the cluster hubs or with 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.

xvi. The scope of practice 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. Please see exclusions section regarding Minor Injuries pathway provision when available.

xvii. The service 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 UTS A&E Front End near-patient troponin testing could also be considered. The capacity for enhanced rapid access diagnostics is available via the Ambulatory Care Unit.

xviii. Bedside diagnostics and plain x-ray facilities, particularly of the chest and limbs, are required.

xix. 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.

xx. 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.

xxi. The service should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.

xxii. 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).

xxiii. The Provider must meet the minimum service access requirements of the Service.

xxiv. Immediate or near immediate actual or virtual access to a decision-making clinician at the time that the patient requires care

xxv. The Provider must commence treatment of Patients potentially suffering from immediate and life-threatening conditions within 3 minutes of them presenting to the UCC.

First Contact
The first point of clinical contact for all will be an experienced Band 7 ENP streamer, who will be available throughout the UTS A&E Front End opening hours.

The streaming staff shall ascertain the most appropriate service provision for the patients presenting condition based on agreed clinical protocols.

Clinical assessment by an appropriately trained clinician will occur within 15 minutes of the patient arriving.

When demand and waiting times permit the provider shall also provide a see and treat service at this first contact enabling less complex patients to be managed more expeditiously including but not limited to simple medication management, symptom control, prescriptions and redirection to a more appropriate service.

3.3 Service Principles
The principles of the service are that of an integrated, flexible and responsive patient pathway that aims to simplify access to UC treatment services and ensure patents are seen by the right person, at the right time, in the right place, first time. The supporting services wrapped around this should be accessible directly from anywhere within this service and information shared in real time.

The UTS service will provide 3 specific functions:

- An integrated front end enhanced triage service via the UTS Cluster Hubs and Band 7 ENP UTS A&E Front End.
- An integrated Primary Care treatment service for urgent Primary Care presentations in the community and at A&E
- Act as the key co-ordinator to Oldham Core and Extended Primary Care to ensure timely and appropriate levels of follow up and care.

3.4 Front End Triage
Standard A&E triage service will operate 24/7, however Band 7 ENP Primary Care streaming through to UTS A&E Front End will only be between the hours of 11am -11.00pm.

Outside of these hours self-presenting patients will be triaged by the A&E triage nurse.

The potential outcomes from the Band 7 streaming nurse are:

1. Streaming the patient to UTS A&E Front End
2. Streaming back to the patient’s GP Practice or UTS Cluster Hub
3. A&E (without a secondary triage)
4. Ambulatory Care Unit (ACU)
5. Home with self-care advice
6. Returned to the relevant GP practice / Cluster for management
7. Community provider (health/care) without treatment
8. Referral to alternative primary care service i.e. pharmacy, optometry, dental etc.

The service will also have access to dedicated support from Social care, Mental Health services, Therapy and Housing support.

The service will have the same admitting rights to acute services as any other primary care service however will also have direct access to both urgent and planned primary care appointments at the patient’s own practice/ cluster.

This could include:

- Booking in to primary care for follow up
- On-going or additional support from community teams
- On-going or additional support from a housing officer
- On-going or additional support from a social worker
- On-going or additional support from Age UK / other third sector services

3.5 Staffing model

During the hours of operation the minimum core team will consist of:

A senior primary care practitioner (there may be times where activity require more than one practitioner per shift, GP and or Advanced Nurse Practitioner)

Administration support

The service requires a pool of regular GPs and other clinicians to work in the UTS A&E front end as we would want clinicians with a good knowledge of the local primary and community health and social care system, to have a good working knowledge of the local DoS to enable signposting and referral to supporting teams out of hospital and avoid admission.

During the hours of operation the core UTS A&E Front End will have direct access to the following:

- Therapy advice and guidance
- Social Worker advice and guidance
- A&E Consultant advice and guidance
- Specialty Consultant advice and guidance
- Transfer of Care Co-ordinator
- Children’s integrated urgent care service
- Core 24’ hour RAID model
- Diagnostics

Operating Hours

- 7 days per week (including bank holidays)
- 11.00am – 11.00pm (The pilot is currently assessing if activity peaks warrant an extension to 8am – 11pm)

3.7 Location

The service will be co-located within the A&E department (Front End) at the ROH.
3.8 Operational Pathway

Diagram 2 Oldham Urgent Care model

3.9 UTS A&E Front End PC stream

Service Description

UTS A&E Front End will deliver a service that will see adults and children with minor illness or injury and will be able to manage more complex primary care patients presenting with an ‘urgent’ primary care need, utilising the ACU pathway.

The service streams clinically appropriate patients from UTS A&E Front End and UTS Cluster Hubs for
assessment, more complex diagnostics, or care and support planning through to ACU. Patients can be triaged to the service from A&E B7 streaming nurse (Enhanced triage) and GPs can also pull from ambulance triage room & A&E department.

In cases where prescribing is required, the service will provide sufficient medication/prescription (preferably via FP10) to patients until their own practice can review them. The service should be able to issue prescriptions, including repeat prescriptions and e-prescriptions and work towards e-prescribing which should be in place in all sites by June 2019.

The service will also have access to pregnancy tests and emergency contraception.

The service will be linked into other community services, such as mental health, community pharmacy, dental, social care and the voluntary sector.

Direct booking back to the patients’ GP cluster is available where clinically appropriate within defined timescales, e.g. 4 hours, next day, within the week and therefore reduces the activity flowing into the A&E.

Through a provider jointly agreed I.T. system solution (The CCG promotes the use of EMIS Tracker to allow integration with the 44 Oldham practices with EMIS web clinical systems, for non-Oldham residents information sharing will be via Share for You in NES), there will be access to up to date electronic patient care records; (this access will be based on patient consent, confirmed where possible at the time of access or in the patient’s best interest in an emergency situation where the patient lacks the capacity to consent). The patient’s registered GP will always be notified about the clinical outcome of a patient’s encounter with the UTS A&E Front End via a Post Event Message (PEM), accompanied by the real-time update of the electronic patient record locally, (for children the episode of care will also be communicated to their health visitor or school nurse, ‘where known’ within 2 working days)

In cases where urgent diagnostics are required the service will have access to appropriate diagnostics as defined earlier within the specification and with the same priorities as A&E and ACU.

In cases where it is clinically appropriate, patients can be streamed or referred through to the ACU for further assessment, diagnostics, treatment and discharge. This is the same pathway for all Oldham GP practices.

It is expected that clinicians employed within the UTS A&E Front End will also work flexibly between A&E front end and ACU. This is designed to enable primary care to input into more complex patient care and to make a valuable contribution to the immediate and on-going care of patients using their knowledge of primary and community care, and support planning.

Discharge from ACU can be supported via the Integrated Discharge Team (IDT) and Oldham Rapid Community Assessment Team (ORCAT) Senior Persons Resilience & Independence Team (SPRINT) and also via direct links with UTS Cluster Primary Care Hubs and the wider Primary Care cluster MDT teams.

The total episode of care should take no longer than one hour from the time the patient is triaged into the service. However this may vary due to the complexity of the patient’s needs and the patient being referred on through the ACU pathway.

The service will complete the episode of care in the majority of cases, however it is expected that there may be the need to refer through to other services for follow up.

3.10 Workforce
- Service staffed by GPs (or other suitably qualified Primary Care clinicians) from 11.00am – 11.00pm (potentially 8.00am-11.00pm), co-located in the A&E department with access to consultant advice where needed.
- Administration staff – model TBD
- Nursing - Triage nursing staff in this model are employed by Royal Oldham Hospital (ROH).

Training
All staff that work in this service must be up to date with all mandatory training including Safeguarding Children and Safeguarding Vulnerable Adults

The workforce must be IG compliant, have completed a comprehensive induction course to the clinical systems and have received an information pack on DoS.

The provider must ensure they work towards cross pollination of knowledge within the acute setting, including peer support and supervision from A&E and ACU consultants for their employees, this will support developing GPwSI and specialist practitioners’ roles in Oldham Clusters.

3.11 Population covered

The cluster based Urgent Treatment Centres will serve the resident and registered population within the Oldham CCG footprint.

Any patient (from inside or outside of Oldham) presenting at the Primary Care A&E Front End streaming on the ROH site will have their needs identified and will be treated as appropriate.

A large proportion of patients that attend ROH A&E are non- Oldham patients. Approximately 30% of all ROH activity is from other CCGs, including a large proportion of HMR patients. Rochdale Infirmary Clinical Assessment Unit which operates in synergy with the UCC has a developed pathway to re-direct HMR patients from FGH site to RI and will commence shortly on the ROH site.

The NES CCGs are working collaboratively to ensure that within the new operating system for PC A&E streaming that this cohort of patients are onwardly referred to the UTS within their home CCG, ensuring that these patients receive their on-going care in a community setting closer to their home.

There is also recognition that Oldham CCG has a cohort of patients that have No Fixed Abode (NFA). This service will be accessible to all unregistered Oldham Patients.

3.12 Any acceptance and exclusion criteria and thresholds

Acceptance

UTS A&E front End
- All attendees at A&E on the Oldham site as determined by the streaming nurses
- Acceptance for UTS A&E Front End streaming – All walk in patients who are suitable for a primary care intervention.

UTS Primary care cluster hubs
- All Oldham patient’s registered with an Oldham GP Practice

Exclusion (for the UTS A&E Front end)
Within ROH A&E there are several established pathways that will be excluded from this service specification; these include:
- Gynaecological assessment and early pregnancy fast track
- Fast track # NOF to Orthopaedics
- Minor injuries – ENP led minor injuries stream
- Raid/Mental Health
• Also any direct referral to speciality attending A&E – MAU, SAU, Gynaecology and Paediatrics.

*Please note a patient who is referred with any of these conditions will be triaged and sent directly through to the appropriate pathway*

3.13 **Interdependence with other services/providers**

- Oldham Metropolitan Borough Council Re-ablement Service
- Community Service Providers
- 3rd Sector Acute & Community Services

3.14 **Clinical Governance**

Service providers will be required to adhere to national standards and any procedures, protocols or additional standards that may be agreed locally and be CQC registered.

Expectations of clinicians will vary depending upon the details of individual cases; therefore the specification of clinical requirements to a level of minutiae will be inappropriate. All professionals are also regulated via their own professional body and are therefore accountable for their own professional practice.

Providers are required to deliver services within the scope of NHS policies, legislation and terms, taking particular cognisance of “Standards For Better Health” including:

- Clinical Audit and Effectiveness
- Risk Management
- Public and Patient Involvement
- Confidentiality, Caldicott Principles
- Complaints Procedures
- Medicines management
- Safeguarding

In order to maintain clinical governance and organisational accountability, and as staff employed within this service will be accountable to their employing organisation and may work to PDG’s/ SOPs within the model.

There will be an agreed shared governance between the joint providers of the UTS and A&E/ACU with regular meetings to discuss SEAs, near misses, complaints overview and any patients streamed down a pathway that subsequently had to be redirected to another pathway e.g. streamed to PC front end and passed back to A&E to ensure shared learning and enable a PDSA type continual learning and refining process.

3.14 **Information collection & Handling**

The provider will be required to demonstrate that the systems they intend to use to manage patient flow through the service are compliant with agreed Information Governance Legislation and that it is capable of recording and reporting all required information and data sets. There must be adequate systems in place to ensure that computer records are backed up regularly and that information is held securely in compliance with data protection legislation.

The provider will be expected to integrate IT systems to interface with current A&E systems. The system must be able to link with EMIS and also enable access to the Oldham Care Plan and have the ability for the IT system to book directly in to primary care appointments.

Information will be supplied monthly to the CCG for payment on an agreed contractual arrangement. This will include details of patients treated including pseudonomised NHS number.

Reporting of incidents should be in line with national and or local policies in existence, with serious untoward incidents being notified within 24 hours to the clinical governance lead at the
CCG. Complaints should be documented and acted on according to a written policy that meets the NHS constitutional requirements.

The service 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.

3.15 Information Management & Technology

The Provider must put in place the information technology infrastructure and systems plus the service management arrangements necessary to support a 24/7 urgent care service.

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

3.16 Clinical System

It is expected that the Provider will use a recognized and accredited primary care clinical systems software system for managing urgent medical care in Primary Care. The CCG promotes the use of EMIS Tracker to allow integration with the 44 Oldham practices with EMIS web clinical systems, for non-Oldham residents information sharing will be via Share For You in NES.

All clinical activity including prescribing must be recorded on the IT system.

The clinical system and supporting systems should be operated in the context of other clinical systems on the care pathway. Existing supporting information (e.g. test results, End of Life records) should be used to support clinical decision making, and appropriate information should be forwarded to any onward referral or to the registered GP.

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.

3.17 Finance and Contracting

UTS A&E Front End will be commissioned via an aPMS contractual agreement, with an honorary contract with the Acute Trust to enable Crown Indemnity for practitioners.

This service will be commissioned via an aPMS contractual agreement.

Remuneration will take place in accordance with the CCG standard financial instructions and procedures and will require the uniform provision of relevant activity data.

All costs of the service including staffing, equipment and premises shall be included within the agreed aPMS contract or existing tariff arrangements.

3.16 Return On Investment

This proposal has been developed as an investable proposition to support the ICO transformation. The service design has followed the development of the interventions which are intended to deliver a reduction in activity in the following areas:

- A reduction in Children’s A&E attendances and Non Elective admissions
- A reduction in A&E attendances, Non Elective admissions and prescribing
- A reduction in adult A&E attendances and Non Elective admissions

These reductions will be achieved through:

- Incrementally reducing the numbers of A&E attendances via improved patient education on how and where to have their primary care needs met.
• Incrementally reducing the volume of A&E activity through the streaming to and provision of more cost effective alternative pathways.
• Reducing the number of patients admitted for further assessment by early identification at triage and the increased capacity to plan a discharge to GP practices directly from the UTS A&E Front End.
• Effective demand and flow management.
• Consistency of pathways and patient education to reduce duplication

The reductions will be monitored by the following means:

Reporting
• The ICO via the Oldham Urgent Care Alliance will monitor co developed Key Performance indicators on a daily, weekly and monthly basis.
• Provide a weekly update report to monitor activity against an agreed trajectory.

Governance
• Formal contract management processes via CCG Governance arrangements
• Formal Clinical Governance protocols to be developed to reflect the joint working arrangements between UTS Cluster Hubs, UTS A&E Front End, ACU and other relevant agencies

4. APPLICABLE SERVICE STANDARDS

4.1 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)
• Urgent Treatment Centres – Principles and Standards
• “Next Steps on the NHS Five Year Forward View (5YFV)”
• The General Practice Forward View

5. APPLICABLE QUALITY REQUIREMENTS AND CQUIN GOALS

5.1 Applicable Quality Requirements

6. Location of Provider Premises

The Provider’s Premises are located at: Royal Oldham Hospital

7. Key performance indicators

Below are the local KPIs that apply to the service in addition to national quality indicators within the NHS Standard Contract.

<table>
<thead>
<tr>
<th>Access – Urgent care appointment in UTS</th>
<th>Appointment same day of request</th>
<th>&gt;=95%</th>
<th>Monthly provider performance report</th>
<th>General condition 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access – walk-in appointment in UTS</td>
<td>Appointment available with 2 hours of arrival</td>
<td>&gt;=95%</td>
<td>Monthly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>Triaged within 15 minutes of arrival at A&amp;E PC UTS</td>
<td>The % of patients who attend the UTS at A&amp;E receive an enhanced triage by a Band 7 ENP and if deemed appropriate are streamed through to the PC A&amp;E UTS</td>
<td>95%</td>
<td>Monthly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Target</td>
<td>Report</td>
<td>Condition</td>
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<tr>
<td>GP electronic</td>
<td>The provider will demonstrate compliance with the integrated electronic messaging service for transmitting correspondence with GPs.</td>
<td>100%</td>
<td>Monthly provider performance report and GP cluster feedback</td>
<td>General condition 9</td>
</tr>
<tr>
<td>communication</td>
<td></td>
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<tr>
<td>Access to electronic</td>
<td>All UTC and A&amp;E / ACU Acute to have access to patient’s records. For Oldham Patients this should be via EMIS Tracker for out of Oldham patients this will be via Share for You.</td>
<td>100%</td>
<td>Monthly provider performance report and GP cluster feedback</td>
<td>General condition 9</td>
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<tr>
<td>patients records</td>
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<tr>
<td>Commissioner</td>
<td>Commissioning Data Set (CDS) to be submitted by the submission dates identified by the HSCIC each month (data to be compliant with SUS requirements).</td>
<td>100%</td>
<td>Monthly provider performance report (submission date to SUS/SFTP site v deadline)</td>
<td>A contract query will be raised if submissions continue to be late. Non-submission of the CDS dataset will result in non-payment of invoices.</td>
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<tr>
<td>information</td>
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<tr>
<td>UTS appointments to be</td>
<td>The % of appointments that can be booked via NHS 111</td>
<td>&gt;95%</td>
<td>Monthly provider performance report</td>
<td>General condition 9</td>
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<tr>
<td>booked via NHS 11</td>
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<tr>
<td>Access- NHS patients</td>
<td>The % of patients who have a pre booked NHS 111 appointment being seen &amp; treated within 30 mins</td>
<td>&gt;95%</td>
<td>Monthly provider performance report</td>
<td>General condition 9</td>
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<tr>
<td>seen and treated within</td>
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<tr>
<td>30 minutes of the</td>
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<tr>
<td>appointment time in UTS</td>
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<tr>
<td>Critically ill patients</td>
<td>Pathways in place to transfer critically ill patients who arrive at an UTS to an appropriate place of care</td>
<td>100%</td>
<td>Monthly provider performance report</td>
<td>General condition 9</td>
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<tr>
<td>arrangements in place</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Access - UTS patients can be referred to an MDT</td>
<td>% of UTS patients referred to a service within the MDT will be seen within 2 hours</td>
<td>&gt;95%</td>
<td>Monthly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>Access – UTS patients can be referred for investigation</td>
<td>% of UTS patients referred for investigation to UCA will receive their investigation within 2 hours</td>
<td>&gt;95% or A&amp;E performance target</td>
<td>Monthly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>Access to Prescriptions, repeat prescriptions and emergency contraceptives</td>
<td>% of UTS patients who will be able to obtain Prescriptions, repeat prescriptions and emergency contraceptives</td>
<td>&gt;95% or A&amp;E performance target</td>
<td>Monthly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>Capturing patient experience</td>
<td>The % of patients referred to the service who have their experience of using that service formally captured including the friends and family test</td>
<td>&gt;=20%</td>
<td>Quarterly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>EX3 Patient satisfaction with the service provided</td>
<td>Patient survey net promoter score (NPS) using the friends and family test</td>
<td>&gt;=75 for NPS</td>
<td>Quarterly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>EX4 Patient rating of care</td>
<td>Mean average score for patients rating the care they received</td>
<td>&gt;=4</td>
<td>Quarterly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>EX5 Patients confident they can manage their own health</td>
<td>% of patients that are ‘somewhat confident’ or ‘very confident’ they can manage their own health</td>
<td>&gt;=95%</td>
<td>Quarterly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>CAS1 CAS alerts</td>
<td>The % of Central Alert System alerts acknowledged within 5 days of target date</td>
<td>&gt;=98%</td>
<td>Quarterly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>CO1 Complaints responded to within timeframe</td>
<td>The % of complaints responded to in writing as per the timeframe in the national complaints management policy (i.e. 25 days or as agreed with the complainant)</td>
<td>100%</td>
<td>Quarterly provider performance report</td>
<td>General condition 9</td>
</tr>
<tr>
<td>KPI Code</td>
<td>Description</td>
<td>Criteria</td>
<td>Reporting Period</td>
<td>Condition</td>
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</tr>
<tr>
<td>CO2</td>
<td>Complaints per 1000 appointments</td>
<td>A three month rolling average of complaints received by the provider per 1000 appointments (information split by service)</td>
<td>&lt;=0.3</td>
<td>Quarterly provider performance report</td>
</tr>
<tr>
<td>MT1</td>
<td>Mandatory training</td>
<td>The % of staff up to date with mandatory training (excluding safeguarding)</td>
<td>&gt;=80%</td>
<td>Quarterly provider performance report</td>
</tr>
<tr>
<td>SF1</td>
<td>Safeguarding training</td>
<td>The % of staff who have attended recognised safeguarding children and adults training commensurate with their role (as defined in the Oldham Local Safeguarding Boards Policy - see <a href="http://www.oldham.gov.uk/lscb/">http://www.oldham.gov.uk/lscb/</a>)</td>
<td>&gt;=95%</td>
<td>Quarterly provider performance report</td>
</tr>
<tr>
<td>IF1</td>
<td>Infection control training</td>
<td>Percentage of eligible staff that have completed mandatory training in infection control (\text{(as per local training policy)}) in the last 12 months. Useful reference: <a href="http://guidance.nice.org.uk/CG139">http://guidance.nice.org.uk/CG139</a></td>
<td>&gt;=85%</td>
<td>Quarterly provider performance report</td>
</tr>
<tr>
<td>RS1</td>
<td>Referrer rating of care</td>
<td>Referrer care rating score</td>
<td>&gt;=3.4</td>
<td>Annual provider performance report</td>
</tr>
<tr>
<td>ST1</td>
<td>Staff satisfaction - friends &amp; family test</td>
<td>Staff survey net promoter score (NPS) using the friends and family test</td>
<td>&gt;=75 for NPS</td>
<td>Quarterly provider performance report</td>
</tr>
<tr>
<td>ST2</td>
<td>Staff development</td>
<td>The % of staff with an up to date appraisal/personal development review</td>
<td>&gt;=95%</td>
<td>Annual provider performance report</td>
</tr>
<tr>
<td>OR1</td>
<td>Onward referral &amp; choice monitoring</td>
<td>Provider submits “Provider Onward Referral Template” as per Referral Management Protocol (i.e. monthly by the 5th and in format and manner directed). See section 4 of the Referral Management Protocol.</td>
<td>100%</td>
<td>Quarterly provider performance report</td>
</tr>
</tbody>
</table>

KPI’s in relation to Direct Access Diagnostic will also be developed and included- based on the urgent/non urgent timescales.