Healthcare for London

NHS
Commissioning Support for London

A service delivery model for urgent care centres:

Commissioning advice for PCTs

Contents

Foreword

About this document

This document deals specifically with the commissioning of urgent care centres on hospital sites. Whether, part of a polyclinic or not, every urgent care centre should be part of a polysystem to enable wider integration and efficient delivery of care. Implementation of this guidance should be seen in this wider context.

Background

Healthcare for London: A Framework for Action[1] is the NHS in London's strategy for improving the capital's health services and the health of Londoners. The Healthcare for London programme was set up to work with and on behalf of London's 31 primary care trusts (PCTs) to support the delivery of this strategy. The programme is now delivered through Commissioning Support for London, established in April 2009 to provide clinical and business support to London's NHS.

The strategy was developed by Professor Sir Ara Darzi (now Lord Darzi) in acknowledgement of the fact that healthcare in London needs to change – many aspects of NHS services are not as good as they should be for a major world city. *A Framework for Action* highlighted eight key reasons why services need to improve:

1. Improve Londoners' health
2. Meet Londoners' expectations of the NHS
3. London is one city, but there are big inequalities in health and healthcare
4. The hospital is not always the answer
5. More specialised care is needed
6. London should be at the cutting edge of medicine
7. Use workforce and buildings more effectively
8. Put taxpayers' money to the best use.

The development of *A Framework for Action* was clinically-led in partnership with patients, the public, voluntary sector organisations and statutory bodies. Clinical working groups considered what needed to change and how. The work focused on eight key clinical pathways:

1. Staying healthy
2. Maternity and newborn
3. Children's' care
4. Mental health
5. Acute care
6. Planned care
7. Long-term conditions
8. End of life care.

Five common principles for the future of healthcare were developed as a result:

- Services should be focused on individual needs and choices.
- Services should be localised where possible and centralised where that improves the quality of care.
- There should be joined up care and partnership working, maximising the contribution of the entire workforce.
- Prevention is better than cure.
- There must be a focus on reducing inequalities in health and healthcare.

Appropriate settings of care were identified in order to ensure a health system suitable for the application of the five principles for delivering better health services in the context of the eight care pathways.

These recommended care settings were:

- home care and self help
- polyclinic
- local hospital
- major acute hospital
- specialist hospital
- elective centre
- Academic Health Science Centre.

A Framework for Action presented a compelling vision for change across London, which was endorsed by Londoners in the 2008 consultation *Consulting the Capital*. This vision for change is now being taken forward by NHS commissioners across the capital. Supported by Commissioning Support for London, commissioners have the lead responsibility for implementing the vision.

The commissioning decisions of London's 31 PCTs and six sectors (set up in 2009 to strengthen commissioning hospital services) are the levers by which the strategy will be implemented to improve the quality and safety of health services across the capital, and in particular improve the experience and outcomes of people who use them.

To support the delivery of the strategy, Commissioning Support for London has carried out detailed work on some of the care pathways and care settings outlined in *A Framework for Action*.

This work explores the original recommendations and provides PCTs with the commissioning tools to support delivery of change in the following areas:

- polyclinics
- local hospitals
- maternity care
- children's and young people's services
- mental health, specifically dementia
- acute care, specifically urgent care, stroke and major trauma
- long-term conditions, specifically diabetes
- end of life care.

The strategy was based on the principle of developing high quality, effective and affordable health services. The NHS in London is committed to improving both the quality and affordability of care offered to Londoners and to our visitors. This means making the very best use of the resources we have in the range of health services that we commission and in the way that services are delivered.

A Framework for Action describes a London population that is growing in size and getting older. Londoners will have greater need and expectations for healthcare in future years. New interventions and technologies will be developed to meet needs and while some will enable care to be delivered in a more cost-effective way, the overall trend is expected to be a rising demand for healthcare.

Patient expectations are also growing. Londoners want services that fit better with their lifestyles.

All Londoners want, and deserve, the very best care from their NHS.

Acute care pathway

Four key recommendations were made for improving acute care:

- Access should be significantly improved through urgent care centres with doctors on site. Urgent care centres in hospitals should be open 24 hours a day, seven days a week (the focus of this document), the hours of those in the community settings will depend on local need.
- There should be a single point of contact (by telephone) for urgent care.
- There should be centralisation and networks for major trauma, heart attack and stroke.
- Dispatch and retrieval protocols for London Ambulance Service need to be aligned with centralisation.

A Framework for Action considered urgent care a key component of the acute care pathway. It highlighted that every year millions of Londoners have non-life threatening short-term illnesses or health problems for which they need prompt and convenient treatment or advice. A much smaller number suffer from serious illness or have a major injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery. To meet these needs, the NHS in London needs to improve access to timely and appropriate unscheduled care, information and advice across the 24-hour period.

Urgent care

A Framework for Action highlighted a number of areas where the provision of urgent care does not meet Londoners' needs.

Compared to other regions London has the highest rates of A&E attendance and admissions in the country – poor access to alternatives, duplication and inconsistency of services and poor public awareness of the multiple urgent care service offerings across the capital and which is best to meet their needs, are significant contributory factors. In addition a clear need has been identified to provide a genuine primary care offering to those self-referred patients currently bypassing primary care and presenting at A&E.

Through *A Framework for Action*, the London recommendation for this is to establish a primary care-led urgent care centre at the front of every A&E in London operating directly in an on site polyclinic or as an integrated part of a wider polysystem. This will be the first point of contact for self-referred patients attending hospital with unscheduled care needs.

In September 2008, Healthcare for London published *Commissioning a new delivery model for unscheduled care in London*. This outlined the case for changing unscheduled care in London and presented a whole-system approach to commissioning more accessible, integrated and consistent services to meet people's unscheduled care needs.

The delivery model includes establishing urgent care centres at the front of hospital A&Es as part of an integrated system of urgent care, which also includes urgent care services delivered in the community through polyclinics.

Acknowledgements

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- **Deborah Colvin** – General Practitioner, Hackney
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- **Nadeem Nayeem** – Consultant in Emergency Medicine, The Lewisham Hospital NHS Trust, and College of Emergency Medicine London Chair
- **Tom Coffey** – Clinical Director of the Healthcare for London polyclinics project and General Practitioner, Wandsworth.

This guidance has been informed by innovation and good practice already being exhibited across the NHS. We extend particular thanks to the commissioners and service providers of the following organisations who shared their experiences in commissioning and delivering urgent care services:

- Birmingham City Hospital Urgent Care Centre
- Dacorum Urgent Care Centre at Hemel Hempstead General Hospital
- Maidstone Hospital Emergency Care Centre
- Royal Sussex County Hospital Urgent Care Centre
- Whipps Cross Emergency and Urgent Care Centre
- William Harvey Hospital Accident and Emergency Department.

Glossary

For the purposes of this document, the following terminology is used.

The College of Emergency Medicine's advice is for all casualty or accident and emergency (A&E) departments to be called 'emergency departments'. However, for the purpose of this document, we use the terms to distinguish between the traditional model and proposed new model:

Accident and emergency department (A&E) – the traditional model where there is not an urgent care centre at the front of the emergency department.

Emergency department – the proposed new model where there is an urgent care centre at the front of the emergency department.

Advanced nurse practitioners (ANPs) – nurses with a Masters qualification or who are on a Masters pathway with competencies to prescribe independently and manage patients with more complex injuries or conditions than are managed by nurse practitioners.

Emergency care needs – serious and life-threatening unscheduled care needs.

Nurse practitioners (including both emergency nurse practitioners (ENPs) and primary care nurse practitioners) – nurses with the competencies to autonomously assess, treat and discharge patients without referring to any other clinician.

Polysystem – a clinically-led model of care involving all partners in the network and supported by a primary care-led polyclinic hub. Polysystems typically provide health and wellbeing services across populations of 50,000 to 80,000 people.

Polyclinic – the infrastructure required to support a polysystem.

Streaming – the decision to direct a patient for assessment and treatment by a particular service (for example, streaming patients to the urgent care centre or the emergency department) or by a particular clinician or pool of clinicians (for example, streaming patients to see a physiotherapist or one of a pool of ENPs).

Unscheduled care – any unplanned contact with the NHS by a person requiring or seeking help, care or advice. This demand can occur at any time and services must be available to meet it 24 hours a day. Unscheduled care includes urgent care and emergency care.

Urgent care needs – unscheduled care needs that are not serious or life-threatening but where patients perceive they require prompt help, care or advice.

Urgent care services – services provided to meet urgent care needs.

1 Introduction

Urgent care centres have the potential to significantly improve the way urgent care is provided and to enable greater integration of the wider unscheduled care system.

Urgent care centres at the front of emergency departments will be staffed by multidisciplinary teams that include GPs and nurse practitioners (including emergency nurse practitioners) who are able to access support and advice, when necessary, from consultants in emergency medicine.

The expected benefits of urgent care centres include:

- Providing, in their place of choice, a more focused and appropriate response to the needs of patients currently attending accident and emergency departments (A&Es) with minor illnesses and injuries that do not require intensive or specialised care.
- Greater integration between urgent care services delivered in hospitals and services delivered in the community – facilitated by the stronger links that primary care practitioners have with community services – enabling patients to be referred more rapidly and seamlessly to relevant pathways, and improving access to community-wide responses to people's care needs.
- Integrating provision of urgent and emergency care, based on clinical need, which makes best use of staff skills across the unscheduled care pathway (e.g. increasing access to GPs for patients with primary care needs and enabling emergency department practitioners to focus on patients with emergency care needs that require specialist care).
- Increasing the interdependency and mutual support of primary and secondary care practitioners, with a gradual transfer of skills, knowledge and shared competencies creating a more integrated and flexible workforce over time.
- Shorter waiting times for patients and fewer emergency admissions across the urgent care centre and emergency department through more appropriate matching of need, skills and expertise, and stronger integration.

In many areas of London and elsewhere across the country PCTs have commissioned, or are in the process of commissioning, urgent care centre-type service models at the front of hospital emergency departments.

A number of PCTs in London are also in the process of commissioning polyclinics on hospital sites that include a urgent care centres as part of their service model. Commissioning an urgent care centre as part of a hospital-based polyclinic is expected to deliver benefits in providing access to a broader range of primary care services, enabling collocation with community services and delivering economies of scale.

This guidance outlines our recommended service model for urgent care centres at the front end of hospital emergency departments. It aims to promote consistency in the way urgent care centres are commissioned in London and to help patients and staff understand the important role these centres play in developing a more integrated unscheduled care system across the capital.

The guidance draws on existing urgent care centre-type service models and service specifications that have been, or are currently being, used to commission urgent care centres. It also draws on existing good practice to describe how urgent care centres and emergency departments should interface with other services and references relevant existing guidance. It includes advice to PCTs on suggested procurement and contracting approaches and discusses the standards and performance measures that should be included in PCTs' commissioning arrangements with providers.

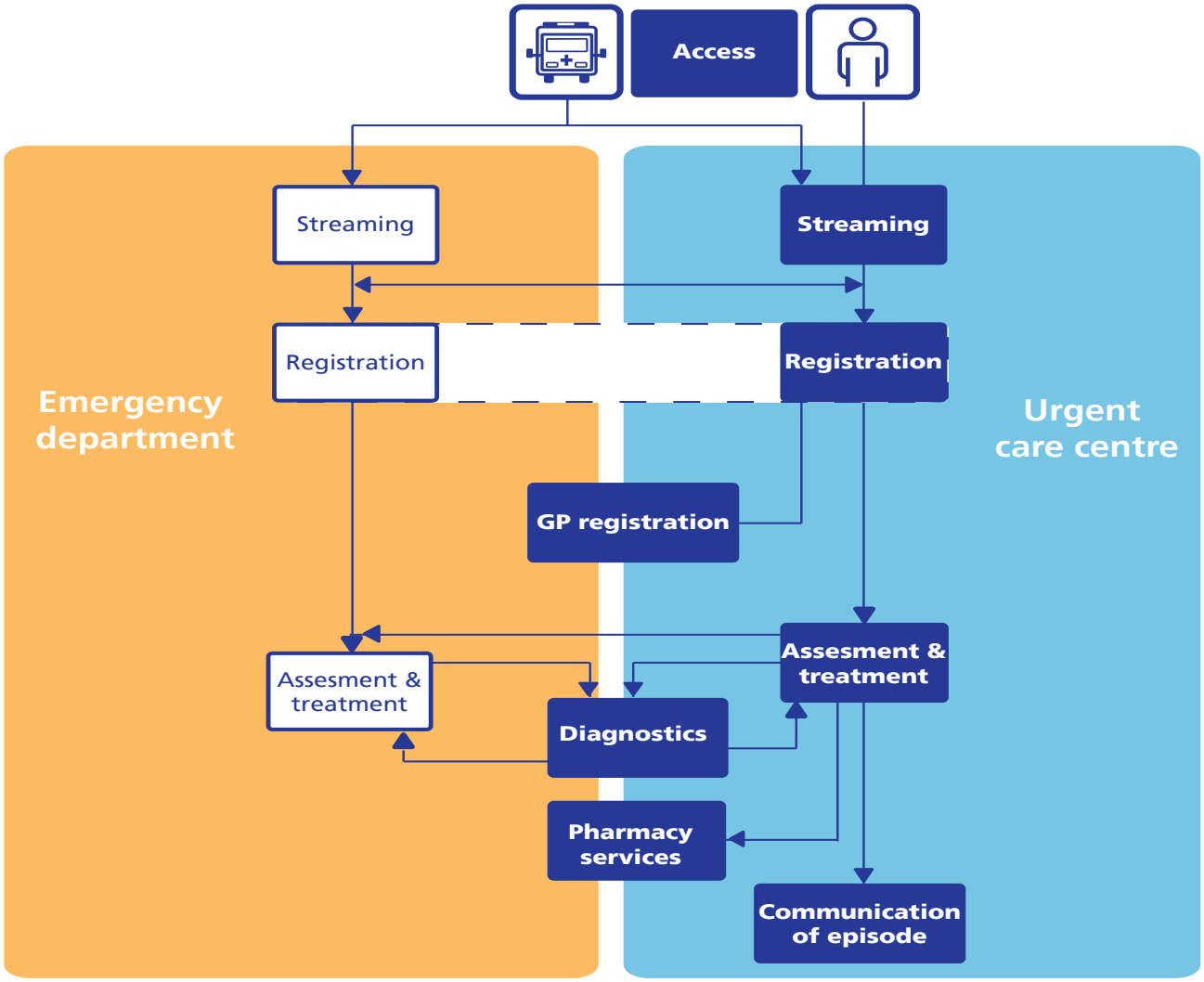
While this guidance is intended to inform development of service specifications for local urgent care centres, the specifications will need to be tailored to reflect local circumstances in terms of existing services and policies. We also expect that, informed by local patient needs, urgent care centres service providers will continue to work with commissioners and other service providers to further develop the urgent care centre service model as part of the broader unscheduled care system.

This guidance applies specifically to the service model for urgent care centres at the front end of emergency departments, which may be part of a hospital-based polyclinic.

We expect the principles underpinning this service model to apply equally to urgent care services delivered in community-based polyclinics or urgent care centres in local hospitals without emergency departments. However, commissioners will need to consider how the service model and standards need to be adjusted for urgent care services delivered in settings that are not collocated with emergency departments. For example, urgent care centres at the front of emergency departments will be open 24 hours a day. Urgent care services delivered in community polyclinics are likely to be open for 12 hours a day, subject to local need.

2 Overview of the service delivery

Illustration of the service model for urgent care centres at the front of emergency departments



Patient pathway

Patient's experience

- Treated with dignity and respect.
- Clean and pleasant environment, with well maintained, safe and hygienic facilities.
- Waiting and treatment areas similar to primary care provision – consultation, where appropriate, in GP-style consulting rooms and not cubicles.
- All staff communicate clearly and patients are supported to understand diagnosis and treatment.
- Patients informed about likely waiting times for assessment and treatment.
- Patients given clear understanding of the broader unscheduled care system and can make informed choices when accessing services in future.
- Appropriate policies and processes ensure safeguarding of children and vulnerable adults.

Access

- Respond to the urgent care needs of registered and non-registered patients 24 hours a day, seven days a week.
- Patients not re-directed to other services if their needs can be met in urgent care centres.

Streaming

- Commissioners agree with urgent care centre and emergency department providers the conditions for which patients should be streamed directly to emergency department upon arrival at an urgent care centre.
- Clinical assessment by trained clinician within 20 minutes of patient arriving to make or review streaming decision.
- Clinical decision within 60 minutes of patient arriving as to whether they will be treated and discharged in an urgent care centre or transferred to emergency department.
- London Ambulance Service staff assess whether patients are taken to urgent care centre or directly to emergency department.
- Emergency departments may also stream patients to an urgent care centre.

Registration

- Patients registered promptly on arrival at the urgent care centre.
- Urgent care centres and emergency departments may have a shared reception.
- Patient data is transferred when patients are transferred between urgent care centres and emergency departments.
- Patients only repeat registration and case history details for safety and clinical purposes.

GP registration

- Urgent care centres help non-registered patients register with a GP.

Assessment and treatment

- Urgent care centres provide timely access to appropriate clinical expertise, so the right response is provided first time, avoiding unnecessary tests and treatment.
- Urgent care centres staffed by multidisciplinary teams, including GPs and emergency nurse practitioners.
- Services provided to treat any illness or injury that does not require intensive or specialised care.
- Treatment includes health and wellbeing advice, and direction to local community services.
- Staff have competencies to assess paediatric, maternity and mental health care needs and refer to specialists.
- Protocols for staff to access specialist advice and support.

Diagnostics

- Urgent care centres have timely access to diagnostic tests and results.
- Staff have competencies to assess need for diagnostics and to interpret results.

Pharmacy services

- Patients have access to dispensing 24 hours a day, seven days a week.
- Patients pay for prescriptions, where prescription payments applicable.

Communication of episode of care

- Summary of episode of care communicated to patient's GP practice by 8am next working day.
- Patients provided with printed summary of episode of care.

Enablers

Information sharing and systems

- Commissioners and providers of urgent care services work collaboratively to ensure effective information sharing.
- Mechanisms established for urgent care centres to access existing patient records and care plans.
- Urgent care centre systems compliant with National Programme for IT and able to interface with the summary care record and London shared patient record.

Integration with other services

- Urgent care centres and emergency departments have joint clinical governance arrangements and consistent standards, ensuring seamless service for transferred patients.
- Arrangements in place to rotate urgent care centre, emergency department and polyclinic staff to transfer skills and knowledge, and enhance professional development. Commissioners ensure strong links between urgent care centres and other health/social care services as part of broader unscheduled care system. Potential forms of integration with other services include:
  - mechanisms to transfer skills and knowledge between urgent care centres and London Ambulance Service staff (e.g. staff placements)
  - collocation with out-of-hours service providers and reciprocal arrangements for advice and support
  - access to support for mental health assessments 24 hours a day, seven days a week
  - access to community nursing and integrated health and social care services to ensure appropriate care is delivered in community, avoiding hospital admissions wherever possible.

Standards and performance measures

- Urgent care centres comply with NHS standards (e.g. Standards for Better Health) and relevant health and safety regulations.
- National four hour A&E target applies to urgent care centres and for patients transferred between urgent care centres and emergency departments (the clock continues across the transfer).

Governance

- Robust clinical governance arrangements.
- Urgent care centres networked to an emergency department to provide professional support, clinical supervision and advice on clinical standards.

3 Patient pathway

In this section, we outline the recommended service delivery model for urgent care centres in terms of patients' overall experience, their access to these centres, and the pathway they follow in the delivery model.

This section provides recommended standards for patient experience, service provision and the competencies of staff working in the urgent care centre. It outlines the clinical principles that should underpin service delivery and, where appropriate, the clinical standards with which urgent care centres are expected to comply. Urgent care centres providers will need to work together with the emergency department and other specialist service providers to develop appropriate local policies and protocols to reflect these principles and standards.

Commissioners should require potential urgent care centre providers to demonstrate how they propose to deliver the service model. Commissioners will also need to engage and commission the emergency department and other specialist service providers to ensure they work with the urgent care centre as required.

3.1 Patient experience

We expect each urgent care centre to provide the following standard of patient experience:

- **Dignity and respect**
  We expect all patients and their carers to be treated as valued individuals with respect for their dignity and privacy, and for staff to be sensitive to the cultural needs of patients.
- **A clean and pleasant environment**
  We expect urgent care centres to deliver services in a clean and pleasant environment with well maintained facilities that are safe and hygienic for patients, carers and staff
- **Clear communications**
  We expect processes to be in place to ensure that all patients are able to communicate with urgent care centre staff and understand their diagnosis and treatment. Urgent care centres will provide non-English speaking patients with access to professional translation services and have arrangements in place to support people with particular needs, for example deaf patients, neck breathers and patients with learning disabilities.
- **A clear understanding of the broader unscheduled care system**
  We expect urgent care centres to ensure patients understand the role the centre plays in the broader integrated system for unscheduled care, so they can make informed choices about how they can access services in future.
- **Provision of estimated waiting times**
  We expect patients to be given an estimate of the likely waiting times for assessment and treatment on arrival at the urgent care centre and to be informed if there are any significant changes to this timeframe.
- **Patients' opinions will be valued**
  We expect urgent care centre staff to involve patients, including children and young people, and seek feedback on an ongoing basis with respect to patient experience and outcomes. We also expect the views of patients, to be monitored and for appropriate action to be taken based on their feedback. *A Guide to Patient and Public Involvement in Urgent Care*[2] provides guidance on mechanisms for using patient and public views to inform the development of service delivery.

[2] Department of Health (2008) *A Guide to Patient and Public Involvement in Urgent Care*

Waiting and treatment areas

We expect urgent care centre waiting and treatment areas to be similar in style to those provided in primary care.

We recommend that treatment be provided, where possible and clinically appropriate, in GP-style consulting rooms rather than the clinical cubicles traditionally used in A&E departments.

We also recommend that there are separate waiting areas for urgent care centres and emergency department patients, where possible.

Appropriate infection control measures must be in place. Urgent care centres must comply with *The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance*[3] and follow current guidance from the Department of Health and the National Institute for Health and Clinical Excellence.

Waiting and treatment areas for children and young people

We expect urgent care centres to comply with recommendations from the *Report of the Intercollegiate Committee for Services for Children in Emergency Departments*[4] with respect to child and family-friendly care. While the recommendations were designed to apply to the traditional A&E setting, we believe the following recommendations are equally applicable to the whole entity of a urgent care centre integrated with an emergency department:

- Urgent care centres and emergency departments must accommodate the needs of children and accompanying families as far as reasonably possible. Where it is not possible to have separate waiting areas for children and young people in both, the urgent care centre and emergency department may wish to consider having a common waiting area for children and accompanying families.
- As well as audio-visual separation from adults, consideration must be given to security issues, availability of food and drink, breast-feeding areas, and hygienic, safe play facilities.
- Teenagers should have access to age-appropriate entertainment.
- Across the urgent care centre and emergency department combined, there should be at least one child-friendly treatment room, clinical cubicle or trolley space for every 5,000 annual child attendances.
- Urgent care centres and emergency departments that jointly see more than 16,000 children per year should employ play specialists at peak times to work across both the urgent care centre and emergency department.
- Feedback should be sought from children and young people to improve services and facilities.

Safeguarding

We expect urgent care centres to have appropriate policies and processes in place to ensure the safeguarding of children and vulnerable adults, in compliance with national and local policies and statutory responsibilities.

[3] Department of Health (2009) *The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance*

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

3.2 Access

We expect urgent care centres to provide services to all patients – whether they are registered with a GP or not – who self-refer or are referred by other health professionals. Urgent care centres should be able to provide a consistent response 24 hours a day, seven days a week to the primary care needs of patients who are unable to access their local healthcare provider. For example, when working away from home.

We expect urgent care centre teams to have the expertise to support vulnerable adults and people with special needs.

While we expect urgent care centres to provide patients with up to date and clear information about the services available in the community to deal with their ongoing needs, patients should not be redirected to alternative services to address their immediate needs, if they can be assessed and treated in the centre.

We expect commissioners and providers to have communications plans in place to promote access to the urgent care centre as part of the broader unscheduled care system.

3.3 Streaming

Shortly after arriving at the urgent care centre, patients should be streamed either to wait and be seen by an appropriate clinician in the centre, or be transferred to the emergency department. The appropriate streaming model will need to be adapted locally, however we expect all models to comply with the following principles:

- Commissioners, informed by the clinical competencies of the urgent care centre staff, will need to agree with the providers of the urgent care centre and the emergency department the circumstances in which patients will be streamed directly to the emergency department upon arrival at the centre.
- A clinical assessment by an appropriately trained clinician needs to occur within 20 minutes (15 minutes for children) of the patient arriving to inform or review the streaming decision. These timeframes are consistent with the *National Quality Requirements in the Delivery of Out-Of-Hours Services*[5] for adults and the recommendations made in the *Report of the Intercollegiate Committee for Services for Children in Emergency Departments*[6].
- Within a maximum of 60 minutes of the patient arriving at the urgent care centre, a clinical decision needs to be made as to whether the patient will be treated in the centre and discharged, or whether they need to be transferred to the emergency department. This standard should ensure that, where patients are transferred, the emergency department is still able to meet the national four hour A&E target (for the time from the patient's arrival at the centre to treatment and discharge or admission).

[5] Department of Health (2006) *National Quality Requirements in the Delivery of Out-of-Hours Services*
[6] Royal College of Paediatrics and Child Health (2007) *Services for Children in Emergency Departments: Report of the Intercollegiate Committee for Services for Children in Emergency Departments*

Various streaming models are currently being used in urgent care centres. These include:

- Streaming by a clinician who may also assess, treat and discharge the patient depending on the complexity of the patient's condition and whether any other patients are waiting to be streamed.
- Streaming by a 'navigator' clinician as soon as possible after the patient arrives. In this scenario the navigator clinician, who is also one of a pool of clinicians treating and discharging patients that have already been streamed, streams new arrivals to the urgent care centre but does not routinely treat and discharge the patient at the point of steaming.
- Streaming by an appropriately trained member of staff using a clinical decision support tool, with patients being streamed directly to an appropriate clinician who is expected to assess, treat and discharge the patient.

Whatever streaming model is used locally, the model needs to comply with the principles outlined above and ensure patients are immediately transferred to the emergency department on arrival at the urgent care centre, where necessary. Protocols also need to be in place to ensure patients are accompanied when transferred from the centre to the emergency department, where appropriate.

The streaming decision for each patient needs to reflect the competencies of the staff working in the urgent care centre. Individual patients may be streamed to be assessed and treated by one of a pool of clinicians or by an individual clinician, dependent on the competencies of the individual staff. For example, where a physiotherapist is part of the urgent care centre team, it may be most appropriate for patients with specific conditions to be streamed to that practitioner.

While it may be more efficient to stream patients to one type of practitioner rather than another, we do not expect GPs, nurses and medical staff to be exclusive in only assessing and treating patients with minor illness or only assessing and treating patients with minor injury. Where no other patients are waiting we would, for example, expect GPs to treat patients with minor injuries – seeking support and advice from colleagues where necessary.

Streaming by the ambulance service

While there may be physical constraints in terms of ambulances being able to access urgent care centres, we recommend commissioners and providers explore the opportunity for the ambulance service to stream appropriate patients directly to the urgent care centre. Where streaming protocols are established, they need to consider how urgent care centres prioritise the clinical handover of patients from the ambulance service so that turnaround times for ambulances are minimised.

Streaming by the emergency department

Where a patient has been taken directly to the emergency department by the ambulance service, we expect arrangements to be in place to enable the emergency department to transfer appropriate patients to the urgent care centre.

Case study: Whipps Cross Emergency and Urgent Care Centre and the London Ambulance Service

Using a separate parking bay and entrance to those used for the emergency department, Whipps Cross Emergency and Urgent Care Centre and the London Ambulance Service have an agreed referral protocol whereby patients with particular conditions are taken to the urgent care centre rather than the emergency department. The referral protocol is available on the Healthcare for London website.

3.4 Registration

In many existing urgent care centre service models there is a shared reception that registers patients who present to the centre and patients streamed by the centre to the emergency department or brought to the emergency department directly by ambulance. There are efficiency gains from the urgent care centre and emergency department sharing a reception, however it may not always be feasible because of local estates issues or because of the specific local service model that is used. For example, where a urgent care centre is part of a polyclinic on a hospital site.

Systems need to be established to ensure patients are only required to repeat their registration and case history details for safety and clinical purposes, and not because data cannot be transferred between the urgent care centre and emergency department.

3.5 GP registration

On average across London around four per cent of A&E attendees are not registered with a GP, with this figure being as high as 14% in some London A&Es[7].

Where a patient who presents to a urgent care centre is not currently registered with a GP, we expect centre staff to provide patients with guidance and support on their entitlements and how to register with a local GP.

Case study: Primary care advisers at Charing Cross A&E

Two primary care advisers work at Charing Cross A&E department between 8am and 8pm Monday to Friday. Their roles include helping non-registered patients to register with GP practices. They help patients complete registration forms, conduct initial health checks, and provide advice on accessing appropriate healthcare services in the community. The primary care advisers also help patients who have been admitted to wards to register with GP practices. In 2008/09 between 60 and 160 patients a month were supported in registering with a GP practice through the scheme.

Around half of all local GP practices have agreed for patients to be able to register with them through the scheme. Where the patient's nearest GP practice is not part of the scheme, the patient is given the option of contacting that GP practice directly or registering with a GP practice that is part of the scheme. Where patients are not eligible to register with a GP practice, they are offered information about accessing private healthcare.

[7] 2008/09 Secondary User Services data

3.6 Assessment and treatment

Urgent care centres must provide timely access to appropriate clinical expertise so the right response is provided to each patient's needs, the first time around.

Urgent care centres are expected to be able to assess and treat any illness or injury that does not require intensive or specialised care. The services provided by urgent care centres should include wound closure, plaster application and canulation.

We expect treatment to include health and wellbeing advice and, where appropriate, for patients to be directed to services delivered in the community to which they can self-refer (for example, smoking cessation services). Commissioners and providers need to ensure urgent care centre staff can access and use up to date information on the services available in the community.

Staffing models

The workforce implications of the new delivery model for unscheduled care are being assessed by NHS London as part of the overall workforce strategy for London. This work is likely to involve considering and producing transitional and sustainable models of staffing for urgent care centres, exploring supply and succession planning requirements, and competency acquisition.

The appropriate staffing model for each urgent care centre will be shaped by the clinical needs of the patients who attend that particular centre and the competencies of individual staff members. Providers are expected to demonstrate how their urgent care centre team's competencies meet the needs of the expected clinical caseload.

We expect all urgent care centre teams to include GPs and emergency nurse practitioners. While this is not an exhaustive list, multidisciplinary teams might also include:

- medical staff in training
- primary care nurse practitioners
- advanced nurse practitioners
- nurses
- emergency care practitioners
- physiotherapists
- pharmacists
- healthcare assistants.

We also expect urgent care centres to have arrangements in place for staff to access support and advice from consultants in emergency medicine without requiring patients to be transferred to the emergency department.

GPs working in urgent care centres should continue to work in general practice and demonstrate a commitment to their continuing professional development in urgent care. We also recommend that, where feasible, emergency nurse practitioners working in urgent care centres continue to also work in emergency departments, and primary care nurse practitioners working in urgent care centres also continue to work in primary care settings.

Clinical competencies

All staff working in urgent care centres must be competent in the basic skills required for safe practice as a first responder in caring for the acutely ill. These competencies include providing immediate life support, paediatric life support and primary survey assessment. Further guidance on the competencies expected of all staff working in facilities providing unscheduled

8 The College of Emergency Medicine, Emergency Nurse Consultant Association and Faculty of Emergency Nursing (2009) Unscheduled care facilities
9 Department of Health (2009) Guidance and competencies for the provision of services using practitioners with special interests (PwSIs) – Urgent and Emergency Care
10 Department of Health (2007) Competence and Curriculum Framework for the Emergency Care Practitioner
11 Royal College of Nursing (2008) Advanced nurse practitioners – an RCN guide to the advanced nurse practitioner role, competencies and programme accreditation
12 Nursing and Midwifery Council (2007) The Code: Standards of conduct, performance and ethics for nurses and midwives

care is available in the *Unscheduled care facilities*[8] guidance produced by the College of Emergency Medicine and the Emergency Nurse Consultant Association.

Appropriate competency frameworks should be used for staff development and training, but they are not minimum requirements for staff being employed in urgent care centre teams. Relevant competency frameworks include:

- *Guidance and competencies for the provision of services using practitioners with special interests (PwSIs) – Urgent and Emergency Care*[9]
- *Competence and Curriculum Framework for the Emergency Care Practitioner*[10]
- *Advanced nurse practitioners – an RCN guide to the advanced nurse practitioner role, competencies and programme accreditation*[11].

We expect all practitioners working in urgent care centres to adhere to the principle of the Nursing and Midwifery Council's code[12], which states: 'If an area of practice is beyond your level of competence or outside your area of registration, you must obtain help and supervision from a competent practitioner until you and your employer consider that you have acquired the requisite knowledge and skill.'

Clinical supervision and training

Urgent care centres need to ensure all staff have access to appropriate clinical supervision for training purposes.

We also expect arrangements to be established to enable staff to be rotated between emergency departments, urgent care centres and polyclinics to facilitate the transfer of skills and knowledge, and to promote professional development. Appropriate reciprocal agreements should be in place to ensure clinical supervision is provided for training purposes where staffing rotations are established. We expect urgent care networks to play a key role in facilitating staffing rotations across different urgent care service settings.

Paediatric care

Commissioners need to engage with the emergency department and paediatric department to agree how the urgent care centre will work with these departments to deliver care for children and young people that complies with the *National Service Framework for Children, Young People and Maternity Services*[13].

The arrangements need to take into account paediatric provision in the hospital and any proposals to reconfigure paediatric inpatient services in the future. Where commissioners are considering the reconfiguration of paediatric inpatient services, reference should be made to the Royal College of Paediatrics and Child Health's guidance *Supporting Paediatric Reconfiguration – A Framework for Standards*[14], which outlines the standards of care expected for general acute paediatrics including emergency departments no longer collocated with inpatient paediatric departments.

Informed by the competencies of the urgent care centre staff, commissioners and providers need to agree the circumstances in which children should be assessed and treated in the centre, and when children should be transferred to the emergency department.

We expect the majority of children attending urgent care centres with minor illness and minor injuries will be assessed and treated by the GPs and nurses in the urgent care centre teams.

Arrangements for paediatric care must comply with recommendations in *Services for Children in Emergency Departments*[15]. These recommendations were designed to apply to

[13] Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services*
[14] Royal College of Paediatrics and Child Health (2008) *Supporting Paediatric Reconfiguration – A Framework for Standards*
[15] Royal College of Paediatrics and Child Health (2007) *Services for Children in Emergency Departments: Report of the Intercollegiate Committee for Services for Children in Emergency Departments*

the traditional A&E setting; however our view is that they are equally applicable to the whole entity of a urgent care centre integrated with an emergency department (although not necessarily to the centre and the emergency department individually). The specific recommendations applying to urgent care centres, including the expected competencies of staff and arrangements for safeguarding children, are available at appendix A.

We recommend that, as part of their continuing professional development, urgent care centre staff assessing and treating children undertake the *Child in Mind*[16] training on children's mental health developed by the Royal College of Paediatrics and Child Health.

Urgent care centres must comply with the requirements of their local safeguarding children board and the *London Child Protection Procedures*[17] and ensure staff are appropriately trained and supervised.

Examples of innovative practice in the area of urgent and emergency care for children and young people are available in the NHS Institute for Innovation and Improvement report *Focus on: emergency and urgent care pathway for children and young people*[18].

Maternity care

Commissioners need to engage with the local maternity team and the emergency department to agree how the urgent care centre will deliver services to pregnant women. The urgent care centre should deliver the services required of all access points for maternity care outlined in *Maternity Matters*[19]. The centre should also comply with the recommendations of the Confidential Enquiry into Maternal and Child Health's *Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003-2005* report[20].

Local arrangements will be influenced by the configuration of local maternity services, the competencies of urgent care centre staff and the diagnostic facilities available. Urgent care centre staff should be able to access specialist consultant advice to help assess pregnant and postpartum women.

Local protocols should be established to cover the following:

- Where women presenting with pregnancy-related conditions requiring specialist input should be directed or transferred. Local maternity teams should be able to advise where women should be directed depending on the gestation period of the pregnancy.
- The appropriate response for women who present with otherwise unexplained symptoms that may be pregnancy-related, such as abdominal pain, severe headaches, hypertension or breathlessness.
- How urgent care centre staff can access support and advice from local maternity teams to inform the treatment of pregnant women with conditions that are not directly pregnancy-related.

[16] Royal College of Paediatrics and Child Health (2009) *'Child in Mind' Workshops*
[17] Local Safeguarding Children Board (2008) *London Child Protection Procedures*
[18] NHS Institute for Innovation and Improvement (2008) *Focus on: emergency and urgent care pathway for children and young people*
[19] Department of Health (2007) *Maternity Matters: Choice, access and continuity of care in a safe service*
[20] CEMACH (2007) *Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003-2005*

Streaming protocols with the ambulance service also need to consider the circumstances under which pregnant women should be brought to the urgent care care and when they should be streamed elsewhere.

We expect that all urgent care centre practitioners who may assess and treat pregnant and postpartum women to be able to recognise symptoms that require emergency hospital admission, including atypical presentations of ectopic pregnancy. Further guidance on recognising serious illness and 'red flag' symptoms in pregnant and postpartum women that may require emergency hospital admission is provided at appendix B.

A pregnancy test should be routinely conducted for women of childbearing age that present to the urgent care centre with a potential pregnancy-related condition, such as unexplained abdominal pain.

Urgent care centres should also follow good practice in recording the episode of care at the urgent care centre in the woman's maternity record and informing the woman's midwife or obstetrician, as appropriate.

We expect urgent care centres to comply with local protocols for confirming that pregnant women are booked with maternity services and attending appointments. We also expect urgent care centres to comply with local protocols for safeguarding vulnerable adults with respect to pregnant and postpartum women.

Future arrangements for how urgent care centres deliver services to pregnant women and work together with maternity services will be shaped by the maternity pathway currently being developed by Healthcare for London.

Mental health care

Commissioners need to work with the emergency department and mental health service providers to agree the circumstances under which patients with mental health needs should be streamed to emergency departments. We expect patients who present with acute self-harm to be streamed directly to the emergency department.

All urgent care centre staff should receive training in appropriately managing people with mental health problems.

Case study: Accessing crisis care plans at Guy's and St Thomas' A&E

In Guy's and St Thomas' Hospital, the A&E department staff are able to access crisis care plans for patients through the psychiatric liaison nurse who is based in the department and has access to the South London and Maudsley Trust's information system on site.

On average there are nine referrals a day from A&E to the liaison psychiatry team, who then establish whether a crisis care plan is in place for the patient and provide the A&E staff with appropriate advice on how to manage the patient.

We expect urgent care centre teams to have the competencies to make initial assessments of patients' mental health and make appropriate referrals to specialist services where necessary. Protocols must be in place so that, wherever possible, urgent care centre staff are able to access patients' crisis care plans to ensure the most appropriate response is made to a patient's needs.

At all times, urgent care centre teams should include staff who can demonstrate the following competencies:

- assessing the legal capacity of patients to consent
- managing uncooperative patients with mental health problems
- assessing and managing imminent violence
- recognising the symptoms of depression and anxiety
- assessing the suicidal patient
- assessing and advising survivors of domestic violence
- understanding the child protection aspects of working with adults with mental health problems.

Providers need to demonstrate how they will ensure staff have the appropriate mental health competencies. Commissioners need to consider their role in engaging with local mental health trusts to help facilitate providers of urgent care centres in accessing appropriate training.

Checklist: Improving the management of patients with mental ill health in emergency care settings[21] provides advice and examples of good practice in treating patients with mental health needs.

Further guidance on how urgent care centres should work with mental health services is provided in section 5.3.

Substance misuse care

At all times, urgent care centre teams should include staff who can demonstrate competencies in assessing substance dependence and substance-related problems (for example, using the AUDIT questionnaire)[22].

Commissioners also need to consider whether they wish urgent care centre staff to deliver brief interventions for substance dependence (see section 5.4), as informed by the needs of the patients who attend the urgent care centre.

3.7 Diagnostics

We expect urgent care centre teams to have the competencies to assess the need for, and order, diagnostics and interpret results.

Urgent care centres must have arrangements in place to guarantee timely access to appropriate diagnostic services (including radiology, blood tests, electrocardiographs, histology and microbiology) to ensure patients are not streamed to emergency departments simply to have a diagnostic test conducted.

Urgent care centres should also have processes in place to ensure patients are contacted as appropriate when results of diagnostics (such as microbiology and histology) are only available after they have been discharged from the urgent care centre.

3.8 Pharmacy services

Commissioners need their PCT chief pharmacist to work with the acute trust chief pharmacist to consider how urgent care centres access the full range of pharmacy services. These include dispensing, provision of over the counter non-prescription medicines, advice on self-care, medication reviews and access to pharmacy minor ailments schemes. Further guidance can be found in the *Commissioning pharmacy services for polyclinics in London* toolkit[23] and the Department of Health guidance *World class commissioning: Improving Pharmaceutical Services*[24].

[21] Department of Health (2004) *Checklist: Improving the management of patients with mental ill health in emergency care settings*
[22] World Health Organisation (2001) *The Alcohol Use Disorders Identification Test*
[23] Healthcare for London (2008) *Commissioning pharmacy services for polyclinics in London*
[24] Department of Health and NHS Primary Care Contracting (2009) *World class commissioning: Improving Pharmaceutical Services*
[25] Medicines Management Network North West (2007) *Delivering urgent access to medicines outside 'normal' hours – Notes for Commissioners and Providers*
[26] NHS Medicines Management (2008) *Medicines in Unplanned Care Toolkit*

Commissioners and providers should ensure the urgent care centre complies with the recommendation made in the Carson review: that all providers of out-of-hours services ensure that, where an individual needs to start a course of medicine without delay (for pain relief or because delay would compromise their care), they should receive the full course of the relevant medicine at the same time and at the same place as the consultation. Further guidance and examples of good practice can be found in *Delivering urgent access to medicines outside 'normal' hours*[25] and the *Medicines in Unplanned Care Toolkit*[26].

Commissioners may wish to explore with acute trusts the possibility of hospital pharmacies dispensing urgent care centre prescriptions. Hospital pharmacies must obtain an NHS contract to dispense FP10 primary care prescriptions. They would also need to establish parallel purchasing arrangements for drugs supplied to fulfil primary care prescriptions that are priced differently to secondary care prescriptions.

Where the urgent care centre is part of a hospital-based polyclinic, commissioners might wish to consider whether a pharmacy should be commissioned as part of the polyclinic service model.

To ensure consistency with urgent care services delivered in polyclinics, urgent care centre patients should pay for their prescriptions where prescription payments are applicable.

Dispensing arrangements should be consistent, irrespective of the practitioner seen in the urgent care centre. It is not appropriate for patients who have seen an emergency nurse practitioner to be able to collect medicines from the hospital pharmacy while patients who have seen a GP have to go to a community pharmacy. Providers may wish to use independent nurse prescribers and patient group directions to support their prescribing arrangements.

We expect urgent care centres to comply with current national requirements from the Care Quality Commission for safe and secure handling of controlled drugs and medicines.

3.9 Communication of episode

We expect urgent care centres to ensure a summary of the episode of care is communicated to the patient's GP practice by 8am the next working day. This is consistent with the *National Quality Requirements in the Delivery of Out-of-Hours Services*[27].

The summary of the episode of care should include:

- the patient's demographic details and NHS number
- the patient's presenting condition and diagnosis
- details of any diagnostics conducted and, where possible, their results
- any treatment provided and medications prescribed
- details of any referral made to specialist services to address the patient's immediate needs
- any recommendations made to the patient for services to which they might self-refer
- any recommendations about appropriate services (including social care services) that the GP might wish to refer the patient for their ongoing needs.

We also expect patients to be provided with a printed summary of their episode of care that summarises their presenting condition, diagnosis and the treatment that was provided. Patients should also be given appropriate printed materials relating to their specific condition. Leaflets for most common conditions can be accessed at the Patient UK website[28].

[27] Department of Health (2006) *National Quality Requirements in the Delivery of Out-of-Hours Services*
[28] Patient UK website, www.patient.co.uk

4 Information sharing and systems

In this section, we describe our recommendations for urgent care centres with regards to information sharing and information systems.

Commissioners and providers of urgent care services are expected to work collaboratively to ensure that information is shared effectively. Urgent care centre providers are expected to demonstrate a commitment to supporting improved information sharing.

4.1 Access to patient records and care plans

Commissioners and urgent care centre providers should explore mechanisms for enabling urgent care centres access to relevant clinical information for patients who present at the centre. Potential opportunities commissioners and providers should investigate include:

- Accessing patient records in GP systems directly – other healthcare professionals with appropriate permissions are now able to access patient records in some GP systems.
- GPs providing urgent care centres with advanced care plans for specific patients who may present to the centre.
- Ensuring polyclinics that do not provide urgent care services 24 hours a day, seven days a week notify their local urgent care centres about patients who may present overnight and their clinical issues.

4.2 Information sharing with the emergency department

Where the urgent care centre and emergency department are not using the same information systems, processes need to be established to enable patient data to be transferred between the systems, ensuring continuity of care between the two settings. This data needs to include the patient's arrival time at the urgent care centre or emergency department to allow the national four hour target to be measured.

To facilitate information sharing, commissioners and providers should also work together to ensure consistent formats and terminology are used for any manual notes and records across the urgent care centre and emergency department.

[29] NHS Data Dictionary website http://www.datadictionary.nhs.uk

4.3 Information systems

We expect commissioners to specify the minimum data set they expect urgent care centre providers to collect and to specify any requirements for the data set being submitted to the PCT. PCTs may wish to use the existing NHS Data Model and Dictionary Service's accident and emergency commissioning data set[29]. The urgent care centres' information systems must be able to support the reporting requirements specified by commissioners.

The urgent care centre information system needs to be compliant with National Programme for IT standards and protocols.

The system should be able to interface with the summary care record (SCR) and London shared patient record (SPR). This means it needs to:

- provide a viewer to access the SCR and SPR
- support the SCR and SPR message sets and use common data sets and forms
- comply with relevant coding systems (SNOM emergency department and HL7)
- provide a means of supporting patient journey workflows
- comply with relevant information management governance rules.

Urgent care centre providers should work with the providers of information systems to develop the most appropriate option for the centre's information system. Some of the options and issues to consider include:

- Using the existing information system used by the emergency department. This option facilitates the transfer of patient data between the urgent care centre and emergency department; however, consideration needs to given to how the system can be developed to enable urgent care centre and emergency department patients to be managed separately operationally and for separate activity, performance and management information reports to be generated.
- Using the existing out-of-hours services system. A number of urgent care centres are currently doing this. At present, where patients are transferred between the urgent care centre and the emergency department, reception staff re-enter patient data on the emergency department information system. Information system providers are exploring how out-of-hours service systems and emergency department systems can be linked to enable patient data to be transferred automatically to avoid this duplication of effort.
- Using the community health system. Commissioners and providers may wish to use the community health system for their urgent care centre where it can be developed to support unscheduled care appointments, particularly where a urgent care centre is part of a hospital-based polyclinic.

5 Integration with other services

Urgent care centres, as part of a wider unscheduled care system, are expected to develop strong links with other health and social care services. In this section, we describe how urgent care centres may work together with other services.

Commissioners need to consider how they engage and commission service providers to work with urgent care centres in an integrated way and liaise with existing providers to develop their local urgent care centre service model.

Urgent care centre providers are expected to demonstrate their commitment to working with other relevant health and social care providers to further integrate unscheduled care services. Appropriate policies and protocols need to be developed locally by urgent care centre providers and providers of services with which the urgent care centre interfaces.

Urgent care networks are also considered in this section.

5.1 London Ambulance Service

Commissioners and providers of urgent care centres should work with London Ambulance Service to explore opportunities to transfer skills and knowledge between urgent care centre and London Ambulance Service practitioners. This might include placements for London Ambulance Service emergency care practitioners in the urgent care centre, joint training for staff and, where feasible, London Ambulance Service using urgent care centres as a base. Urgent care centres and London Ambulance Service may wish to establish arrangements where it provides placement emergency care practitioners in urgent care centres at no cost, in return for clinical supervision and staff development.

Agreements currently exist between the London Ambulance Service and a number of walk-in centres to provide placements for London Ambulance Service emergency care practitioners. These placements develop the skills and knowledge of both London Ambulance Service and walk-in centre staff, and enable practitioners to develop local networks for accessing support and advice.

Developing the skills and competencies of London Ambulance Service staff enables more patients to be treated at the scene by the service. Along with developing robust pathways for London Ambulance Service to stream patients to community urgent care provision, this is expected to reduce the number of patients being unnecessarily brought to hospitals for assessment and treatment.

Case study: London Ambulance Service placements at Barnet and Teddington walk-in centres

The London Ambulance Service and walk-in centres in Barnet and Teddington have service level agreements that provide a rotating placement for London Ambulance Service emergency care practitioners, which equates to one full-time equivalent.

A copy of the service level agreement for the Barnet walk-in centre can be found on the Healthcare for London website.

5.2 Out-of-hours service providers

In a number of existing urgent care centre-type service models, the primary care out-of-hours service is collocated with the urgent care centre. This arrangement can help reduce waiting times for patients and provide clinical support for both urgent care centre and out-of-hours staff, where reciprocal agreements are in place for the two teams to provide clinical advice and support to each other, and to pick up each other's caseload when either team has no waiting patients. Commissioners and providers will need to consider the implications of such arrangements on their information systems and payment mechanisms. PCTs may also wish to consider commissioning their out-of-hours service and urgent care centre provision from a single provider.

5.3 Mental health services

Commissioners need to consider how urgent care centres will interface with mental health services, including acute psychiatric liaison services. The Academy of Medical Royal Colleges provides guidance for this in its report *Managing Urgent Mental Health Needs in the Acute Trust*[30].

A liaison mental health team that is based in the acute trust, works in partnership with community crisis teams, and is available 24 hours a day, seven days a week is recommended good practice. There should be a dedicated approved mental health worker with responsibility for mental health services provided to the emergency department. For children and young people, recommended good practice is for a child and adolescent mental health service (CAMHS) liaison team to be available for working-hour referrals and for a rota of suitably trained CAMHS professionals to be on-call at all other times.

Commissioners will need to work with urgent care centre, emergency department and liaison psychiatry service providers to ensure urgent care centres can access appropriate support from the liaison psychiatry service. While we expect that on site psychiatric liaison practitioners will be based in the emergency department (where they are required to support any ambulance-delivered self-harm patients and police presentations), we expect them to be available to provide support to the urgent care centre.

Where on site psychiatric liaison support is not in place 24 hours a day, seven days a week, commissioners need to establish arrangements that, at the very least, ensure the maximum response times recommended by the Royal College of Psychiatrists and the College of Emergency Medicine are met for mental health services being provided to emergency departments. In urban areas these maximum response times are 30 minutes from being called for a first line attendance and 60 minutes from being called for a section 12 – approved doctor attendance. The same response times should apply to urgent care centres.

We expect mental health assessments to be conducted at the urgent care centre by local mental health service providers regardless of the patient's home address and for appropriate protocols to be followed for mental health admissions.

Where urgent care services are delivered through polyclinics that are not based on hospital sites, community mental health teams should be responsible for mental health support.

[30] Academy of Medical Royal Colleges (2008) *Managing Urgent Mental Health Needs in the Acute Trust*

5.4 Substance misuse services

Commissioners need to consider how the urgent care centre most effectively interfaces with substance misuse services. The Academy of Medical Royal Colleges report *Managing Urgent Mental Health Needs in the Acute Trust*[31] recommends same day or next day brief intervention services are established for patients attending A&E departments with alcohol-related needs.

Case study: Substance misuse services at St Mary's A&E

St Mary's Hospital employs a full-time clinical nurse specialist (alcohol). A&E staff use the one-minute Paddington alcohol test to identify patients to be referred to the alcohol health worker for a brief intervention.

Between 10 and 20 referrals are made each week, with most of the interventions being delivered on the same day as the referral or the following day. A randomised controlled trial and economic evaluation[32] demonstrated that the brief interventions both reduce alcohol consumption and reduce re-attendance rates at the A&E department.

5.5 Community nursing and integrated health and social care services

We expect PCTs to consider how urgent care centres should interface with community nursing services and to liaise with local authorities to consider how urgent care centres interface with integrated health and social care services. We expect PCTs and local authorities to establish pathways that enable appropriate care to be delivered to patients in the community, avoiding unnecessary hospital admissions.

Commissioners and urgent care centre providers need to ensure urgent care centre staff can access up to date information on the services available in the community (including their operating hours) and that clear referral pathways are in place.

Commissioners also need to consider how urgent care centres interface with existing rapid response services and intermediate care services based in the community and in the acute trust. Ideally, urgent care centres should be able to refer patients for rapid delivery of an enhanced package of community support 24 hours a day, seven days a week, where this may avoid an admission to hospital.

Urgent care centres should be able to refer patients directly to services provided in the community, such as community matrons, to support chronic disease management.

We expect PCTs to commission services to enable older people (including residents of nursing homes, care homes and specialist supported accommodation) to access specialist assessment in the community in order to prevent unnecessary presentations at urgent care centres and emergency departments. PCTs should also commission services to support end of life care outside of hospitals to prevent patients presenting to urgent care centres and emergency departments when care is more appropriately delivered in the community.

[31] Academy of Medical Royal Colleges (2008) *Managing Urgent Mental Health Needs in the Acute Trust*
[32] Crawford, Patton, Touquet et al. (2004) *Reducing alcohol misuse in patients attending an accident and emergency department: a randomised controlled trial and economic evaluation*

Case study: Multidisciplinary team working at Lewisham A&E

In Lewisham, social workers and district nurses in the A&E department support patients being discharged by arranging transport, equipment and care packages in the home where appropriate. Patients who frequently attend the A&E department are also identified and participate in a review with multidisciplinary teams to develop personalised support packages aimed at reducing unnecessary attendances at A&E. The multidisciplinary team may include a GP, the complex discharge coordinator, the intermediate care service manager, a community matron, and practitioners from the acute trust or community who know the patient.

5.6 Role of urgent care networks

Urgent care networks will play a key role in implementing the new delivery model for unscheduled care across London. 'Networks' in this respect refers to the mechanisms established by commissioners to review the performance of the overall unscheduled care system and to facilitate service improvement, as opposed to managed networks of clinicians.

The membership and terms of reference of local urgent care networks vary. In some cases providers are actual members of the networks and in others they are engaged as needed to support the development of an integrated unscheduled care system. As a minimum, we would expect providers to attend urgent care network meetings periodically to help develop the overall unscheduled care system and explore opportunities to improve integration between service providers.

As part of commissioning arrangements, PCTs need to ensure urgent care centre providers participate in urgent care networks. We envisage urgent care networks to be the mechanism for emergency departments, urgent care centres, polyclinics and other health and social service providers to agree collaborative and reciprocal arrangements for delivering unscheduled care services in an integrated way. This may include:

- facilitating staffing rotations and placements
- providing professional support and clinical supervision
- agreeing consistent standards
- developing inter-provider processes and protocols.

Some examples of good practice in urgent care networks can be found in the reports *A preliminary study of Emergency and Urgent Care Networks*[33] and *Emergency and urgent care system – Final Interim Report of phase 2006-2008*[34], based on a study commissioned by Department of Health and conducted by the University of Sheffield.

[33] The University of Sheffield (2008) *A preliminary study of Emergency and Urgent Care Networks*
[34] The University of Sheffield (2009) *Emergency and urgent care system – Final Interim Report of phase 2006-2008*

6 Standards and performance measures

In this section, we outline the standards and performance measures that we recommend commissioners apply to urgent care centres.

The performance measures should be informed by the set of outcome measures being developed by Healthcare for London for the unscheduled care system as a whole.

We also expect the performance measures commissioners require urgent care centres to report on reflect local priorities and needs.

6.1 Standards and performance measures

We expect urgent care centres to comply with NHS standards, such as the *Standards for Better Health*[35], that describe the level of quality all NHS service providers are expected to meet in terms of safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, and public health. We also expect urgent care centres to comply with the relevant health and safety regulations that apply to all NHS providers in terms of estate, facilities and clinical procedures (including diagnostics).

Outlined in this section are the specific standards that we expect urgent care centres to achieve, along with performance measures we suggest PCTs use. The specific performance measures that PCTs require urgent care centres to report on should be informed by the outcome measures and metrics that are being used locally to assess the overall performance of the unscheduled care system.

National four hour A&E target

We expect urgent care centres integrated with emergency departments to meet the Department of Health performance target to have at least 98% of patients attending an A&E department seen, treated and admitted or discharged in under four hours.

The clock will start when the patient arrives at the urgent care centre or emergency department and will continue if the patient is transferred between the urgent care centre and emergency department. We expect the joint performance of the urgent care centre and emergency department against this performance target to be reported in performance indicators for the acute trust. The PCT should hold the urgent care centre or emergency department accountable for any breaches of the target, depending on the cause of that breach.

Where urgent care services are being delivered through community-based polyclinics or urgent care centres in local hospitals without emergency departments, we do not expect the clock to continue when patients are transferred to emergency departments, but for the clock to re-start on arrival at the emergency department. This scenario is similar to a patient being referred to the emergency department after a consultation at their local GP practice.

[35] Department of Health (2006) *Standard for Better Health*

Time to clinical assessment

We expect a clinical assessment by an appropriately trained clinician to occur within 20 minutes (15 minutes for children) of the patient arriving. This assessment will be used either to make or review the streaming decision. The timescale is consistent with the *National Quality Requirements in the Delivery of Out-Of-Hours Services*[36] for face-to-face consultations with adults and the recommendations made by the Intercollegiate Committee in its report *Services for children in emergency departments*[37], which we consider are also appropriate for urgent care centres.

We recommend this standard is used initially as a performance measure that commissioners monitor and benchmark against before setting a target against which urgent care centres are expected to comply.

Time for urgent care centre to transfer patient to emergency department

Within 60 minutes of the patient arriving at the urgent care centre, a clinical decision needs to be made as to whether the patient will be treated in the urgent care centre and discharged, or whether they need to be transferred to the emergency department. This should ensure that, where patients are transferred to the emergency department, the emergency department is still able to meet the national four hour A&E target.

We recommend commissioners expect urgent care centres to comply with this standard for all patients.

Time for communicating the episode of care to the primary care team

We expect urgent care centres to ensure a summary of the episode of care is communicated to the patient's GP practice by 8am on the next working day. This is consistent with the *National Quality Requirements in the Delivery of Out-Of-Hours Services*[38].

For children and young people we also expect the episode of care to be communicated to their health visitor or school nurse no later than 8am on the subsequent working day (that is, by 8am on the second working day following the child or young person's episode of care). This additional working day may be needed to obtain the contact details of the patient's health visitor or school nurse.

We recommend commissioners expect urgent care centres to comply with these standards for all patients.

[36] Department of Health (2006) *National Quality Requirements in the Delivery of Out-of-Hours Services*
[37] Royal College of Paediatrics and Child Health (2007) *Services for Children in Emergency Departments: Report of the Intercollegiate Committee for Services for Children in Emergency Departments*
[38] Department of Health (2006) *National Quality Requirements in the Delivery of Out-of-Hours Services*

Urgent care centre activity and performance data

As well as monitoring performance against the standards outlined, we recommend commissioners monitor the following activity and performance data on a monthly basis and require urgent care centre providers to report accordingly:

- Activity volumes for assessment and treatment, broken down by presenting condition for individual practitioners.
- Diagnostic activity volumes broken down by presenting condition for individual practitioners.
- Waiting times for patients in the urgent care centre before discharge.
- Patients streamed to the emergency department and their presenting condition, including the proportion of patients streamed, broken down by individuals making the streaming decision.
- Patients transferred to the emergency department following full clinical assessment and the reason for their transfer, including the proportion of patients transferred, broken down by individual practitioners.
- Robust clinical outcome measures, including mortality and morbidity rates. We suggest these measures are tailored to reflect local priorities and may also be monitored through selective clinical audits.
- Referral volumes to the acute trust's on-call teams for admissions and volumes admitted.
- Referral volumes to specialist services. For example, to mental health services.
- Response times for mental health liaison.
- Volumes of non-registered patients helped to register with a GP.
- Identification of frequent attenders.

Urgent care centres are also expected to report regularly on the arrangements for patient involvement and the outcome of patient feedback and clinical audits.

Emergency department activity and performance data

As well as monitoring activity and performance data for the urgent care centre, we recommend commissioners also monitor the following emergency department activity and performance data before and after the urgent care centre is established to compare against baseline performance:

- activity volumes jointly and individually across the urgent care centre and emergency department, broken down by presenting condition
- diagnostic activity volumes jointly and individually across the urgent care centre and emergency department, broken down by presenting condition
- emergency admission rates
- emergency re-admission rates
- robust clinical outcome measures, including mortality and morbidity rates.

6.2 Evaluation

Urgent care centres are a new service delivery model and, to date, there has been little formal evaluation of the impact of the service model. Where urgent care centres are part of polyclinics, they will be included in the polyclinics evaluation programme. Where urgent care centres are not part of polyclinics, commissioners should establish a system to evaluate the impact of the urgent care centre service model locally and refine it appropriately in response to the evaluation results.

7 Governance

In this section, we make recommendations for the operational and clinical governance arrangements for urgent care centres.

7.1 Operational governance

Urgent care centre providers are expected to establish operational governance arrangements to review operational processes and resolve any issues that arise. Urgent care centre providers will be expected to demonstrate how their operational governance arrangements engage services (including the emergency department) with which the urgent care centre interfaces. We recommend that, at least for an initial period, a commissioner representative attend relevant operational governance meetings.

Commissioners also need to consider the form and frequency of performance review meetings with the urgent care centre to review performance against relevant standards and performance measures.

7.2 Clinical governance

Urgent care centres are expected to demonstrate to commissioners that appropriately robust clinical governance arrangements have been established. We expect all urgent care centres to be networked to an emergency department that is able to provide professional support, clinical supervision and advice on clinical standards.

Registration

We expect all urgent care centre providers to be registered with the Care Quality Commission and to comply with all appropriate national regulatory requirements.

Clinical standards

We recommend commissioners engage a consultant in emergency medicine from the emergency department, an experienced GP, and an experienced nurse to work with the commissioner to define the clinical standards the urgent care centre provider must comply with.

The urgent care centre provider is expected to identify a clinical lead for clinical governance. Their role will be to ensure clinical standards are being adhered to and to liaise on an ongoing basis with the clinical governance lead for the emergency department, to ensure appropriate clinical governance arrangements are in place for the urgent care centre and emergency department working together.

Complaints procedures

Urgent care centre providers must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure.

Urgent care centre providers are expected to provide anonymised details of each complaint and how it has been dealt with to the commissioning PCT. All complaints must be audited for each individual staff member so appropriate action can be taken where necessary.

The employing organisations will continue to have legal accountability for complaints brought against any practitioner in a urgent care centre or emergency department. However, where the organisational model for the urgent care centre means that a patient would perceive their care is provided by the emergency department's acute trust, we recommend the urgent care centre and emergency department agree a memorandum of understanding to respond jointly to any complaints received by the urgent care centre or by patients transferred between the urgent care centre and emergency department.

Clinical audits

Commissioners should require urgent care centres to conduct the same internal audits required of out-of-hours service providers. This means urgent care centre service providers must regularly audit a random sample of patient contacts and appropriate action must be taken based on the results of those audits. Regular reports of the audits should be made available to commissioning PCTs. The sample must be selected in a way that provides sufficient data to review the clinical performance of all staff working within the service. The audit must be led by a clinician with suitable experience and must consider prescribing patterns and analyse and interpret the diagnostic results.

We also expect urgent care centres to participate in appropriate external clinical professional audits relevant to their staff.

Serious untoward incidents

Urgent care centre providers are expected to demonstrate their arrangements for recording and investigating serious untoward incidents and near misses, and the processes they have in place for learning from these incidents. Centres also need to comply with local protocols for notifying commissioners of serious untoward incidents.

Major incidents

In the event of a major incident we expect urgent care centre staff to be mobilised as directed by the appropriate clinician in the emergency department's acute trust who is coordinating the response to the major incident. We expect urgent care centres to work with acute trusts to develop appropriate arrangements.

Legal protection

Urgent care centre providers must demonstrate that they are appropriately indemnified to meet the costs of any legal claim, by having full indemnity and liability insurances in place.

8 Procurement and contracting

In this section, we provide guidance for PCTs on the issues that need to be considered around the procurement and contracting arrangements for urgent care centres.

8.1 Procurement approach

The development and procurement of urgent care centre service models should comply with NHS London's *Reconfiguration Programme Guide*[39], informed by whether the relevant Local Authority Overview and Scrutiny Committees judge the proposed service change to constitute a substantial change to a health service requiring formal consultation.

It is the responsibility of individual PCTs to undertake thorough health market analyses, in line with NHS London's *Using markets in system management*[40] guidance, to determine whether the procurement of urgent care centre services should be subject to direct competition. Any procurement should be informed by the Department of Health's *PCT Procurement Guide for Health Services*[41] and comply with the *Principle and rules for Co-operation and Competition*[42].

A number of PCTs, such as Waltham Forest, have developed their existing urgent care centre service models by commissioning their urgent care centre service from their existing out-of-hours service provider, in partnership with the acute trust. In some cases PCTs have taken this approach as an initial step in developing their service model and refining and assessing the impact on activity volumes, with a view to subsequently procuring the urgent care centre service through a competitive process. Other PCTs, such as Hammersmith & Fulham, have moved directly to a competitive procurement process for their urgent care centre service.

8.2 Contracting and payment mechanisms

National Payment by Results (PbR) tariffs do not apply to urgent care centre activity because urgent care centres are not formally designated type 1 or type 2 A&E departments or minor injuries units.

A number of commissioners are currently paying sessional rates for urgent care centre staff and reimbursing acute trusts for costs, such as accommodation and access to diagnostics. In most cases these arrangements have been established for a transitional period with a view to subsequently establishing a local tariff for urgent care centre activity. Other PCTs are negotiating local tariffs for urgent care centre activity with potential providers through a process of competitive dialogue.

As well as agreeing local tariffs for urgent care centre activity, PCTs may wish to consider agreeing minimum and maximum levels of funding as part of their contracts with urgent care centre providers for a transitional period while actual activity levels are monitored.

When negotiating local tariffs for urgent care centre activity, commissioners need to consider the following different types of urgent care centre activity:

- Patients assessed, treated and discharged at the urgent care centre – commissioners will need to consider whether a single tariff is sufficient for this type of activity or whether there should be different tariffs for different types of activity (for example, separate tariffs for minor illness and minor injury). Commissioners will also need to consider whether a separate tariff should be applied for diagnostic activity or whether, in a similar way to the current PbR A&E tariff, it should be incorporated into different tariffs for

[39] *NHS London (2008) Reconfiguration Programme Guide*
[40] *NHS London (2009) Using markets in system management*
[41] *Department of Health (2008) PCT Procurement Guide for Health Services*
[42] *Department of Health (2007) Principle and rules for Co-operation and Competition*

assessment and treatment depending on the type of diagnostic test.

- Patients streamed to the emergency department – commissioners will need to consider whether any urgent care centre tariff should apply for patients streamed to the emergency department, taking into account the streaming model and the level of assessment made by a clinician prior to the streaming decision. We would not expect a tariff to apply for patients who are streamed directly to the emergency department on arrival at the urgent care centre. Similarly, we would not expect an A&E tariff to apply if a patient is streamed directly from the emergency department to the urgent care centre on arrival at the emergency department.
- Patients transferred to the emergency department following a full clinical assessment in the urgent care centre – a urgent care centre tariff should apply when a urgent care centre clinician makes a full clinical assessment (including recording of vital signs and any necessary diagnostic tests) and, informed by the assessment, decides to transfer the patient to the emergency department although this tariff might be less than the one applied for a patient who is treated and discharged in the urgent care centre.
- Patients supported in registering with GPs – commissioners may wish to negotiate a separate tariff to incentivise urgent care centres to help non-registered patients register with GPs. Alternatively, commissioners may simply request providers to demonstrate how they will help non-registered patients in registering with a GP and incorporate the cost of this activity into their tariffs for assessing and treating patients.

Each urgent care centre provider's information systems need to be able to code activity to reflect the different activity types to which local payment tariffs apply.

We recommend PCTs contract a single provider organisation for their urgent care centre service. We expect that single provider organisation to then sub-contract with any other providers and agree appropriate reimbursement arrangements with the acute trust of the emergency department for providing accommodation, diagnostics, and clinical advice and support as required.

Case studies: Payment mechanisms for urgent care centres

Hammersmith & Fulham PCT developed its broad approach to the urgent care centre payment mechanism and then tested and refined the approach with providers as part of competitive dialogue during the procurement process. It uses a block contract based on the PCT's A&E expenditure with deductions for premises costs met by the PCT, patient transfers to the emergency department (applied at PbR tariff plus an uplift to discourage inappropriate transfers) and any incomplete datasets preventing the PCT recharging for out-of-area urgent care centre attendees. Providers were also required to propose an overall adjustment to the block contract that would provide a cost saving to the PCT. More details of the Hammersmith & Fulham urgent care centre payment mechanism approach are available on the Healthcare for London website.

Camden PCT is considering a commissioning model that would differentiate between 'urgent care see and treat' and 'rapid assessment only' payment tiers. The latter of these would apply to patients streamed either directly to the emergency department, or back to community primary care following the initial clinical assessment.

Cross-boundary flows and reimbursement mechanisms

Urgent care centre information systems need to be able to capture each patient's registered GP or, if the patient is not registered with a GP, their PCT of residence. Healthcare for London, through its polyclinics project, is working to establish a pan-London mechanism for reimbursing PCTs for patients treated in urgent care centres and polyclinics who are not residents of the commissioner PCTs.

Estimating costs of urgent care services

Commissioners may wish to estimate the costs of delivering urgent care centre services in their local settings to guide their negotiations with potential providers. PCTs may use the *Polyclinics Financial and Commissioning Models* (available on request from the Healthcare for London polyclinics project team by emailing polyclinics@csl.nhs.uk) to estimate the cost of delivering urgent care centre services. The model enables PCTs to add additional packages of care to estimate costs at a more detailed level than minor illness and minor injury. It also enables overall costs to be estimated taking into account costs for staff, accommodation and diagnostic tests. The model also provides the flexibility to add additional cost factors, such as the cost of pharmacy-related services and the provision of clinical advice and support from the emergency department.

8.3 Indicative activity volumes

PCTs may wish to commission local reviews of A&E attendances to inform their estimates of urgent care centre activity levels. In a study commissioned by Healthcare for London of unscheduled care across six PCTs available on the Healthcare for London website, GPs assessing A&E attendances estimated that 60% of non-major attendances could have been assessed and treated by a GP.

We expect commissioners to provide an indication of the clinical case mix they expect to be assessed and treated in the urgent care centre and an estimate of potential activity volumes. We then expect potential providers, as part of their discussions with commissioners, to recommend appropriate staffing models and provide an indication of their estimated urgent care centre activity volumes.

Outlined overleaf are examples of the type of A&E activity data commissioners might use to inform their estimate of urgent care centre activity volumes and include in their service specifications to help providers develop a staffing model and make their own estimates of urgent care centre activity volumes. Pan-London A&E activity analysis is included in appendix C.

- Overall volumes of A&E attendance profiled against months of year, days of week and hours of day.
- Volumes and proportions of walk-in patients and patients arriving by ambulance, broken down by admissions and discharges.
- Volumes and proportions of activity classified as major and minors.
- Volumes and proportions of activity broken down by presenting condition .
- Volumes and proportions of activity allocated to different A&E tariffs .
- Volumes and proportions of A&E activity by diagnostic investigation.
- Volumes and proportions of completed episode against time .
- Volumes and proportions of activity against consultation time.
- Volumes and proportions of attendances of patients unregistered with a GP profiled against days of weeks and hours of day.

Reference cost activity information may also be used to estimate urgent care centre activity volumes.

8.4 Commissioning specifications

We expect PCTs will initially liaise with existing service providers to develop the service specification for their local urgent care centre service model, but the specifications should be further developed through discussions with potential service providers.

Examples of commissioning specifications used for urgent care centres in London and elsewhere are available on the Healthcare for London website. Healthcare for London's *Polyclinics Planning Framework* and *Polyclinics Commissioning Specification* template (available on request from the Healthcare for London polyclinics project team by emailing polyclinics@csl.nhs.uk) may also be used in the planning and procurement of a urgent care centre.

Appendices

Appendix A – Arrangements for paediatric care

We expect the arrangements for paediatric care to comply with recommendations of *Services for Children in Emergency Departments*[43].

While these recommendations were designed to apply to the traditional A&E setting, they apply equally to the whole entity of a urgent care centre integrated with an emergency department, although not necessarily to the urgent care centre and the emergency department individually.

This section describes the recommendations from this report we expect to apply to urgent care centres and how these may be applied.

Service design – an integrated urgent care system

- All front-line staff delivering urgent care to children must be competent in the basic skills required for safe practice, in whichever setting they work.
- Commissioners and providers must work together to provide safe urgent care for children in a geographical network, taking local needs into account – where in place, children's clinical networks and urgent care networks need to work together to establish appropriate and coordinated provision.
- The skills of the whole network should be utilised with a flexible approach to traditional professional, organisational and/or managerial boundaries.
- In order to smooth the interface between organisations, commissioners and providers should encourage shared or rotational posts, or regular secondments to the acute unit.
- Notification of the child's attendance at any urgent care setting should be made in a timely way to their primary care team.
- Urgent care centres and emergency departments should prevent unnecessary hospital admissions by being aware of alternative options, and developing care pathways for common conditions with community and paediatric colleagues.

Child and family-friendly care

- Urgent care centre and emergency departments must accommodate the needs of children and accompanying families as far as is reasonably possible – where it is not possible to have separate waiting areas for children and young people in both the urgent care centre and emergency department, the centre and emergency department may wish to consider having a common waiting area for children and accompanying families.
- As well as audio-visual separation from adults, consideration must be given to security issues, availability of food and drink, breast-feeding areas, and hygienic, safe play facilities.
- Teenagers should have access to age appropriate entertainment.
- Across the urgent care centre and emergency department combined, there should be at least one child-friendly treatment room, clinical cubicle or trolley space for every 5,000 annual child attendances jointly across the urgent care centre and emergency department.
- Urgent care centre and emergency departments that jointly see more than 16,000 children per year should employ play specialists at peak times to work across both the urgent care centre and emergency department.
- Comments should be sought from children, young people and their carers to improve services and facilities.

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

Initial assessment of children

- All children attending urgent care centres and emergency departments must be visually assessed within minutes of arrival to identify an unresponsive or critically ill child – reception staff in urgent care centres need to have received appropriate training and stream patients immediately through to the emergency department where appropriate.
- A brief clinical assessment by an appropriately trained doctor or nurse should occur within 15 minutes of arrival, if it is not possible for a full clinical assessment to be conducted in this time period.
- A system of prioritisation for full assessment must be in place if the waiting time for a full clinical assessment exceeds 15 minutes.
- The initial assessment must include an assessment of the requirement for analgesia using an appropriate pain score and treatment of pain then delivered within 20 minutes.
- The initial assessment needs to consider whether there are any child protection concerns and whether the child protection register should be checked.
- Registration details must include specific additional information. For example name and relationship of accompanying adult, school, health visitor, social worker.

Treating the sick child

- All facilities receiving sick or injured children must be equipped with an appropriate range of drugs and equipment.
- All staff working in facilities where children present must be trained in paediatric basic life support. At least one member of the urgent care centre team should have training in advanced paediatric life support (APLS) and should establish and monitor guideline and protocols to ensure the safe transfer of a child from the urgent care centre to the emergency department.
- All urgent care centres should have a named paediatrician with designated responsibility for urgent care centre liaison.
- Systems must be in place to ensure safe discharge of children, including advice to families on when and where to access further care if necessary.
- All urgent care attendances in children must be notified to their primary care team: ideally both the GP and the health visitor or school nurse.

Staffing and training issues

- All staff working in urgent care centres (including receptionists) need to have been trained in recognising serious illness in children. The Department of Health-commissioned interactive DVD is designed to help healthcare professionals identify children with serious illness.
- All urgent care centre nurses and doctors caring for sick and injured children should have the same basic competencies in caring for children as they do for adults. For example, recognition of serious illness, basic life support, pain assessment, and identification of vulnerable patients.
- Nurses caring for sick and injured children in urgent care centres require at least basic competence in both emergency nursing skills and in the care of children. Nurses caring for children in urgent care centres should be competent in:
  - communicating with children and their families
  - the assessment and recognition of the sick child
  - basic life support skills
  - recognition of vulnerable children, the ability to identify when safeguarding procedures are necessary, and the ability to implement the emergency department's child protection policy
  - pain assessment and management
  - administration of medication, ideally by Patient Group Directives (PGDs) for analgesia
  - the current legal and ethical issues pertaining to children, including consent and confidentiality issues.

Minimum competencies in relation to caring for children and young people have been defined by Skills for Health[44], the Department for Education and Skills[45], the Royal College of Nursing[46], the Faculty of Emergency Nursing (FEN)[47] and the *Emergency Care Framework for Children and Young People in Scotland*[48].

- Where emergency nurse practitioners work autonomously to see and treat children in urgent care centres, the nurses must have had specific education in the anatomical, physiological and psychological differences of children. They must also have specific training in history-taking, examination skills and diagnostic reasoning in children, including interpretation of investigations. When nurses prescribe medication for children, they must have the necessary knowledge of paediatric pharmacology.
- All emergency departments receiving children should have an RN (Children) lead nurse for the care of children and young people and a lead nurse responsible for safeguarding children. Depending on the local organisational model, these lead nurses may also be responsible for the urgent care centre. Where this is not the case, the urgent care centres should have their own lead nurses for these roles who liaise closely with the corresponding emergency department lead nurses and ensure there are consistent processes across both the urgent care centre and emergency department.
- Acute trusts should employ sufficient RN (Children) nurses to provide one per shift in emergency departments receiving children – commissioners and providers should seek to agree that the RN (Children) nurses in the emergency department are available to provide clinical supervision to urgent care centre staff where required.

[44] Skills for Health, www.skillsforhealth.org.uk
[45] Department for Education and Skills (2004) *Common core of skills and knowledge for the Children's Workforce*
[46] Royal College of Nursing (2004) *Services for children and young people: preparing nurses for future roles*
[47] Faculty of Emergency Nursing (2009) *Competency Framework*
[48] Scottish Executive (2006) *Emergency Care Framework for Children and Young People in Scotland*

Training of doctors sub-specialising in paediatric emergency medicine

- Emergency departments integrated with a urgent care centre that jointly see more than 16,000 children per annum should employ a consultant with sub-specialty training in paediatric emergency medicine. Commissioners and providers should seek to agree that the consultant is available to provide clinical supervision to urgent care centre staff where required.
- Hospital paediatric departments with an on site urgent care centre and emergency department that see children should aim to appoint a paediatrician with special expertise in paediatric emergency medicine as the designated liaison paediatrician for the urgent care centre and emergency department.

Child protection in urgent care centres – safeguarding children

- All urgent care centres should comply with the requirements of their local safeguarding children board and the *London Child Protection Procedures*[49].
- All urgent care centre staff (clinical and non-clinical) must receive training in safeguarding children appropriate to their posts.
- All emergency departments should nominate a lead consultant and lead nurse responsible for safeguarding children in the emergency department. Depending on the local organisational model, these leads may also be responsible for safeguarding children within the urgent care centre. Where this is not the case, the urgent care centres should have their own lead medical clinician and nurse responsible for safeguarding children who liaise closely with the corresponding emergency department leads and the provider organisations' named professionals for safeguarding children, to ensure there are consistent processes across both the urgent care centre and emergency department.
- All urgent care centres must have guidelines for safeguarding children, specific to the urgent care centre.
- All urgent care centres must be able to access child protection advice 24 hours a day, from a paediatrician and social services. Direct or indirect access to the child protection register should be available.
- Urgent care centres should inform, where in place, the acute trust's paediatric liaison nurse/health visitor of each attendance who should be available to provide advice to urgent care centre staff and lead on liaison with primary care teams, schools and social services where appropriate.
- Systems must be in place to identify children who attend frequently.

[49] Local Safeguarding Children Board (2008) *London Child Protection Procedures*

Information systems and data analysis

- The needs of patients, clinicians, managers, commissioners and regulators need to be defined and used to inform the development of urgent care centre information systems.
- Urgent care centre staff should participate in the national information technology agenda, and engage proactively with local service providers to design local systems.
- The minimum dataset for the information system used by the urgent care centre should incorporate the specific needs of children.
- Urgent care centre information systems should link with other health information systems, so that data on all local health service contacts are available in the urgent care centre.
- Urgent care centre information systems should enable a child's attendance at the urgent care centre to be notified automatically to their primary health care team (ideally both the GP and health visitor or school nurse).
- Surveillance of local patterns of injury should be possible.

Further guidance may be found in *Services for Children in Emergency Departments*[50].

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

Appendix B – Recognition of 'red flag' symptoms for pregnant and postpartum women

The following guidance is based on the recommendations for general practice in the CEMACH report *Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003-2005*[51].

We expect all urgent care centre practitioners who may assess and treat pregnant and postpartum women to have the competencies to identify serious illness in pregnant and postpartum women. The following signs should alert practitioners that serious illness is a possibility:

- a heart rate greater than 100bpm
- a systolic blood pressure of 160 mm/Hg or above or lower than 90 mm/Hg, and/or a diastolic blood pressure of 90 mm/Hg or more
- a temperature greater than 38 degrees Centigrade; and/or
- a respiratory rate more than 21 breaths per minute – the respiratory rate is often overlooked but rates over 30 per minute are indicative of a serious problem.

Practitioners should also have the competencies to recognise the 'red flag' symptoms in pregnant women who require emergency hospital admission, which include the following:

Pulmonary embolisms

A sudden onset of breathlessness in a pregnant or postpartum woman, in the absence of a clear cause, such as asthma, should raise the suspicion of pulmonary embolus, especially if the woman has risk factors.

Women with suspected pulmonary embolus should be referred as an emergency to hospital as the diagnosis of pulmonary embolus can only be made or excluded by secondary care investigations.

Severe headaches in or after pregnancy/pre-eclampsia and cerebral bleeds

Women with a headache severe enough to seek medical advice or with new epigastric pain should have their blood pressure taken and urine checked for protein as a minimum.

Women with severe incapacitating headaches described as the worst they have ever had should have an emergency neurological referral for brain imaging in the absence of other signs of pre-eclampsia.

The threshold for same day referral to an obstetrician is hypertension
≥ 160mm/Hg systolic and or
≥ 90 mm/Hg diastolic or proteinuria
≥1+ on dipstick.

The systolic blood pressure is as significant as the diastolic.

Automated blood pressure machines can seriously underestimate blood pressure in pre-eclampsia. Blood pressure values should be compared with those obtained by auscultation (an anaeroid sphygmomanometer is acceptable).

[51] CEMACH (2007) *Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003-2005*

Ectopic pregnancies

Clinicians in primary care need to be aware of atypical clinical presentations of ectopic pregnancy and especially of the way in which it may mimic gastrointestinal disease.

Fainting in early pregnancy may indicate an ectopic pregnancy.

Sepsis

Puerperal infection is not a disease of the past and health professionals are still failing to recognise its classic early symptoms and signs.

Puerperal sepsis should be considered in all recently delivered women who feel unwell and have pyrexia.

Women with sepsis can deteriorate rapidly, with the potentially lethal consequences of severe sepsis and septic shock. Abdominal pain, fever and tachycardia are indications for emergency admission forintravenous antibiotics.

Heartburn and ischaemic heart disease

The prevalence of ischaemic heart disease in pregnancy and the puerperium is increasing.

The possibility of ischaemic pain should be considered in women who have risk factors and atypical heartburn.

If a woman is suspected of having cardiac chest pain she should be admitted as an emergency.

Appendix C – Analysis of A&E activity

On the following pages we provide an analysis of A&E activity data across London.

The analysis is based on an extract of 2008/09 Secondary User Services data as at the end of April 2009. Timing and comprehensiveness of data submission means the data set is not complete and issues of data quality exist. In aggregate this analysis should be considered indicative of patterns of A&E activity across London.

We encourage commissioners to use local A&E activity data to inform their estimates of urgent care centre activity volumes.

Unless otherwise stated, the analysis is at a pan-London level.

Figures 1 and 2 illustrate the A&E activity volumes across the months of the years, days of the week and hours of the day.

Monday has, on average, the highest A&E attendances – with attendances being nine per cent above the average.

Across the average day, A&E attendances tend to rise rapidly from their lowest volume around 6am to a peak around noon and then gradually decrease across the day, falling rapidly from around 9pm.

Figure 1: Annual A&E attendances in London, by day of week

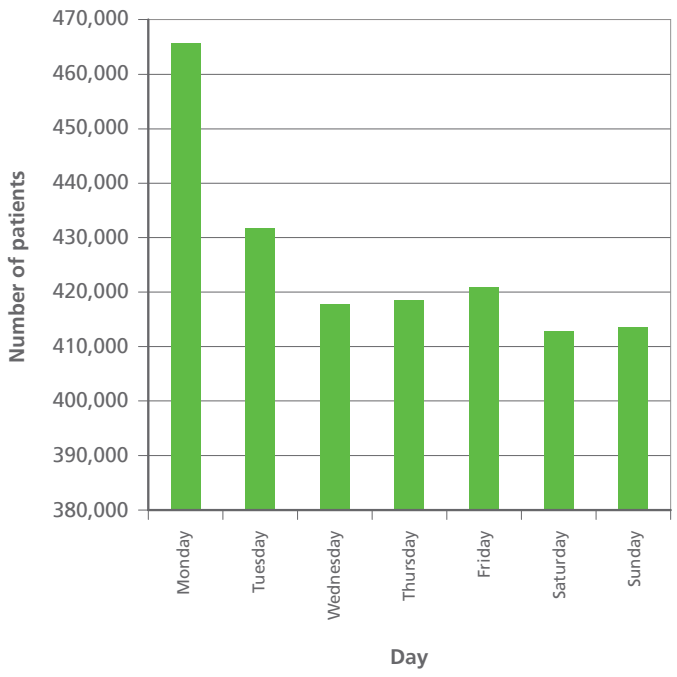
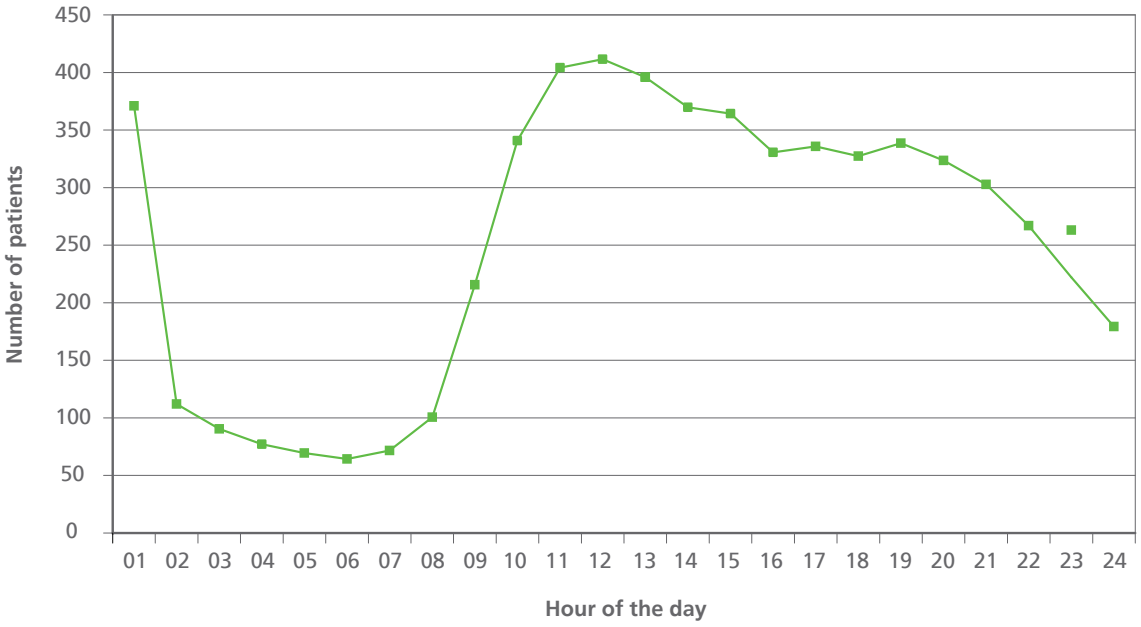


Figure 2: Annual A&E attendances in London, by hour of the day

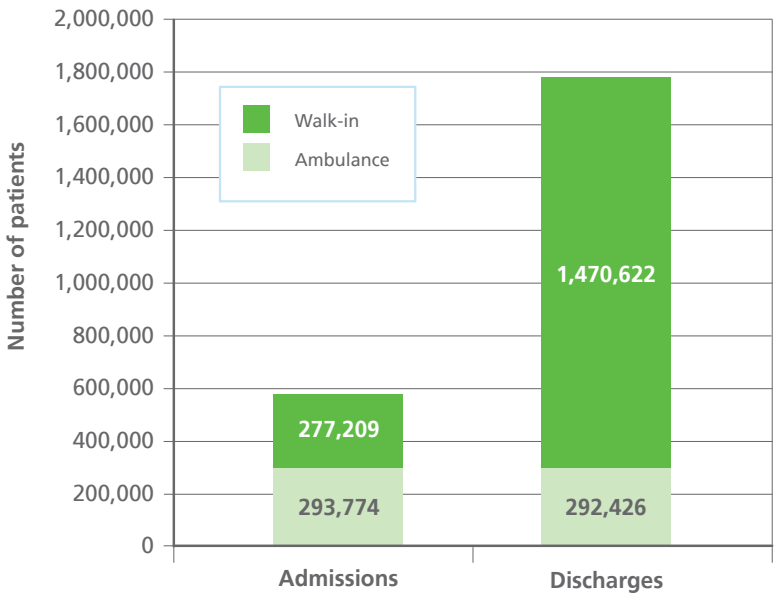


Note – Data coding issues may mean that the activity volume between midnight and 0100 is overestimated.

Figure 3 illustrates the volume of patients admitted and discharged following attendance at A&E, broken down by walk-in patients and patients arriving by ambulance.

Around 76% of all A&E attendees are walk-in patients. Around 84% of walk-in patients and half of patients that arrive at A&E by ambulance are discharged.

Figure 3: A&E admissions and discharges in London, broken down by ambulance and walk-in arrivals



Figures 4 and 5 illustrate A&E activity broken down by PbR tariff across London and for individual trusts.

PbR tariff for A&E activity is based on whether a diagnostic investigation is conducted. There are separate tariffs for where no investigation is conducted, where a low cost investigation is conducted (ECG, haematology, biochemistry and other low cost investigations) and where a high cost investigation is conducted (CT, X-ray, cross match, histology and ultrasound).

Across London A&Es, 51% of walk-in attendees and 30% of attendees that arrive by ambulance require no diagnostic investigation.

Figure 4: Proportion of A&E tariff activity in London by PbR tariff, broken down by ambulance and walk-in arrivals

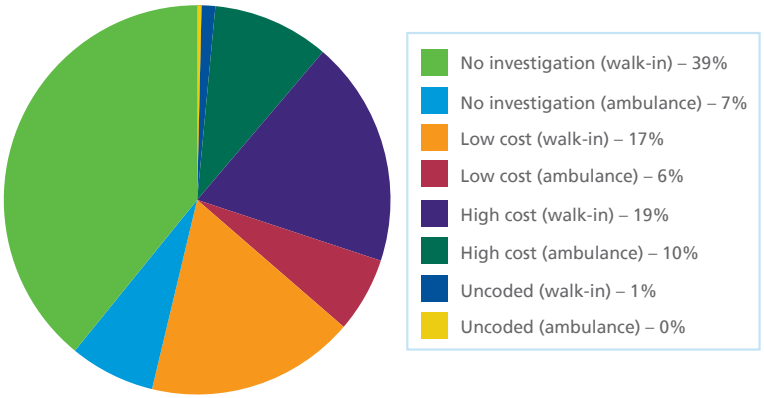


Figure 5: Volumes of A&E activity by PbR tariff, by trust

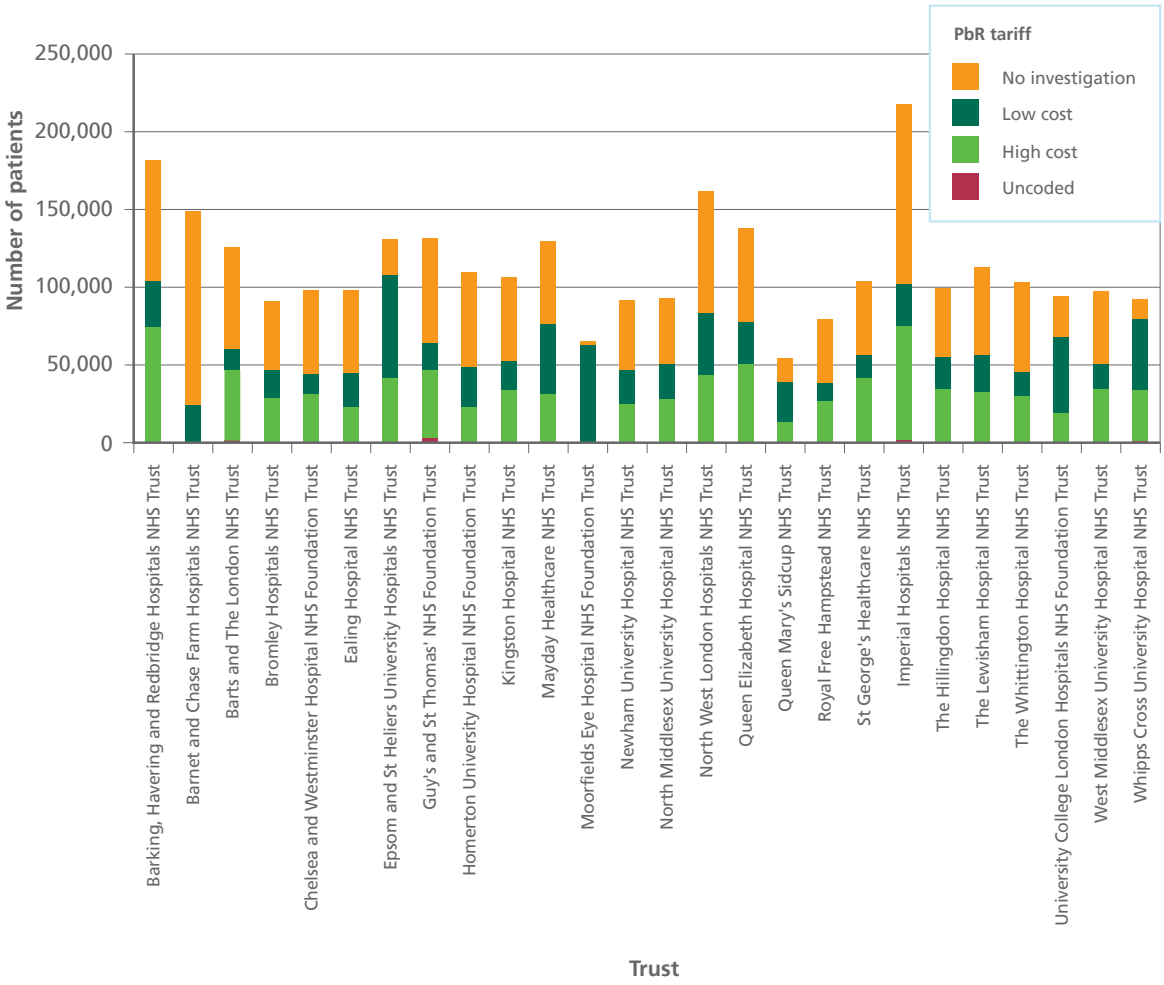
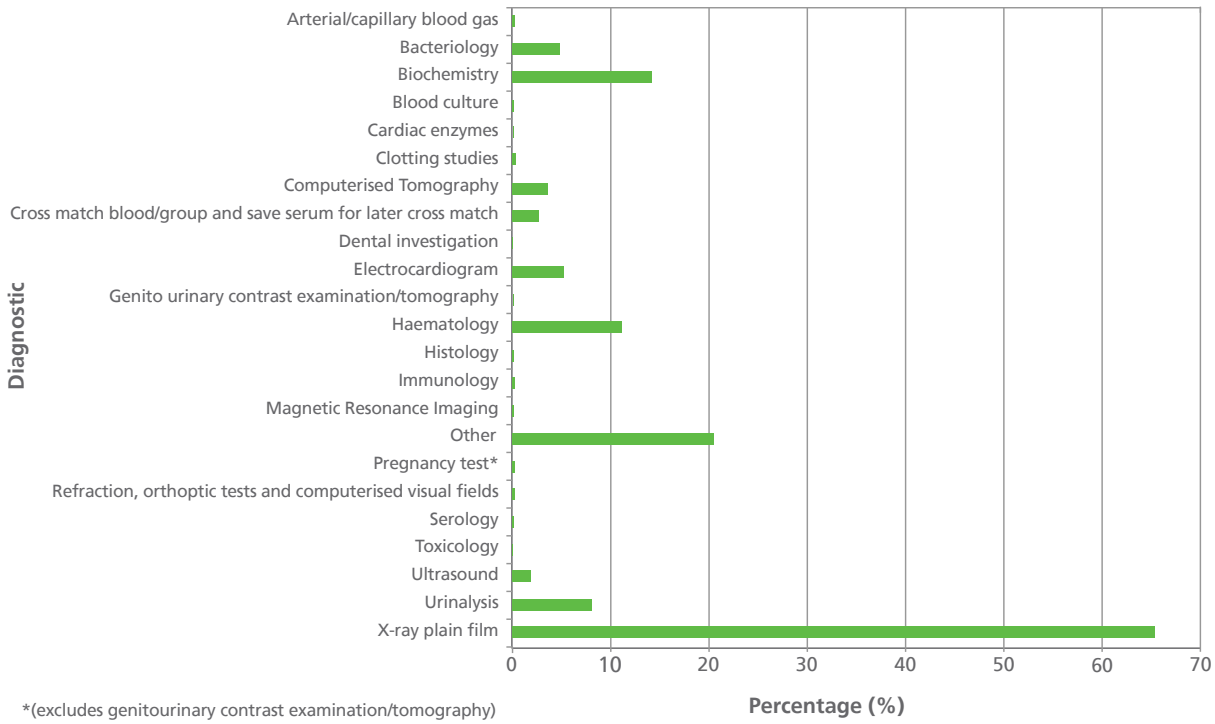


Figure 6 illustrates the volumes of diagnostic investigations that take place across London A&Es.

X-rays account for 47% of all diagnostic investigations, followed by biochemistry (10%) and haematology (eight per cent).

Figure 6: Proportion of diagnostic investigations in A&Es in London



*(excludes genitourinary contrast examination/tomography)

Figures 7,8 and 9 illustrate the time to completion of episode (either discharge or admission) across A&Es in London and broken down by individual trust.

Figure 7 shows that half of all A&E episodes are completed with two hours.

Figure 7: Proportion of completed A&E episodes by time in London

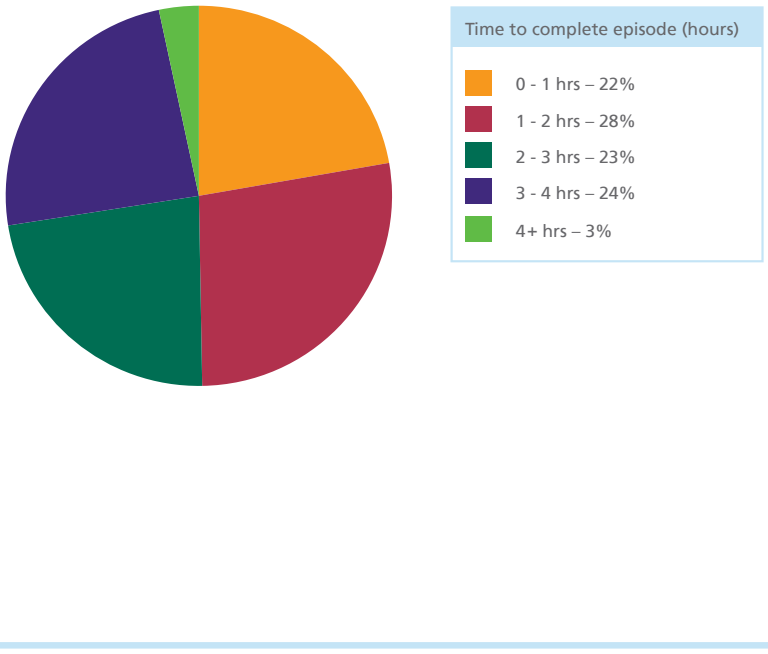
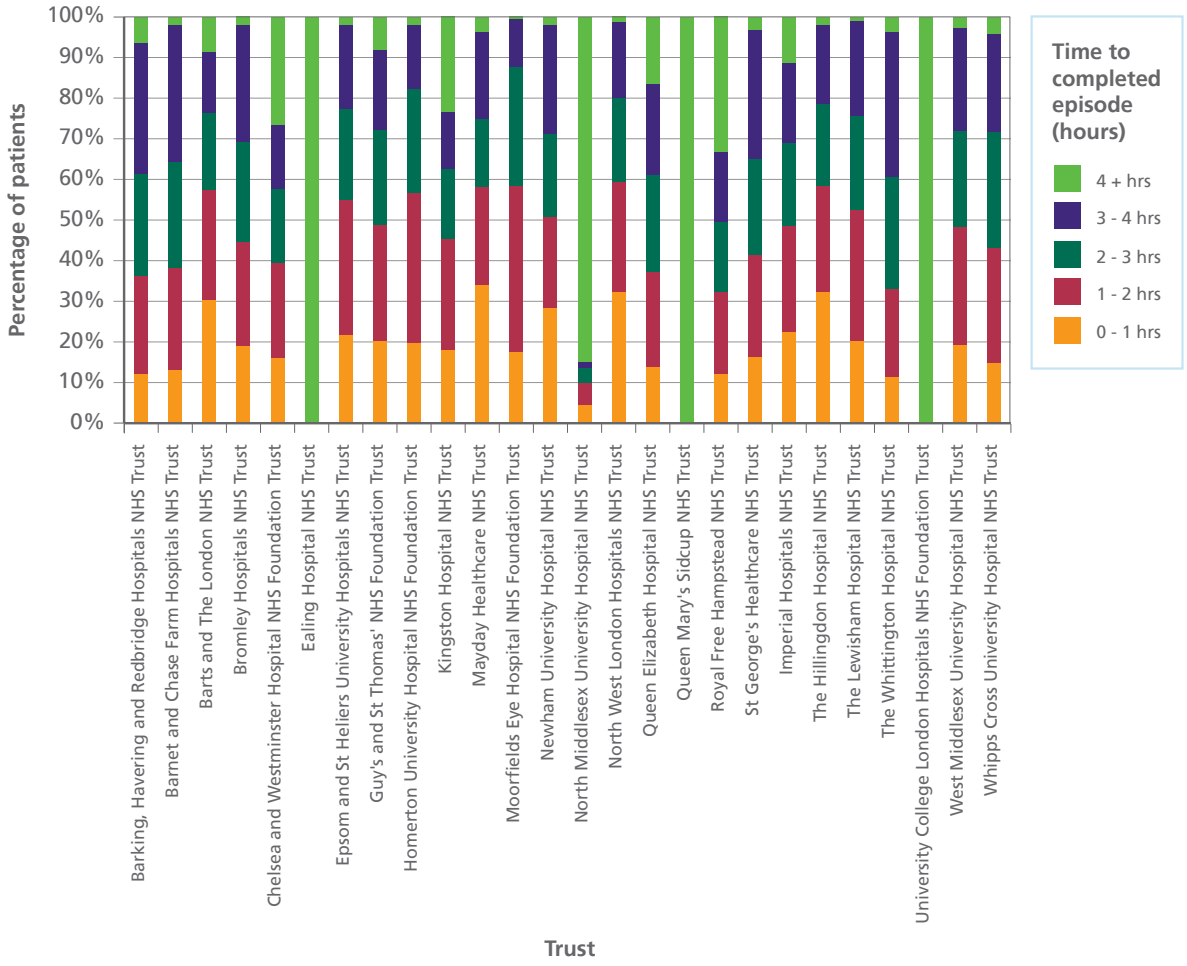


Figure 8: Proportion of completed A&E episode by time, by trust



While 66% of all patients discharged are discharged within two hours, there remains significant volumes of patients who are not discharged within two hours even when no investigation is conducted.

Figure 9: Time to completion of A&E discharges in London, broken down by A&E tariff

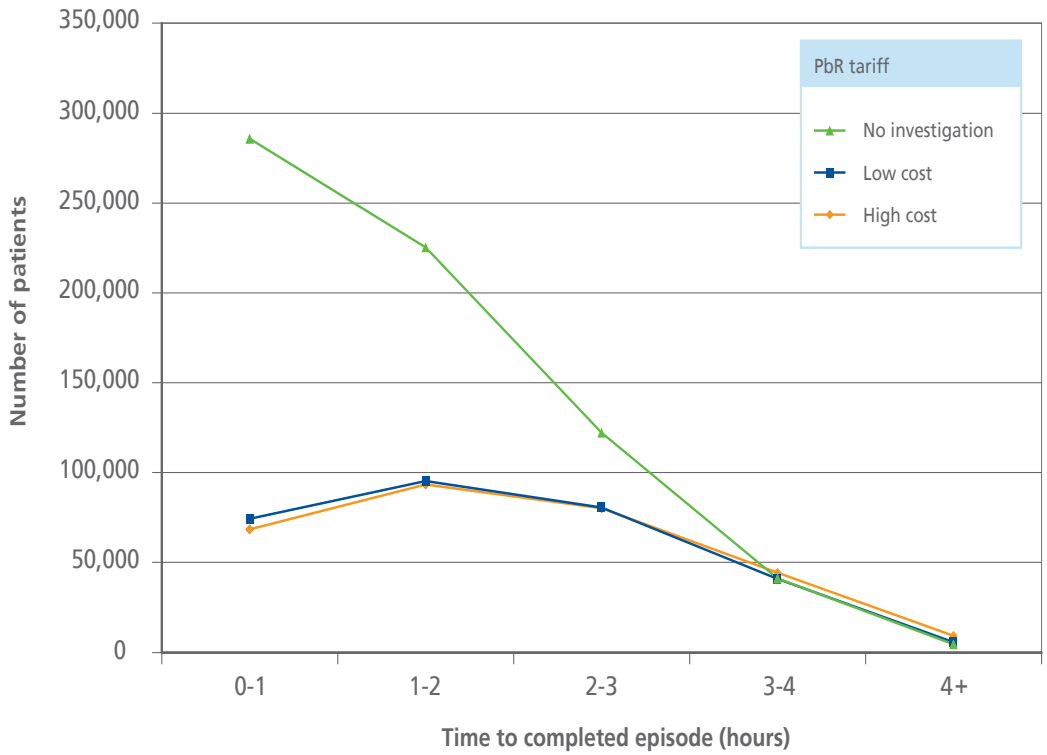
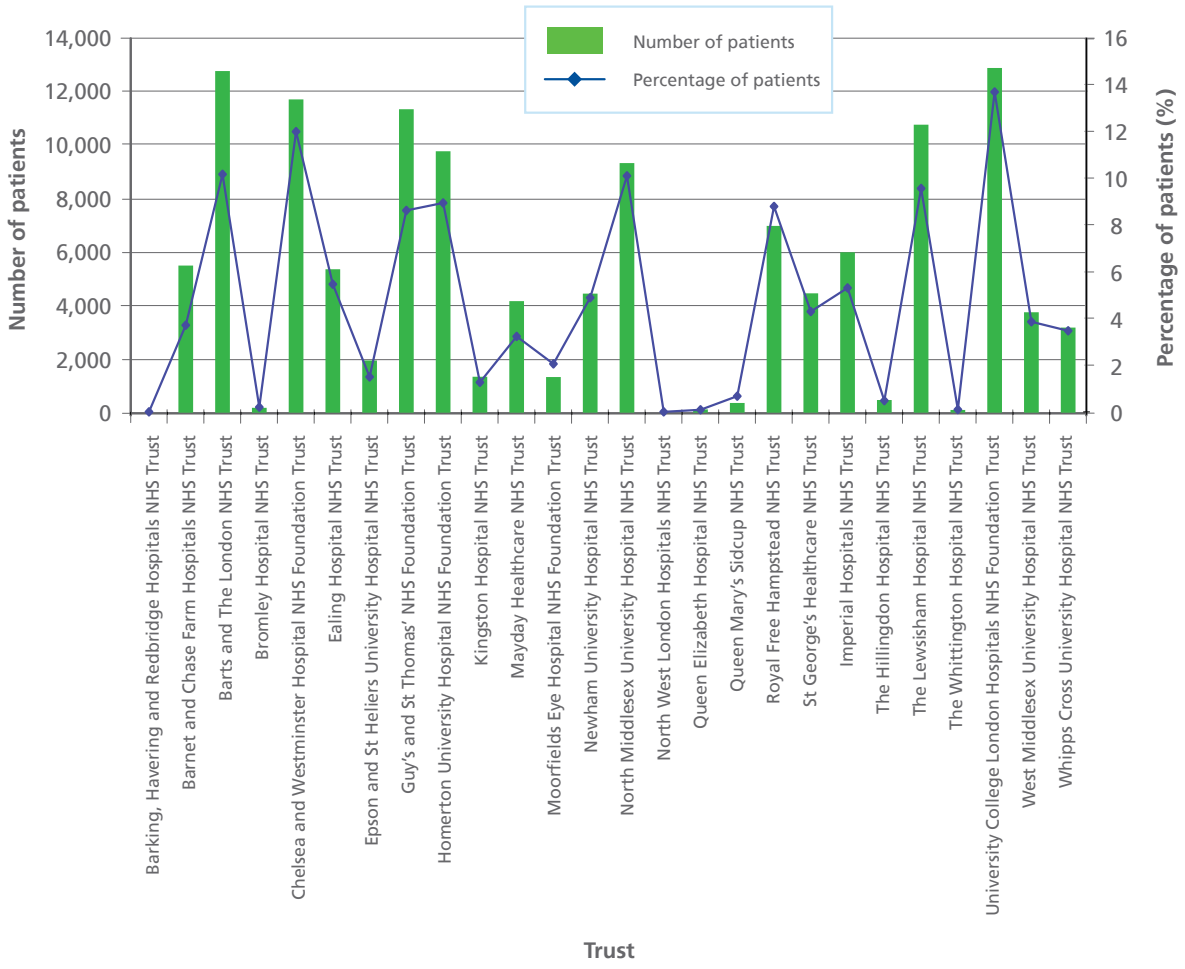


Figure 10 illustrates the volumes and proportion of A&E attendees without a registered GP across London trusts.

While there is wide variation, there are significant volumes of unregistered patients attending A&E in many trusts.

Figure 10: Volumes and proportion of A&E attendees with no registered GP, by trust



Index

Key elements	Section	Page
Procurement approach	8.1	
Registration	3.4	
Networks	5.6	
Standards and performance measures	6.1	
Streaming	3.3	
Out-of-hours service providers substance misuse services	5.4	

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