Health Scrutiny Committee

Monday 22nd September, 2014, at 5.00pm
In Committee Room 2 at the Council House, Priory Road, Dudley

Agenda - Public Session

(Meeting open to the public and press)

1. Apologies for absence.

2. To report the appointment of any substitute Members for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and sign the minutes of the meeting held on 16th July, 2014 as a correct record.

5. Public Forum – To receive questions from members of the public:-

   The Public are reminded that it is inappropriate to raise personal cases, individual details or circumstances at this meeting, and that an alternative mechanism for dealing with such issues is available.

   Please note that a time limit of 30 minutes will apply to the asking of questions by members of the public. Each speaker will be limited to a maximum of 5 minutes within the 30 minutes.

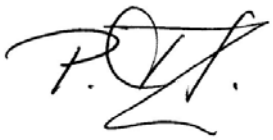
6. Dudley Group of Hospitals CQC Outcomes and Financial Strategy Update (Presentation)

7. Update on Urgent Care Development

8. Clinical Commissioning Group/Council: Better Care Fund Planning and Care Act Reforms – Update

9. Dudley Group Hospital Foundation Trust: Delayed Transfers of Care and Accident and Emergency (To Follow)

10. To consider any questions from Members to the Chair where two clear days notice has been given to the Director of Corporate Resources (Council Procedure Rule 11.8).



Director of Corporate Resources
Dated: 12th September, 2014

Distribution:

Members of the Health Scrutiny Committee:
Councillor C Hale (Chair)
Councillor C Elcock (Vice-Chair)
Councillors N Barlow, D Brothwood, M Hanif, D Hemingsley, S Henley, K Jordan, I Kettle (Sub), M Roberts, E Taylor and K Shakespeare
Ms Pam Bradbury – Co-opted Member

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- Information about the Council and our meetings can be viewed on the website **www.dudley.gov.uk**

- The Democratic Services contact officer for this meeting is Manjit Johal, Telephone 01384 815267 or E-mail manjit.johal@dudley.gov.uk

Minutes of the Health Scrutiny Committee

Wednesday 16th July, 2014 at 6.00 p.m.
in Committee Room 2 at the Council House, Dudley

Present:-

Councillor C Hale (Chair)
Councillor C Elcock (Vice-Chair)
Councillors N Barlow, K Turner, M Hanif, D Hemingsley, S Henley, M Roberts, K Shakespeare and E Taylor and Ms Pam Bradbury – Chair of Healthwatch

Officers

M Farooq (Assistant Director – Law and Governance (Lead Officer to the Committee), A Sangian (Senior Policy Analyst – Directorate of Adult, Community and Housing Services) and M Johal (Democratic Services Officer – Directorate of Corporate Resources)

Also in Attendance

Mr Richard Haynes – Dudley Clinical Commissioning Group
Mr Jason Evans – Dudley Clinical Commissioning Group
Ms Marsha Ingram – Dudley and Walsall Mental Health Partnership NHS Trust
Ms Rosie Musson – Dudley and Walsall Mental Health Partnership NHS Trust

1 **Apologies for Absence**

Apologies for absence from the meeting were received on behalf of Councillors P Brothwood and K Jordan.

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2 **Declarations of Interest**

In accordance with the Members' Code of Conduct, non-pecuniary interests were declared by the following:-

Councillor S Henley in agenda item No 6 (Dudley and Walsall Mental Health Partnership NHS Trust) and agenda Item No 7 (Update on Urgent Care Development) in view of the fact that his partner works at Russells Hall Hospital as a Ward Clerk.

Councillor E Taylor in agenda item No 6 (Dudley and Walsall Mental Health Partnership NHS Trust) and agenda Item No 7 (Update on Urgent Care Development) in view of the fact that her daughter works at Russells Hall Hospital as a staff nurse.

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3 **Minutes**

Resolved

That the minutes of the meetings of the Health Scrutiny Committee held on 27th March and 8th April, 2014 be approved as correct records and signed subject to the following amendments to Minute No 62:-

Page No HSC/40 – To replace the date in the last sentence in the first paragraph from "8th May, 2014" to" 20th June, 2014".

Page No HSC/42 – To delete the following words in the second bullet point, second paragraph "Walsall's model as they were currently operating a combined facility" and replace with the words "examining a variety of designs and models".

Page No HSC/45 – to replace the date in resolution No 3 from "May, 2014" to "July, 2014".

4 **Public Forum**

No issues were raised under this agenda item.

5 **Dudley and Walsall Mental Health Partnership NHS Trust – CQC Assessment Outcome Update**

A report of the Dudley and Walsall Mental Health Partnership NHS Trust – Care Quality Commission Assessment (CQC) was submitted on the outcome of the recent assessment and on the actions that had been undertaken by the Trust to ensure full compliance with the CQC requirements. Copies of presentation slides were also circulated to Members of the Committee.

Arising from the presentation of the report Ms Ingram and Ms Musson responded to queries and comments made by Members as follows:-

- It was confirmed that the Trust had been made aware of the inspection visit in advance as it had been an announced visit. Although it was an announced visit it was pointed out that the Trust had not been aware of the framework and the specific areas or sites that were to be inspected. Members were assured that, where there were compliance concerns, spontaneous inspections were undertaken by the CQC and that the CQC also utilised various other methods to gather information for ongoing monitoring purposes.

- In relation to the query regarding any work being undertaken to address the Child and Adolescent Mental Health Services (CAMHS) out of hours pathway and whether it was an area of concern, it was reported that CAMHS, although not a high compliance issue, it was an area that had been identified where improvements should be made and subsequently a review of CAMHS was being undertaken.

- Responding to queries about staff and whether consideration had been given to addressing the issues, particularly that not all staff engaged in change, some felt bullied and were change exhausted, it was reported that the Trust had undergone various changes to services over the last three years and there had been some friction from staff. However, to alleviate some of these problems it had been agreed to utilise independent specialist advice with a view to engage with the staff to ascertain their feelings on change. With regard to maintaining staffing it was stated that NHS Trusts are required to publish the number of staff that are employed and that it was also mandatory to review staffing levels on a six monthly basis.

- It was confirmed that the Local Authority stakeholders for the Independent Mental Health Act services were primarily the Director of Adult, Community and Housing Services and the Assistant Director for Quality and Commissioning.

- With regard to the reference to building a high performing organisation and the framework associated to improved training and development for staff, it was reported that there was a comprehensive training programme, particularly for clinical staff, and that all staff had to complete mandatory training such as in health and safety. Inspectors had picked up on the need to offer training on specific areas such as dealing with patient cohorts and it was stated that there was a specific budget allocated for training requirements. Consideration was also being given to developing a training programme for staff to increase their awareness on dementia so that patients needs can be met. It was also stated that should there be staff shortages the Trust had their own internal “bank” of staff that they could utilise to ensure that continuous care could be given to patients.

- Regarding 4.1 – Compliance Notice 1 – Ensuring the dignity, privacy and independence of service users and the query about the number of mixed sex wards and whether they promoted or detracted dignity, it was reported that older adult wards were mixed, however, it was pointed out that they conformed to National Health Service (NHS) guidelines. There were certain issues where patients with dementia were concerned and there was a need to be acute to dignity in these cases. Efforts were made to draw up an Action Plan prior to the admission of patients to ensure that their individual needs could be met.

- There was a robust programme in place to ensure that information and leaflets were available in a variety of formats and, since the inspection, all wards had been inspected with a view to ensuring that information was available and updated.

- It was reported that each Ward had a designated activity co-ordinator and The Trust had pledged to undertake a complete review of inpatient activities with a view to expanding and exploring the delivery of activities during the out of hours period. Ms Ingram undertook to feedback the comments made about elder community groups and that various organisations, such as Age Concern, experienced similar difficulties and the suggestion that activity co-ordinators should collaborate with a view to developing a programme to benefit the community.

- Ms Ingram undertook to provide to the Senior Policy Analyst for circulation to Members a document containing information in relation to the timescales of completion for the actions plans and recommendations relating to the compliance areas. It was reported that the Action Plan was closely monitored by the Board.

In concluding the debate the Chair requested that an update report be submitted to the Committee for consideration at its meeting to be held in November, 2014.

Resolved

(1) That the information contained in the report and slides as circulated at the meeting on the new Care Quality Commission Assessment (CQC) processes and inspection regime and the outcome of the assessment, as contained in the report and slides circulated at the meeting, be noted;

(2) That the work of the Trust undertaken to fully address the “Must, Should and Could” identified actions/areas for further improvement, be supported.

(3) That a further update report from the Trust be submitted to the Committee at its meeting to be held in November, 2014.

6 **Update on Urgent Care Development**

A report of the Chief Accountable Officer was submitted on progress made towards the opening of the new Urgent Care Centre (UCC) in Dudley.

Mr Evans and Mr Haynes in presenting the report also provided background information, highlighting the issues and concerns that had previously been discussed by the Committee, for the benefit of new Members,

Arising from the presentation of the report Mr Evans and Mr Haynes responded to queries and comments made by Members as follows:-

- It was expected that the new Urgent Care Centre (UCC) would open towards the end of April of next year and it was commented that it would genuinely be a better, safer and more efficient model of care.

- The bidding process was explained and it was reported that the applicants had been provided with a brief for the Centre and that they were expected to come back with suggestions and their offer by 10th August, 2014. Following the completion of this stage the service specification could be made available to the Committee for their perusal, together with preliminary drawings and floor plans to include the number of bays etc. The Multi-Disciplinary Panel would then scrutinise the information with a view to awarding the contract to the most suitable provider in early October.

- In relation to a query that an earlier version of the specification did not reflect what the GP service provision would be and their role in the initial assessment, if any, it was confirmed that although the GP's may not be doing the streaming the Urgent Care Centre would be a GP led service. However details relating to the exact numbers of GP's and other staff that would be available and on site at any given time would be finalised following submissions from potential providers. A flow diagram would also be made available.

- It was explained that the Urgent Care Facility would comprise of a single point of entry and that a robust process would be in place with a view to seeing patients. Patients that presented themselves by "walking in" or via ambulance at the Urgent Care Centre would be seen by a Senior Nurse for an initial assessment and depending on the outcome of the assessment the patient would be directed to the Urgent Care Centre or the Accident and Emergency Department for treatment.

- A significant amount of work had been undertaken in conjunction with NHS England to improve and develop GP practices. GP's had been encouraged to consider extending their opening hours which had a positive impact as the number of patients not being able to get an appointment with their GP had declined. Although retaining and recruiting GP's was a national problem and an ongoing challenge consideration was being given to attract GP's to Dudley. It was confirmed that discussions were taking place with a view to smaller practices combining and merging with the larger practices.

- With regard to an update on the position in relation to a twenty four hour pharmacy on site it was reported that although there were plans to explore the option it was the responsibility of the Dudley Group NHS Foundation Trust and a decision for them to make.

- In relation to whether any appropriate training would be given to the "navigator" to resolving conflict with patients it was reported that the current version of the specification contained more detailed information and that potential providers would also be scored on their suggested submissions.

- In relation to managing the increase in the numbers of patients, the potential delays that would occur and insufficient car parking spaces to cope with the demand, it was stated that there were various mechanisms in place to alleviate problems. These included the NHS 111 first call triaging for all patients that telephoned the centre who could potentially be offered a more appropriate alternative which may mean that the patient did not need to access the urgent care centre. Furthermore the urgent care centre would deal with minor injuries far more rapidly than the current Accident and Emergency service resulting in patients being on site for a lesser time. Also the centre offering booked appointments for the out of hours service would help to keep time spent on site for patients using this service to a minimum. The development of GP practice appointment capacity across Dudley and the opening of the maternity staff car park for public use would also help alleviate parking issues. Concerns about parking in adjacent roads and the arising problems for residents were noted.

  Arising from discussions on parking issues and concerns the representatives of the Dudley Clinical Commissioning Group agreed to:-

  Consider a contingency plan relating to parking issues being included in the Centre's Business Continuity and Disaster Recovery Plans;

  Consider the suggestion for installing additional pay machines to alleviate the queuing problem;

  Invite representatives of Interserve to the next meeting of the Committee to respond to concerns about parking fees and issues with concession passes;

  Consider sharing the final specification document with Centro with a view to consideration being given to improve public transport to Russells Hall Hospital.

  Circulate to Members of the Committee the final version of the specification, together with preliminary drawings and floor plans following the completion of the tendering process in August, 2014.

Resolved

(1) That the information contained in the report updating Members on the development of the urgent care centre, be noted;

(2) That a further update report to include the final version of the specification be submitted to the meeting of the Committee to be held in September, 2014.

(3) That representatives of Interserve be requested to attend the next meeting of the Committee with a view to responding on concerns relating to parking fees.

8 **Work Programme 2014/15**

A report of the Lead Officer to the Committee was submitted on the health scrutiny work plan for 2014/15.

Arising from the presentation of the report the Chair suggested that Members contact him directly within the next seven days should they wish to include any further items in the work plan and that consideration for inclusion of any additional items would be made in consultation with the Vice-Chair and Lead Officer to the Committee.

The Chair requested that all relevant information and background papers relating to future reports be provided for information for the benefit of Members and also that reports and information be received together in advance of the meeting.

In response to a request the Senior Policy Analyst undertook to circulate to Members a hard copy of the Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

The Committee noted that since submission to the Overview and Scrutiny Management Board a change in the topic for the in-depth review for the Committee for 2014/15 was proposed and it was considered that the Committee's area for review should be Dudley Physical Activity and Sport Strategy.

Resolved

(1) That, the information contained in the report and Appendix to the report submitted on the proposed work plan, be approved.

(2) That Members be requested to inform the Chair within the next seven days of any further items that they wished to be considered for inclusion in the Committee's work programme.

(3) That the Overview and Scrutiny Management Board be requested to consider the Committee's proposal to change the Committee's area for scrutiny from "Elements of Patient Experience in Acute Care" to "Dudley Physical Activity and Sport Strategy".

(4) That, subject to approval of (3) above, a Working Group be appointed to consider the proposed area for scrutiny, Dudley Physical Activity and Sport Strategy, and that membership of the Group comprise the Chair and Vice-Chair of the Committee together with Councillors K Shakespeare, N Barlow, S Henley, P Brothwood and E Taylor.

The meeting ended at 8.40 p.m.

CHAIR

The Dudley Group NHS
NHS Foundation Trust

I'm proud to work at The Dudley Group because it...

Paula Clark, Chief Executive

The Dudley Group NHS
NHS Foundation Trust

Why are we talking about money?

The NHS has been protected from Government cuts hasn't it? Sadly No, what we get paid drops by 4% a year

The recession is over isn't it? Government still making budget cuts to 2017

I hear DGNHSFT made a small profit last year so we're still OK £300k on £300m! Tiny!

If we overspend the CCG will help us out? Money is tight for them too

Finance always pull a rabbit out of the hat Not this time; we're running out of cash in the bank

at a glance

NHS provider sector finances

Foundation Trust Network

Since the formation of the NHS in 1948, health expenditure has increased by around **4 per cent** annually in real terms. However, since 2010/11, government expenditure on health has increased at only **0.1 per cent**. If this trend continues, and the NHS budget remains flat in real terms, this will have fundamental implications for provider sector finances and the care they are able to deliver to patients.

£130bn
Required health expenditure by 2020/21

30bn
Funding gap

100bn
Expected NHS England budget

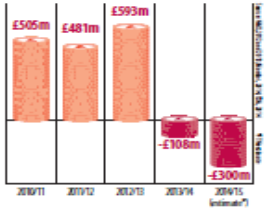
What does this mean for provider finances?

Number of providers in deficit

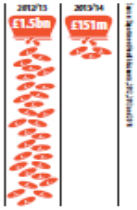
Financial performance (EBITDA for FT sector)

"I'm putting in the trust's first deficit plan for over twenty years"
Finance director at an NHS trust

Net provider financial position (trusts and FTs)



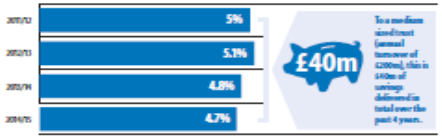
DH revenue underspend



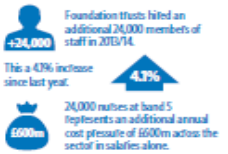
64% of providers are concerned about the financial and operational sustainability of their trust in the next 5 years.

NHS providers are still managing to deliver high quality care, despite unprecedented levels of efficiency savings

Financial savings delivered



Staff numbers (FT sector)



What needs to be done?

If current trends continue, the number of providers in deficit will continue to grow. It is unsustainable for NHS providers to keep absorbing cost pressures by going in to deficit or by cutting surpluses that would otherwise be used to improve patient services. We need:

A FUNDING AND PAYMENT SYSTEM for providers which more realistically matches resource to demand.

RECOGNITION that transforming services requires invest-to-save funding support rather than annual budget slicing.

A MULTI-YEAR SETTLEMENT for the NHS after the general election to give providers a stable platform to plan from.

The NHS challenge:

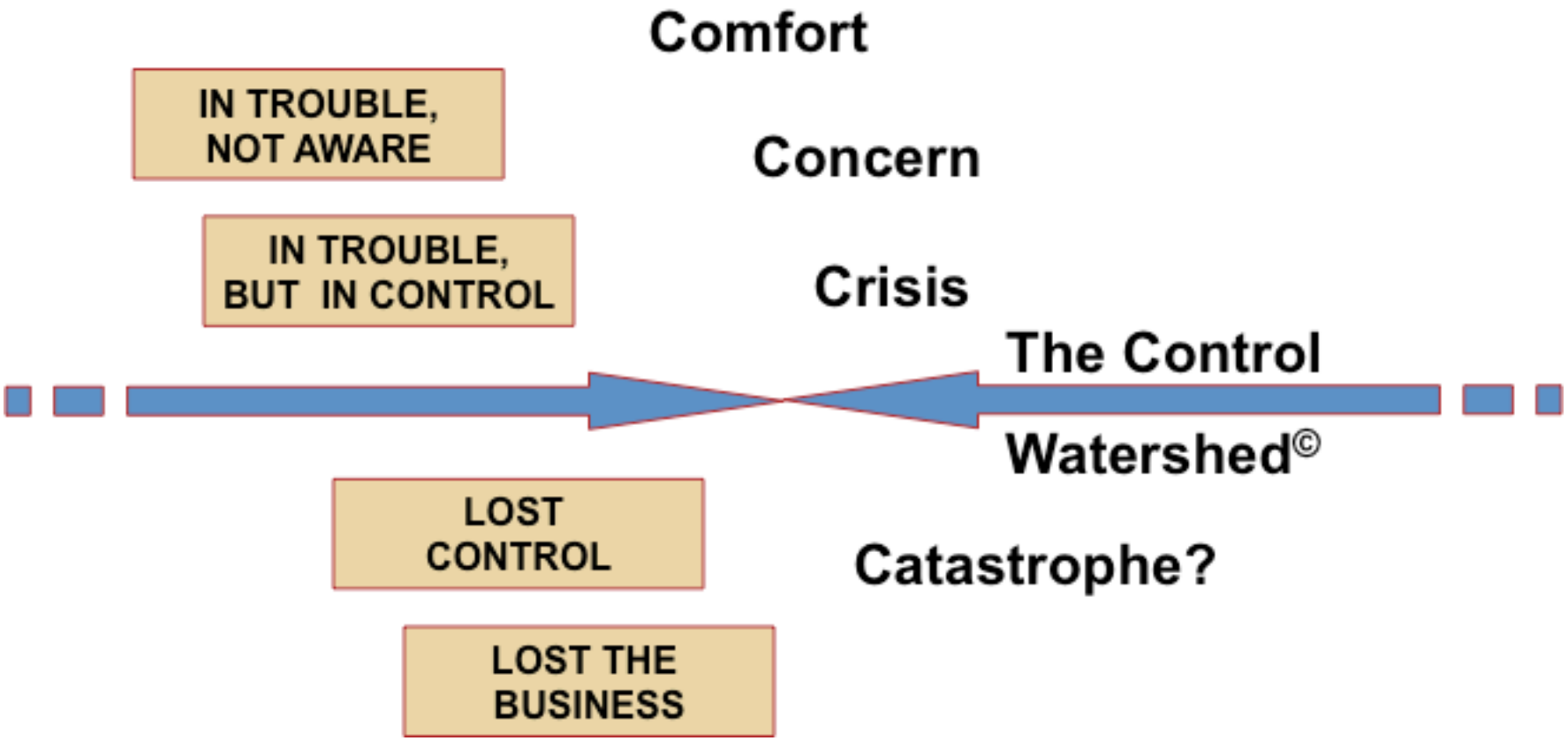
The Dudley Group NHS
NHS Foundation Trust

- NHS spending has increased on average by 4% a year.
- For the decade ahead, the NHS budget is likely to remain flat in real terms.
- Demand is expected to rise as people live longer, have more complex health problems and more advanced treatments become available.
- These trends in funding and demand have in part led to a financial gap in The Dudley Group of £21m for 2014/15 and £30m over the next two years.
- Forecasting a deficit for the first time in our history
- To meet this challenge, our organisation and the wider health services must change.
- We have placed ourselves in turnaround to try to prevent this being enforced upon us by our regulator Monitor
- Monitor in June agreed our planned £6.7 million deficit

Chief executive's introduction:

The Dudley Group NHS
NHS Foundation Trust

Staying in control of our own destiny:



Our Clinical Professional Leaders – Doctors & Nurses at the heart of change

The Dudley Group NHS
NHS Foundation Trust

- We must protect the safety and quality of our service and continue to provide good care to the people of Dudley.
- We must deliver the quality priorities as agreed in the quality accounts.
- Changes to operations directorate to empower clinical leaders and managers to work within our financial restraints.
- We are working to get nurse staffing establishments correct and recruiting overseas to fill vacant posts as well as 'growing our own'.
- We must enhance and embed ward-based Nurse leadership.

The Dudley Group NHS
NHS Foundation Trust

We are:

- Implementing a financial recovery plan to gain control
- Ensuring ward nurse establishment right by the end of 2014/15 (1:8 plus)
- Investing £3m in nursing establishment
- Cost controls are in place to regain control
- Investing in IT systems to enable us to be more efficient e.g. reducing manual processes
- Scrutinising every vacancy through a thorough quality impact assessment process
- Eradicating agency spend

At a glance 2014-2016

The Dudley Group NHS
NHS Foundation Trust

The Dudley Group operational plan

A place where people matter through values of

CARE

RESPECT

RESPONSIBILITY

The big seven

Grow three key specialties

Vascular

Stroke

Maternity

Redesign four specialties

Paediatrics
Renal
Care of the elderly
Neonatal

IT

Biggest IT investment in DG history to provide a clincally developed Electronic Health Record.

£3.1m
investment in registered nurses

Challenges and risks

- Improve and sustain urgent care performance.
- Recruit to nursing posts.
- Plan for a lower level of admissions under the Better Care Fund (BCF) intentions.
- Plan for the delivery of seven day services.
- Recover deteriorating financial position through turnaround and further service improvement.

Central to success of our plans

- The creation of significant inpatient capacity to improve our elective activity contract and Referral To Treatment performance.
- Integration of community services to ensure multi-agency teams focused on long term conditions and care of the older person.
- Embrace redesign of other specialties.

The greatest quality risks

- Poor patient flow leading to poor patient experience.
- Inpatient nursing establishment, not yet optimised in all areas.

Turnaround plan delivery

National targets

How will we deliver this?

Turnaround

Local Health Economy

Wider Black Country Review

One third of benefit can be delivered by local service improvement/turnaround effort within the Trust
Redesign and improve patient services to improve quality and efficiency, through, for example. shorter lengths of stay; assume 2% savings per annum.

One third can be delivered across the local health economy
Redesign care pathways to transform how patient care is provided across the system and reduce unnecessary emergency admissions, improving quality and efficiency; assume between 1 and 2%

One third requires wider system intervention
In the Black Country we propose that a Black Country review is considered, to help identify a range of ways providers can work together.

Strategies

Clinical
Estates
Staff Engagement
IT
Quality
Workforce
Medical Workforce
Patient Experience

Overarching principles

- **Quality** – strong nursing standards, good governance systems, 24/7 cover in core district general hospital services, standardised medical best practice, excellent patient experience scores
- **Services** – clear decisions on future of our sub-regional specialist services and estate/IT strategy matching service need
- **Activ** – greater balance between core DGFT emergency and elective income, reduced emergency admissions, simplified urgent care model and consistent 4 hour target delivery, robust and significant surge capacity contingency, best in class standards on length of stay and outpatients
- **Workforce** – stable and well established nursing workforce, fully integrated health and social care teams, 24/7 cover where applicable
- **Finances** – improved liquidity, upper decile performance, capital developments with strong return on investment

Agenda Item No. 7

Health Scrutiny Committee – 22nd September 2014

Dudley Clinical Commissioning Group

Report of the Chief Accountable Officer, Paul Maubach

Update on Urgent Care Development

1.0 Purpose of Report

To update members on progress towards the opening of a new Urgent Care Centre (UCC) in Dudley.

2.0 Background

The CCG is currently going through a procurement process for the development of a new Urgent Care Centre (UCC) to be sited next to the Emergency Department (ED) at Russell's Hall Hospital.

The development will deliver a significant improvement in urgent care, offering 24/7 access to urgent primary care services, and will deliver care seamlessly with, the Emergency Department at Russells Hall Hospital. The UCC will replace the current Holly Hall Walk In Centre (WIC), which currently opens 8.00 am to 8.00 pm, as well as providing a new base for the GP Out of Hours (OOH) service.

Once open, the UCC will replace the Walk-in Centre (WIC) currently based at Holly Hall and will provide an enhanced service to the one currently offered at the WIC. (The WIC and GP Out of Hours contract have been extended to March 2015 to allow sufficient time for the UCC to be built, staffed and opened). Planning arrangements are in place to ensure there is a continuation of the Holly Hall facilities throughout the transition from the current service configuration into the new UCC model. If required due to slippage in the procurement or mobilisation stage of the UCC, the current contracts with Primecare have the facility to be extended.

The Dudley UCC is a key enabler for the new system of urgent and emergency care envisaged in Dudley CCG's Primary Care Strategy 2013/14 and Operational Plan 2014/16, as approved by the Health & wellbeing Board.

The CCG's proposals were the subject of widespread public consultation at the end of 2013. Regular updates have been given to the Committee since the project began in September 2013. The most recent update was on 16 July 2014.

This report provides a summary of progress since 16 July 2014 and outlines the next steps in the development of the UCC.

3.0 Report

The CCG will expect the appointed provider of the new UCC service to focus on two main objectives:

- **to ensure the delivery of a safe, high quality, efficient urgent care service**

which works seamlessly with the Emergency Department at Russells Hall Hospital

- **to play an active part in encouraging a culture change across the urgent care system, which supports innovation by staff in delivering the service and improves the ability of patients to access services appropriately.**

The CCG expects measurable quantitative outcomes from commissioning the UCC service. Features of a successful UCC include:-

- improved patient experience of urgent care and ensuring a patient's on-going healthcare needs are met in the most appropriate setting within the community or primary care;
- improved performance against NHS Constitution targets to patients around waiting no more than four hours to be seen, treated and admitted or discharged;
- reducing the number of patients attending Dudley Group NHS Foundation Trust (DGFT) Emergency Department. This will be achieved by treating and / or redirecting non-urgent patients presenting at the new UCC back to primary care and other community services;
- reducing the number of Russells Hall Hospital admissions from the ED. This will be achieved by the different approach to the clinical treatment of patients seen in the UCC by experienced GPs and Nursing Staff;
- support patients, where appropriate, by ensuring they are registered with a GP practice and aware of alternative care pathways which may be better suited to their needs;
- when required, provide clear information on the appropriate use of urgent and emergency care services.

The UCC will not:

- be a further access point for routine primary NHS care in the local health economy (these patients will be appropriately and actively navigated back into core primary healthcare services in the community); or
- duplicate existing service provision by primary care services.

Developments since the last update to HOSC

Following input from potential providers to the service specification a final version was completed and signed off by the project board the week of 11 August 2014. As agreed, this final version was forwarded for information to the Chair of the HOSC on 14 August. A copy is attached as Appendix 1.

The Committee will be aware that the procurement involves the tendering of an NHS contract will a value in excess of £15 million. The CCG is bound to a process which involves very high degrees of confidentiality and control over all documentation. Nationally, procurements of this size and nature now have many examples of unsuccessful providers suing commissioners where they find breaches in due process or protocol. The CCG will be undertaking an extensive public media campaign later in the year and will ensure at that point, Dudley residents and patients are informed of the new developments and benefits for the borough from the new service.

The UCC service has been developed with significant and continuing stakeholder input steered by a UCC Reference Group which meets monthly to oversee the development

of the specification and associated work streams. This multiagency group consists of all key stakeholders of the UCC and includes representatives from DGFT, West Midlands Ambulance NHS Trust, NHS 111, Dudley and Walsall Mental Health Partnership NHS Trust, Dudley MBC, Healthwatch, Primecare Ltd and patient representatives from the CCG's Patient Opportunity Panel (POPs).

A further UCC Project Board, with board level representation from the CCG and Dudley Group, has recently been constituted to lead on mobilisation of the UCC. This includes oversight of the associated capital development.

Next Steps

At the time of writing this report (10 September 2014)) the timetable for the rest of the process was as follows-

- the tender 'scoring' process will be completed by 12 September;
- The moderation of bidder's scores will begin the week of 15 September;
- a recommendation of contract award to the successful bidder will be made by the evaluation team by 1 October;
- a recommendation on contract award will be made to a CCG Board meeting on 9 October;
- following contract award and a ten day stand-still period the successful provider will begin the mobilisation plan of the UCC service, working towards a 'go live' date of 1 April 2015;

4.0 Recommendations

Members are asked to note the contents of the report.

Paul Maubach
Chief Accountable Officer, Dudley CCG
Contact Officer: Neill Bucktin
Telephone: 01384 321745
Email: neill.bucktin@dudleyccg.nhs.uk

Thinking Differently

NHS
Dudley
Clinical Commissioning Group

SERVICE SPECIFICATION

Dudley Urgent Care Centre

14th August 2014

Final Document
V0.1

This version was issued to potential Providers on the 11th July 2014.
Providers lease note that whilst every effort has been made to ensure this service specification is complete and final as possible, some minor updates may be required prior to the agreement of any contracts awarded as a result of this tender.

Version Control

VERSION	AUTHOR	DATE	COMMENTS
0.1	Jason Evans	13 February 2014	Initial draft completed
0.2	Jason Evans	14 February 2014	Revised draft following 13.02.14 Health and Wellbeing Forum
0.3	Rachel Denning	14 February 2014	Initial DGNHSFT feedback on outline UCC model
0.4	Jason Evans	28 February 2014	Comments included from 28.02.14 Urgent Care Centre Reference Group meeting
0.5	Jason Evans	06 March 2014	Comments included from 05.03.14 UCC GP Working Group meeting
0.5	Jason Evans	11 March 2014	Comment worked in from Dr Steve Mann Clinical Lead for Urgent Care
0.6	Jason Evans	18 March 2014	Comments on spec from Dudley CCG Clinical Development Committee
0.7	Jason Evans	20 March 2014	Comments from UCC Reference Group members. • WMAS • Healthwatch • Representatives of Dudley CCG Patients opportunities Panel • DGNHSFT • D&WMHT • Current WiC and OOH Provider
0.8	Jason Evans	25 March 2014	Comments from Dudley CCG Clinical Development Committee meeting
0.9	Jason Evans	26 March 2014	Comments from Dudley Health and Wellbeing Board
0.9	Jason Evans	26 March 2014	Comments from Paul Maubach, Responsible Officer, Dudley CCG
0.9	Jason Evans	8 April 2014	Comments from Dudley Health, Overview and Scrutiny Committee Meeting
0.10	Jason Evans	23 April 2014	KPI's reviewed at Dudley CCG Clinical development Committee Meeting
0.11	Jason Evans/ Rachel Denning/ Raj Pawl	23 June 2014	Building in comments and contributions from nine weeks of design, planning and stakeholder engagement. Significantly is the contribution throughout the document from Rachel Denning (Transformation Project Facilitator - Urgent Care) and Raj Paw (Head of Medical Services A&E) of Dudley Group Foundation Trust
0.12	Jason Evans	28 June 2014	Building in comments and contributions from final week of stakeholder, clinical and patient review. A full list of contributors and suggested/ adopted amendments is available if required
0.13	Jason Evans	30 June 2014	Comments added from 27 June meeting with DGNHSFT UCC steering group (Comprising of Trust Executives and Head of ED). Comments added following detailed Healthwatch feedback report. Comments added from Director of West Midlands NHS 111
0.14	Jason Evans	04 July 2014	Comments added following 20 June and 7 July scrutiny meetings of V0.13 with Dudley CCG Senior, Executive Managers and Clinical Leads
FINAL	Jason Evans	11 July 2014	Final specification to be issued to providers agreed and signed off
FINAL 0.1	Jason Evans	14 August 2014	Amendments made following ITT provider clarification questions process

Document Approval

Dudley Clinical Commissioning Group	Date
Paul Maubach Chief Accountable Officer	11 July 2014
Dr David Hegarty, Chairman	11 July 2014
Dr Steve Mann Clinical Executive for Acute and Community Commissioning	11 July 2014
Dudley Group of Hospitals NHS Foundation Trust	
Final comments received and considered, amendments made.	30 June 2014
West Midlands Ambulance Service	
Final comments received and considered, amendments made.	30 June 2014
Dudley Metropolitan Borough Council	
Shared for comment.	23 June 2014
Dudley Health and Well Being Board	
Comments received and considered, amendments made.	26 March 2014
Dudley Healthwatch	
Final comments received and considered, amendments made.	30 June 2014
Dudley and Walsall Mental Health Partnership Trust	
Final comments received and considered, amendments made.	01 July 2014

Table of Contents

1. Document Terminology

The following terminology will be used throughout this document:

'Urgent Care Centre' (UCC) depicts a single point of access facility, integrating entry points for patients to access and be streamed into Emergency and Urgent Care services relevant to their clinical need located at Russells Hall Hospital site (RHH).

'Emergency Department' (ED) means the Dudley Group NHS Foundation Trust (DGNHSFT) Accident and Emergency department located at RRH as currently configured (i.e. consisting of majors, resuscitation, minors, paediatrics and Clinical Decision Unit).

'Streaming' depicts a short process of a visual and verbal assessment by a qualified and experienced clinician of the patient at formal registration at the UCC when they arrive, in order to signpost the patient to the most appropriate onward service. This will apply to all patients who attend the UCC irrespective or mode of arrival (the only exception being West Midland Ambulance Service (WMAS) direct access pathways and pre alerts for the RHH ED resuscitation room).

'Primary care service' depicts the provision of 24 hours a day, 7 days a week, 365 days a year primary care service, of the type normally provided by General Practitioner (GPs), for appropriate patients who require primary care, urgent care or the provision of Out of Hours (OHH) services.

'Assessment' depicts the performing of a clinical assessment +/- additional appropriate tests, investigations or treatment (commensurate with primary care) on patients after streaming. These investigations will inform the clinical assessors of the patient's onward clinical pathway and their prioritisation of treatment according to their clinical condition.

'Treatment' depicts any interventions/ administration of medication etc a patient receives within the UCC post streaming and following initial assessment, if appropriate (see Appendix 1 for diagrammatical overview of patient journey through the UCC).

2. Executive Summary

On the 9th January 2014 the Board of Dudley Clinical Commissioning Group (the Commissioner) [1] agreed to commission a procurement exercise to identify a suitable Provider for the new UCC on the RHH site, adjacent to the existing ED. The start date of the new UCC service is 1st April 2015. The Contract will be for a term of 5 years with the possibility of extending the term by 2 year(s) beyond the initial contracted duration by mutual agreement. Key aspects of this contract are as follows:

- The commissioning by Dudley CCG of the UCC will replace the existing Dudley Walk-in Centre (WiC) and Out of Hours service (OHH). Dudley WiC and OHH service will as a result cease to operate from its current location at Holly Hall Clinic, Stourbridge Road, Dudley, DY1 2E.
- Providing a 24 hours a day, 7 days a week, 365 days a year single point of access UCC service, streaming patients (both ambulatory and ambulance conveyed[2]) either into services provided by DGNHSFT – such as ED; or into the primary care component of the UCC;
- Providing a 24 hours a day, 7 days a week, 365 days a year urgent primary care and OOH assessment and treatment service;
- A key feature of the new UCC will be the seamless integration with the NHS 111 service;
- As part of the triage process, the UCC provider will be expected to redirect non-urgent primary care cases elsewhere and encourage unregistered patients to register with a GP;

1. See Dudley CCG Board Paper 'Dudley CCG Urgent Care Reconfiguration V.8 09.01.14
2. The exception to this being medical emergency conveyances requiring immediate ED care i.e. Resuscitation.

- One of the key principles of the UCC will be the ability to facilitate the timely turnaround of patient transfers from ambulances to waiting clinical staff and that capacity will be in place at the UCC to deal with planned and unplanned surges in ambulance conveyances;
- Suitable qualified clinical practitioners with emergency care experience or equivalent qualification will be employed to help safely stream patients, along with dedicated non-clinical Navigators who will assist patients in booking alternative appointments (i.e. GP Practice, community service, voluntary sector Provider);
- The primary care service will offer a mix of walk-in appointment slots and bookable appointment slots (OOH only). The latter will be bookable in advance via NHS 111.
- Over 95% of all presenting patients at the UCC who are either turned around or streamed into the primary care service, will be seen and discharged within two hours;
- The UCC service provider will be expected to be flexible – managing the mix of appointments and the scheduling of appointments over time in order to both meet emergent demand whilst complying with performance standards;
- The Provider will be expected to operate to the same protocols that Dudley CCG member practices operate when providing urgent care. These protocols will be regularly updated over time by Dudley CCG. The Provider will be expected to participate in; and contribute to; the development of these protocols and Dudley CCG membership education and training sessions.
- The UCC will operate the same IT system as all Dudley member practices (EMIS Web) and have access to Dudley GP records. The protocols for sharing and updating records back to individual member practices will be negotiated through mutual agreement between the UCC provider and Dudley CCG.

There are two fundamental contributions which we will be looking for from the new Provider of the UCC:

- To work in partnership with DGNHSFT to provide a safe, comprehensive, effective and seamless urgent care service which meets NHS Constitution Standards;
- To work as an associate member of Dudley CCG, both:
    - ensuring that the primary care service operates to the same protocols as Dudley CCG member practices; and that it makes its contribution to the broader agenda of primary care improvement across Dudley; and
    - Contributing to the wider system culture change across Dudley to change the way the UCC is used by both the public and other providers.

The UCC Provider will contribute to changing the culture and behaviour of both patients and other service providers and the Commissioner will expect them to be an active participant in the local health and social care system. The Commissioner will be looking for innovative approaches from the successful bidder in making this contribution; including but not limited to:

- Streaming of patients through the UCC resulting in reduced attendances in ED and that treatment from UCC GPs will also help cut unplanned admissions;
- Streaming non-urgent patients away from the UCC and educating regular attenders on the appropriate use of services;
- Providing continuous audit data on inappropriate attendances and referrals, with a view to highlighting opportunities for changing operational working practices elsewhere in the system. This would then include contributing to Dudley CCG education and training events and service redesign workshops in order to help develop the improvements needed to make those changes;
- Promoting opportunities to improved integrated working between other organisations within the urgent care pathway;
- The patient activity and turnaround times from registration to discharge within the UCC will be counted towards RHH ED 4 hour wait target;

3. Background

Most urgent care problems are not life-threatening. For these problems patients need help, advice and simple treatments delivered as close to home as possible. The vast majority of people already seek and receive treatment and care for their urgent and emergency care needs in the most appropriate setting. However, it is the case that thousands of people every year do receive advice and treatment in ED departments when they could be better served in a primary care setting. Dudley CCG recognises a huge opportunity through the commissioning of an effective UCC to shift treatment and advice from acute hospital based services to primary care or other community based services (see figures 1 & 2 (page 44-45) for national and local service model).

Primecare Ltd currently operates the Dudley WiC and OOH services which are geographically located 700 metres from the existing DGNHSFT ED Department. Local consultation and national best practice identifies that this configuration for patients can be confusing when they make choices on accessing urgent care. It can also promote inefficiencies in the use of resources to have two services which can treat similar patients operating independently but so geographically close together. Annual patient attendances within the existing urgent care configuration are **164,700** (combined ED, WiC and OOH attendances) approximately **450** patients per day (see Activity section 13.1 – 13.9 for full details of current and estimated patient numbers modelling).

It is commonly estimated nationally that 25-40% of patients currently presenting at ED could be treated in community primary care facilities. It is further held that 80-90% of patients presenting at WiC facilities could be treated in community primary care facilities. A recent Dudley CCG Nurse led streaming audit of **3000** presenting patients to RHH ED, confirmed the proportion of cases that could be treated by primary care practitioners to be **32%**. This means that with the WiC, OOH and ED streamed primary care cohort activity combined, the new UCC will see approximately **99,500** patients per annum and ED **65,300**. Future modeling indicates that contract activity will see a growth of **2.1%** over the next five years (i.e. 0.52% per year).

4. About This Document

This document should be read in conjunction with the following other UCC project documentation:

Document Title	Status	Owner
UCC Business Case	Version 0.8 submitted to the CCG Board meeting on the 09.01.14. Approval given to proceed to procurement.	Dr Steve Mann – CCG Clinical Lead for Urgent Care, Dudley CCG
UCC Procurement Timeline	Produced by the Commissioning Support Unit (CSU) on the 05.02.14	Jason Evans - Commissioning Manager of Urgent Care
ITT Requirements	Published by the Commissioning Support Unit (CSU) on the 04.07.14	Jason Evans - Commissioning Manager of Urgent Care, Dudley CCG
Dudley CCG Operational Plan 2014-16	Produced by Dudley CCG April 2014	Dudley CCG
Dudley CCG Five Year Strategy (v4)	Produced by Dudley CCG April 2014	Dudley CCG
Dudley CCG Constitution	Produced by Dudley CCG December 2013	Dudley CCG

This final UCC Service Specification will be inserted into Schedule 2 of the main contract between the Commissioner and the Provider.

5. Service Aim and Objectives

5.1 Service Aim

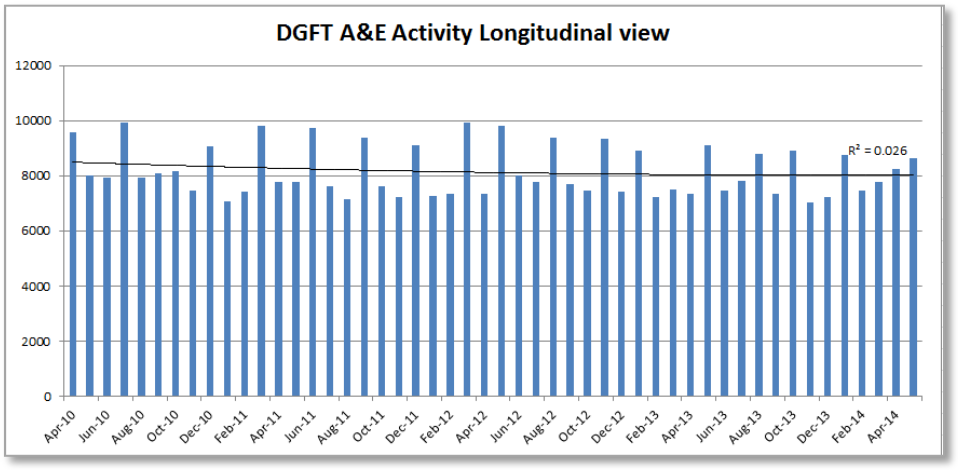
The purpose of the UCC will be defined as following:

To develop a coherent 24 hours a day, 7 days a week, 365 days a year urgent care service in the borough of Dudley that makes sense to patients when they have to make choices about their care. This will provide streaming for all presenting patients a seamless relationship with NHS 111 and if required urgent medical care with a clinical professional.

5.2 Service Objectives

As graph 1 overleaf shows, analysis of patient activity by month from April 2010 through to April 2014 confirms no significant trend of growth of patient numbers at DGNHSFT emergency department.

Graph 1.



ED activity by day from late September 2013 through to early June 2014 does however show a rise in activity. There has also been an increase in the number of ambulance conveyances and complexity of emergency admissions via the department. Furthermore the WiC has seen significant levels of growth since it was commissioned by Dudley Primary Care Trust in 2009.

By commissioning the UCC, the Commissioner requires the Provider (including the DGNHSFT) to operate with a fundamental change in philosophy, culture and mind-set about how patients are managed when they seek urgent care to avoid this trend continuing. With this in mind, the Commissioner expects measurable quantitative outcomes from commissioning the UCC service. Factors which will constitute a "successful" UCC are:

- Reducing the number of patients attending DGNHSFT ED, which in turn will contribute to DGNHSFT sustaining the A&E four hour wait target. This will be achieved by treating and/or redirecting non-urgent patients presenting at the new UCC back to primary care and other community services (see Section 7.6 Redirections);
- Reduce the number of RHH admissions from the ED. This will be achieved by the different approach to the clinical treatment of patients seen in the UCC by experienced GPs and Nursing Staff (see Section 7.12 Assessments and Treatment);
- Provide where applicable, information and educational support to presenting patients to ensure they are registered with a GP practice and are made aware of the range of alternative pathways of care which may have been more appropriate for their needs;
- When required, provide clear information on the appropriate use of urgent and emergency care services; and
- Development of a high quality service, which has a focus on effectiveness, patient experience and safety.

Other expected outputs from commissioning the UCC are to:

- Refine the patient flow through the DGNHSFT ED which will in turn:
    - Ensure the patient is efficiently and clinically prioritised and directed to the right area of RHH and to see the right clinician and receive the right treatment; and
    - Improve the patient experience and quality of service provided to patients.
- Ensure a patient's on-going healthcare needs are met in the most appropriate setting within the community or primary care;
- Reduce the numbers of patient handover delays (15 minute and 1 hour delays) from WMAS to RHH;

- Improve the integration of primary, community, OOHs, secondary and mental health services in the local area and help provide seamless care pathways between different service Providers;
- Develop the distinctive culture and approach of a primary care service within the RHH site;
- Use EMIS Web patient record system throughout the UCC which allows staff access to summary patient GP records where permitted (see Section 7.20 Patient Records);
- Use an integrated IT system to support patient flows and decision making across the UCC;
- Maximise the use of existing human resources in terms of skills, knowledge and competencies;
- Facilitate the registration of unregistered patients with a GP Practice;
- Provide information on health promotion, self-management, health education and sign posting of patients to other primary healthcare services in the community;
- Operate as a fully integrated element of urgent care provision on the RHH site with a seamless patient transition from UCC to ED and other parts of the Hospital (and vice versa) where required; and
- Provide a seamless pathway to any further assessment required within RHH, including referral (if necessary) to a hospital specialist.

The UCC will not:

- Be a further access point for routine primary NHS care in the local health economy (these patients will be appropriately and actively navigated back into core primary healthcare services in the community);
- Provide an emergency dental treatment service; or
- Duplicate existing service provision by primary care services.

6. Commissioner Service Requirements

The Commissioner requires the Provider to implement and operate a robust primary care led patient streaming function followed by primary care assessment and treatment for appropriate patients, facilitating and delivering a primary care led UCC which shall:

- Have a service model as described in Section 7;
- Integrate with other healthcare services as described in Section 8;
- Meet the quality and clinical governance standards as described in Section 9;
- Meet the service commencement date as described in Section 10;
- Meet the activity and performance measures as described in Section 11; and
- Utilise the payment model as described in Section 12; and
- Meet the Commissioning Standards of the UCC Contract.

7. Provider Service Model

7.1 Overview

The UCC will provide a senior GP clinical led service 24 hours a day service, 7 days a week, 365 days a year, delivering:

- A safe and consistent streaming service to all patients presenting to the UCC via consistent adherence to DGNHSFT ED clinical governance and all other related service policies;
- Provide a primary care assessment, prioritisation and treatment service (see Section 7.5 Streaming) to all appropriately streamed patients presenting at the UCC;
- Provide an OOH advice call, face-to-face and home visiting service where appropriate;
- Provide a "navigation service". Once identified as appropriate the Navigators safely redirect patients away from the UCC to other community based services more appropriate to meet their needs, as well as assisting unregistered patients to register with a GP Practice; and
- A central reception that will be the single point of patient registration for all ambulatory, OOH and ambulance bound patients (meeting the West Midlands Ambulance Service (WMAS UCC) inclusion criteria).

7.2 Name

The New UCC will need careful development in regards to communicating effectively with staff and service users and how it is identified to ensure patients do not use it inappropriately, particularly within GP core opening hours. It is proposed the UCC is called 'Dudley Urgent Care Centre,' however further consultation is required on this with Dudley CCG and DGNHSFT.

7.3 Access

7.3.1 General Principles

The Provider will work in collaboration with Dudley CCG and the CCG clinical membership to develop and deliver the UCC service model. The Provider will be expected to be open to future innovation and service development and focus on offering their own solutions to further develop and refine the service model.

Upon presentation at the UCC a clinical streamer will determine if a patient is to be seen in the primary care stream, directed to ED or directed to alternative pathways (see Section 7.5 Streaming). The Provider must contract to supply to all patients with communication difficulties a professional translation service.

Educating patients about the appropriate use of healthcare services will be a core component and aspiration of the UCC culture and service delivery model. Encouraging appropriate use and changes in attitude by patients to urgent care use (when appropriate) is a key aim to ensure patients attend their own GP at every opportunity. This will be a pervasive theme as patients move through the UCC pathway. This will include, for example, the Navigators helping unregistered patients register with a GP Practice or providing leaflets to patients on local pharmacy or dentistry services.

7.3.2 Opening Hours

The UCC will be open 24 hours a day, 7 days a week, 365 days per year.

7.3.3 Telephone Access

As a rule the UCC will not provide clinical advice over the telephone to patients. Patients will call NHS 111 and first be call screened by a call handler through the Pathways Call Triage System. The patient will as a result be either dispatched an emergency ambulance via 999; encouraged to make an appointment with their own GP Practice, or directed to attend the UCC in person. If OOH, NHS 111 may directly book an appointment for the patient at the UCC or transfer the patient call to an UCC GP to discuss the option of an OOH home visit.

Direct booking for OOH appointments at the UCC will be undertaken by NHS 111. This removes an administrative step and potential delay for patients. Patients that book an appointment at the UCC via NHS 111 may find there is a wait to see a clinician reduced as a result. This approach is highlighted as the national intention within the June 2014, NHS 111 Commissioning Standards.

If the patient requires an OOH home visit, NHS 111 will pass their details to the UCC call handler (standards will be set for transfer and response times between NHS 111 and the UCC). The process of assigning OOHs home visits will be managed by an UCC GP. The GP will contact the patient and discuss their condition in order to determine whether a visit is the most appropriate outcome and if so what priority it should be given. If still appropriate, a home visit appointment will be arranged. There would be a significantly large number of calls via NHS 111 that would come through each month to the UCC and a small administration team will be required to manage this. Call volume for the WiC and OOH services in 2013/14 is detailed below in Table 1. for reference purposes:

Table 1. **Call volume for current WiC and OOH services 2013/14**

Referral Method	Total	%
NHS 111	14,614	93.8%
West Midlands Ambulance	201	1.3%
GP or Other HCP	119	0.8%
General Public	577	3.7%
Other Source	61	0.4%
Total	**15,572**	**100.0%**

7.3.4 Appointments

The UCC will provide pre-booked appointments to patients outside of GP practice core hours (18:30 – 08:00 weekdays, weekends and Bank Holidays). The use of the UCC by patients as an alternative to primary care should be actively discouraged by the Provider and form part of the programme of information, marketing of the service and education of patients. Patients will not be offered or be able to book appointments at the UCC for the follow up of any conditions. Follow-up treatment must take place via their own GP or identified alternative Provider.

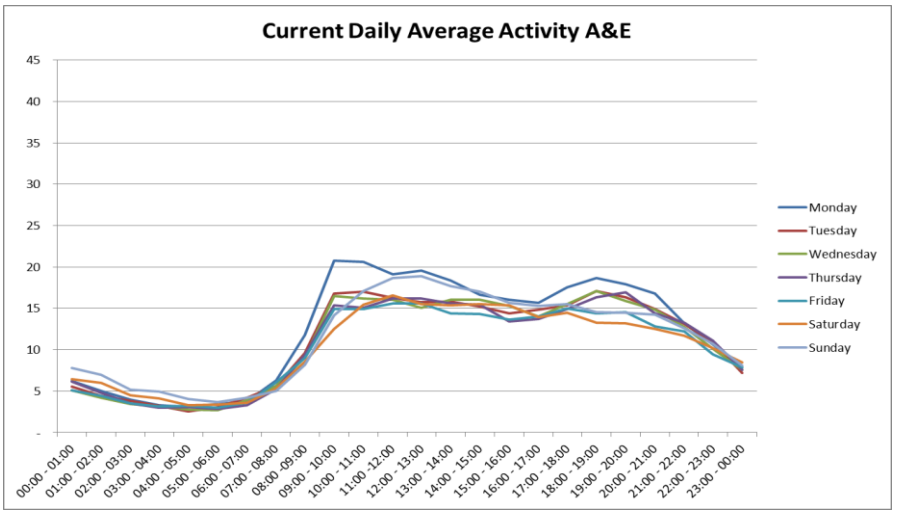
7.3.5 Registered Patients

The UCC will not be a “traditional GP Practice” in the sense that it will not have a list of registered patients. The UCC is designed to stream, assess and treat (where clinically appropriate) patients that would normally try to access a GP, ED or the WiC for an urgent or primary care need. The UCC will then, if required, direct patients back to their own registered GP for necessary follow up care or encourage registration with a GP if they are not already registered.

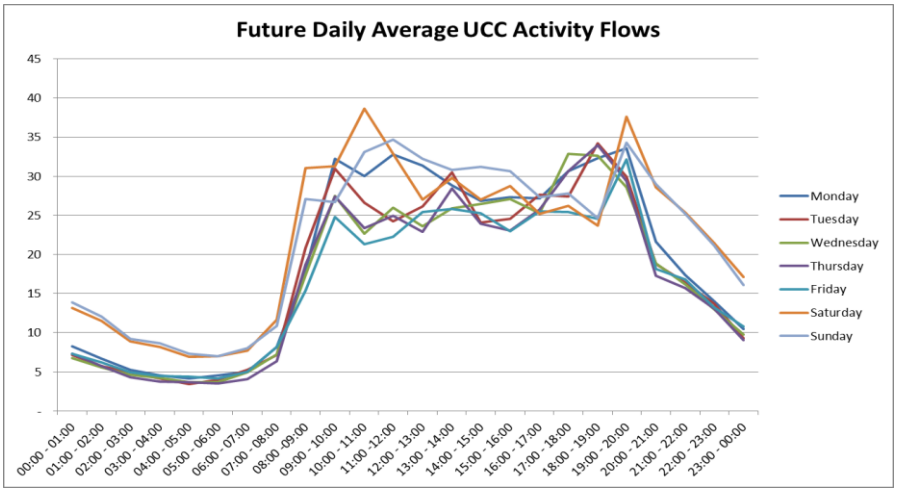
7.4 Patient Flow

The current average daily patient flow through RHH ED is shown in graph 2 below. The estimated daily patient flow through the new UCC (Including ED, WiC & OOH activity) is summarised in graph 3. A comprehensive suite of data and analysis on current and predicted levels of activity will be made available to the Provider following the publication of the UCC Service Specification.

Graph 2.



Graph 3.



The patient flow is described in Appendix 1. Streaming, primary care assessment and redirections will be the subject of on-going scrutiny and continual refinement by the Provider and the Commissioner to ensure the best possible service model is achieved for patients. Consideration and staffing provision will need to be in place by the Provider for increases in UCC activity due to seasonal variation and/ or other factors which may affect demands on primary care. The potential range of presentations per hour at the UCC is summarised in table 3 below.

Table 3. **Average presentations per hour in the UCC**

Average range of presentations per hour	4 to 38 patients per hour
Average streaming/ registration time	3 minutes 30 seconds
Triage minutes per hour	14 to 133 minutes

7.5 Streaming

All patients arriving at the UCC (either by ambulance or self-presenting walk-in patients) will present for initial streaming and (if required) registration. The rationale behind having streaming integrated into the formal registration of a patient is to achieve a rapid, clinical, verbal and visual assessment of the presenting patient as soon as possible. This allows for immediate prioritisation of a patient based on clinical need. The streaming will be swift, systematic, safe and consistent, both in terms of the clinical staff delivering the function and the time of day when it is done. The screening tool to be used is an adaptation of the Manchester[3] Triage System (See Appendix 2*).*

7.5.1 Staffing

The staff undertaking the streaming will be experienced qualified clinicians (see Section 7.21) who will have sufficient clinical skills and experience in emergency care, including the confidence to safely redirect patients (see Section 7.6 Redirections). They will work closely with the UCC reception staff.

To avoid queues of patients waiting for their streaming/ registration the volume of staff undertaking the streaming/ registration will be sufficient, appropriately scheduled and rapidly scalable up and down, to meet patient throughput (See section 13. Activity for estimation of the number of patients who will present at the UCC (ambulatlory and ambulance conveyed) at low and peak activity times).

7.5.2 See and Treat

There will never be “see and treat’’ (i.e. seeing patients when they arrive, assessing their needs, and providing treatment) during the streaming, although “see and advise” (e.g. “you need to see a dentist”) is within the scope of streaming. The rationale for this is the volume of patient attendances at the UCC and the queues that could form if the streaming/ registration clinicians were also treating patients[4].

7.5.3 Length of Time

The optimal target time for streaming/ registration will be 3 minutes 30 seconds. This is to manage the high volume of patient presentations and avoid queues of patients waiting. The 3 minutes 30 seconds is an average target time which will allow for some streaming/ registration to be shorter (less than 1 minute) and some to be longer (e.g. to make a clinically safe redirection decision). The average target time for streaming/ registration will be monitored and performance managed.

[3] The Manchester Triage Group was set up in 1994 with the aim of establishing consensus among senior emergency physicians and emergency nurses about triage standards. The MTS is not designed to provide a diagnosis, but a clinical priority, determined by a series of discriminators based on presentational recognition. The MTS is an algorithmic aid utilising a series of flow charts that lead the triaging healthcare professional to a logical choice of triage category also using a five-point scale. There are 50 MTS Algorithms which cover the majority of presentations likely in an emergency environment.

[4] If the process was for patients to first formally register on arrival with a non-clinician before being seen by a clinician, there is the potential for a seriously ill patient to be queuing behind a minor illness patient for some time as they wait to be registered. With the volume of attendances at UCC this process is clinically unacceptable.

7.5.4 Physical Layout

There will be a number of stations for streaming/ registration of patients arriving by ambulance and stations for walk-in patients. There will be clinical assessment rooms for the streamed primary care component. There will be dedicated waiting space for primary care streamed patients and ED streamed patients. Detail of these requirements will be found in the UCC Schedule of Accommodation and floor plan provided with the Invitation to Tender documentation.

7.5.5 Destination

Using the streaming/registration process will result in a patient directed to one of the following:

1. The Navigators for redirecting to other healthcare or social services in the community (see Section 7.6 Redirections);
2. A GP, Advanced Nurse Practitioner (ANP) or other clinician in the UCC for primary care assessment and treatment;
3. Another hospital or community based service that is appropriate to the patients clinical needs;
4. A voluntary or community sector organisation appropriate to the patient's needs;
5. ED;
6. Resuscitation[5];
7. Immediate Redirection; the patient may be advised no assistance can be provided at the UCC (see Section 7.6.3 Immediate Redirection).

7.5.6 4 Hour Clock

A patient will go through the streaming/ registration process (Target 3 minutes 30 seconds). On completion of this registration the "4 hour clock" will begin for the purposes of recording total patient time spent in the RHH Urgent & Emergency Care pathway.

7.6 Redirections

There are three patient pathway options when a patient is deemed appropriate for redirection outside the UCC:

1. GP Practice redirection (in hours) or when the practice is next open;
2. Social Services/ Community Services redirection (hours dependent on individual Providers);
3. Voluntary/ Community sector Provider.
4. Patient informed/ self-care

The redirection model described here will be developed by the Provider in partnership with Dudley CCG, NHS 111 Directory of Services (DOS), Dudley Community Information Directory and local services before the UCC service commencement. The redirection model will be the subject of on-going scrutiny and continual refinement to ensure the best possible outcomes are achieved for patients.

7.6.1 GP Practice Redirection (in hours)

The Provider will work with Dudley CCG and local GPs to establish a mutually agreed system whereby patients may be redirected to their registered practice within an appropriate timeframe and within GP core opening hours (Monday to Friday 08.00 to 18.30). The direct booking of a patient's appointment with the patient's GP by UCC staff is currently being explored.

[5] There is the potential for a very seriously ill patient to self-present at the UCC and be seen by the streaming clinicians. The Provider will ensure an "alert" system and handover process is in place for the immediate transfer of these patients to the ED department.

7.6.2 Redirections to other Statutory, Voluntary and Community Services Providers

The Provider will work with Dudley CCG and local statutory, community and voluntary sector Providers to when appropriate, redirect/ signpost patients to Community/ voluntary sector services. These may include but are not limited to local dentists, opticians, community pharmacies, social services, expert patient programmes, drug and alcohol services etc. The Provider will use NHS 111 Dudley Directory of Service and Dudley Community Information Directory for this purpose. Dudley CCG has a strong and formal relationship with Dudley Council for Voluntary Service (DCVS). It is expected that the Provider works with Dudley CVS to identify a range of Providers and services which the Navigators and clinical staff can signpost to, when required.

The Provider will also work with Dudley Healthwatch and develop links to their Information Points and Information Champions so the UCC is a key conduit in obtaining the patient and public voice on health and social care matters.

7.6.3 Immediate Redirection

A patient may present who has no clinical need and will therefore be advised at streaming/ registration that no further assistance can be offered. These patients may still however be directed to a Navigator for advice on informed/ self-care and/ or contact details for a more appropriate service.

7.7 UCC Reception

There will be one UCC reception area. The UCC Reception will be the only place where walk-in and ambulance conveyed patients (the only exception being WMAS direct access pathways and pre alerts for the RHH ED resuscitation room) are streamed/ registered. The UCC reception will have a number of reception stations. These will be staffed by streamers and reception staff working together at each station. The stations will be suitable for ambulatory patients and receiving ambulance conveyed patients. They will provide appropriate privacy and dignity to maintain patient confidentiality.

The existing RHH ED and paediatric waiting areas will be retained for patients that are directed through to these services by UCC streamers. Separate waiting areas will provide clearly visible and operational definition of waiting patient cohorts and support the ethos of clear clinical ownership of each cohort by clinicians responsible for their on-going care.

7.8 Patients not registered with a GP

All patients will be asked at their streaming/ registration if they are registered with a GP Practice. Any unregistered patients will be encouraged to register with the assistance of a Navigator if required. The Navigator may offer to contact a GP Practice on behalf of the unregistered patient and arrange a convenient appointment for completion of their preliminary health checks necessary for GP Practice registration. If the patient does not wish to choose a GP Practice while at the UCC, or if the GP Practice of their choice is not accessible, the Navigator will supply the patient with hard-copy information about relevant GP Practices and of the treatment they have received. A new patient registration pack will be available for distribution to identified patients to support this process.

Patients not registered with a GP will be offered a GMS1 by a Navigator so they can register at a practice of their choice.

7.9 Payment for patients not registered with a Dudley GP

The Commissioner will not provide a payment or tariff to the Provider for patients that are seen and/ or treated at the UCC and who are not registered with a Dudley CCG GP. Rather, it will be the responsibility of the Provider to identify the patient's registered GP practice and invoice their 'home' CCG for reimbursement of costs. The Provider will be required to provide sufficient administration staff to facilitate this process. Table 4 below details the commissioner split for the financial year 2013/14.

Table 4. **Estimated Commissioner Split of existing activity**

CCG	A&E	WIC	OOH	Total	Split
Dudley	69,737	38,641	13,478	121,857	74%
Other	26,358	12,203	4,256	42,817	26%
Total	**96,095**	**50,844**	**17,734**	**164,673**	**100%**

7.10 Flagged Patients

DGNHSFT and other organisations will issue the Provider with a list of "flagged patients" (for example, patients within virtual wards, frequent attenders, registered mental health patients that present risk or potential risk to staff etc.) along with guidance as to what action should be taken for each flagged patient that presents at the UCC. At patient registration, the EMIS Web system will have the ability to facilitate some of this process.

7.11 Waiting Areas

The UCC waiting area will comply with accepted standards, national and local policies and statutory responsibilities[6].

7.12 Assessment and Treatment

The main primary care assessment/ treatment element of the UCC service model will be based in one area and delivered by a mix of qualified and experienced clinicians such as a GPs, ANPs, paramedics or clinical nurses. These clinical staff will treat and discharge within two hours of registration:

- Patients with minor injury (out of scope of minor injury are patients requiring X-ray, who will be streamed to ED) or minor illness; or
- Patients that have a problem that may need further assessment, investigation, diagnostics or observation, but who are not regarded as requiring their main treatment in ED.

The assessment will define their urgent care need and provide appropriate treatment/ advice to safely discharge the patient back to their normal residence with appropriate follow up arrangements or arrange admission to the appropriate specialist service at DGNHSFT.

The UCC principal assessment/ treatment area will be similar in style and specification to those provided for that of a General Practice, in particular utilising individual consulting rooms to facilitate privacy and confidentiality.

[6] For example, the Royal College of Paediatrics and Child Health (2012) Standards for Children and Young People in Emergency Care Settings: Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings.

7.13 Children

The Provider will need to respect the different needs and approaches to delivering a primary care service to children and respond appropriately. The Provider will ensure paediatric training and safeguarding awareness is a key component of the clinical and non-clinical UCC staff team. The Provider must have within the clinical workforce, paediatric trained nurses as per Nursing and Midwifery Council regulations to assess and care for children. If appropriate the Provider will communicate with external children's service providers when children who attend the UCC are recorded as Looked After Children, Universal Partnership Plus Care Pathway, Child Protection Plan or identified as a child in need. The Provider must adhere to the 2011 'Your Welcome' guidance quality criteria for young people friendly health services.

7.14 Diagnostics

The UCC staff will have access to suitably identified diagnostics commensurate with primary care treatment (ECG, urinalysis, clinical observations, outpatient booked appointment based pathology and radiology). Any further investigations, for example X-ray, will only be available via the ED streaming pathway within DGNHSFT. UCC clinicians will only offer diagnostic tests relevant to the presenting illness. All other non-urgent problems should be referred back to the patient's registered GP. The Provider will work with DGNHSFT and agree protocols, governance and referral pathways.

7.15 Discharge

Where the UCC Provider treats a patient, the Provider will pass the patient's details, information of the care provided by the UCC and any further information (for example, the need for the GP to follow up with the patient) electronically within six hours of discharge or by 8am the next day (whichever comes sooner) to the patient's own GP Practice.

Patients who are directed to another clinical pathway within the hospital, for example the Medical Assessment Unit (MAU) will be transferred with electronic summary of their episode of care at the UCC, summarising their presenting condition, diagnosis (if undertaken) and the treatment that was provided (if given). If required patients should also be given appropriate printed materials by the Provider relating to their specific condition. If a patient has any questions once they have been discharged from the UCC, they will be asked to call their own GP Practice.

7.16 Follow Ups

The UCC will not provide any follow-up service. The Provider will not provide a bookable appointment service for following up any conditions. If further follow-up care is required, the Provider should signpost the patient appropriately (for example: to their own GP, a community bed, care at home or other intermediate care services), and will need to agree processes with other local Providers for this to happen.

7.17 Telephone access to the UCC

Direct telephone access to the UCC will not be available to patients in GP core hours 08:00 – 18:30 or OOH. Patients will call NHS 111 and if appropriate a patient disposition may mean they attend the UCC or by offered an OOH or home visit appointment.

7.18 OOH service

Access to the UCC out of GP core hours 18:30 – 08:00 weekdays, weekends and Bank Holidays will be via NHS 111. Patients will call NHS 111 and first be assessed by a 111 call handler through the Pathways call triage system. The patient will, as a result be either dispatched an emergency ambulance via 999; encouraged to make an appointment within core hours with their own GP Practice or directed to attend the OOH service at the UCC in person. If an OOH appointment at the UCC is offered it will be the patient's own responsibility to make their way to the UCC (WMAS will not transport patients to and from OOH appointments). The booking will be made by NHS 111 and a time allocated to the patient. This will then be sent via a link to the system at the UCC so they know what patients are due to arrive and what time. A touch screen patient registration kiosk will be available within the UCC waiting area to expedite patients booking into an OOH appointment.

If NHS 111 deems the patient to require an OOH home visit, they will pass the patients details and/ or transfer the call to the UCC team. The process of giving advice and (if appropriate) assigning OOH home visits will be managed by an OOH GP within the UCC. The GP will contact the patient and discuss their condition in order to determine whether a visit is the most appropriate outcome and if so what priority it should be given. A home visit will only be required if a patient's physical, social and/ or mental health circumstances means they are unable to attend the UCC. OOH home visits should be an exception and would ordinarily only be expected to be appropriate in the following circumstances:

- Patients with terminal illness;
- Patients who are truly "bed bound";
- Patients for whom a car journey could lead to unnecessary deterioration of their condition; or unacceptable discomfort.

The home visiting service will be available during the following times:

- 18.30pm to 08.00am every weekday;
- 24 hours a day every weekend;
- 24 hours a day every public holiday.

Any need for UCC GPs to carry out a home visit during OOH must not leave the UCC short-staffed and vice versa.

The provider will also need to plan and ensure capacity is in place for urgent patient care to cover the times practices are closed for Dudley CCG GP Membership training events. These events take place within GP core hours, eight times a year and last approximately two hours. For each session Dudley CCG will provide a list to the Provider of the participating practices and which, as a result will require cover. When a patient phones a practice at these times they will be directed to call NHS 111 and if appropriate, they may be then sent to the UCC for assessment and treatment.

7.19 Supply of Medicines

7.19.1 Overview

In the UCC, medication will be available to patients via three methods:

a) Patient Group Directions (PGDs). Nurses can supply a range of medicines (pre-labelled pre-packs or single doses) without a prescription under an agreed PGD
b) DGNHSFT ED prescriptions. Any doctor or independent nurse prescriber working within the UCC will have access to DGNHSFT ED prescriptions.
c) FP10 prescriptions will also be available to be used by the UCC prescribing staff.

7.19.2 During RHH Pharmacy Opening Hours

The RHH pharmacy opening hours are as follows:

Pharmacy	Monday Friday	Saturday	Sunday
Russells Hall Hospital	9am – 7pm	10am – 3pm	10am – 3pm

The patient (or representative) may take the UCC prescription to the RHH outpatient pharmacy or a community pharmacy of their choice to be dispensed. Normal NHS prescription charges will apply. A maximum of up to 28 days supply of medication will be provided to patients.

7.19.3 Outside RHH Pharmacy Opening Hours

Pre-labelled pre-packs can be issued to patients by UCC clinicians under a PGD. If clinically necessary a single dose of the medicine can be administered in the UCC. FP10 prescriptions will also be available to be used in the UCC and can be presented at a 24 hours a day pharmacy. In addition there is an on-call pharmacy service for emergency supply from 8am to midnight seven days per week. Plans are also in place to explore the potential for a 24 hour pharmacy to be opened on the RHH site. This development is separate to the UCC but will provide a potential route for UCC patients to gain access to prescription medication out of hours.

7.19.4 Formulary

All medicines must be prescribed according to the Dudley CCG Formulary and some combination products may be issued as separate constituents as per this Formulary.

7.19.5 Private Patients

A prescription issued within the UCC can be used as a private prescription to enable supply for non-NHS patients. The patient will be charged for these drugs where the normal prescription levy is not applicable. High street community pharmacies will treat hospital prescriptions as private prescriptions and private prescription charges may vary.

7.19.6 Advice

Advice on medicines is available from the DGNHSFT Medicines Information department and/ or the Dudley Office of Public Health Medicines Management Team.

7.19.7 Out of Hours prescribing

OOH the UCC must comply with the recommendation made in the Carson review and comply with relevant DH guidance on the supply of medicines. The Provider must 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 (up to 28 days) of the relevant medicine at the same time and at the same place as the consultation.

7.20 Patient Records

The Provider will ensure all staff and UCC processes follow the patient information and governance arrangements and guidance held by the Department of Health, DGNHSFT and Dudley CCG.

7.20.1 GP Patient Records

The majority of Dudley GP patient records will be accessible through EMIS Web on a "read only" basis and read by staff (who have been granted access rights) at the UCC. For non-Dudley patients, if available the NHS Summary Care Record can be utilised by UCC staff. Where the UCC treats the patient, the relevant GP Practice will need to be informed electronically about the episode of care (with appropriate details) within 6 hours or by 8am the next day (whichever comes sooner). The Provider must provide patients with a printed summary of their episode of care that summarises their presenting condition, diagnosis and the treatment that was provided. Patients may also be given appropriate printed materials relating to their specific condition.

7.20.2 Community Patient Records

Development of this is being considered and explored by Dudley CCG and by partner agencies and would involve an intranet based patient record combining Local Authority and NHS key information on supported care etc. Currently this initiative is planned to be trialed in 2015 therefore will not form part of the UCC mobilisation plan.

7.21 Workforce

The Provider's full staff model for the UCC will reflect the need for a highly skilled primary care presence, with experience of urgent and emergency medicine, from the clinicians doing the streaming/ registration, the clinicians in the UCC doing the main assessment/ treatment, to the Navigators providing advice about alternative primary care services in the community.

7.21.1 Clinical Staff

The proposed full clinical staffing establishment in the UCC is to be set out by the Provider and assessed against the Commissioners standard in the Invitation to Tender stage of the procurement process. The success of the model is dependent on skilled, experienced and confident streamers. Staff within this role will need as a minimum three year's experience as an independent practitioner working within the primary care/ urgent care system and be registered with one of the following professional bodies:

- General Medical Council (GMC)
- Nursing and Midwifery Council (NMC)
- Health and Care Professions Council (HCPC)
- UK Association or Physician Associates (UKAPA)

The skill mix for all staff will be regularly reviewed in light of the UCC mobilisation, development and winter surge flexibility. The staffing complement for the UCC will need to be sufficiently skilled, robust and resilient to safely see the patient numbers detailed (See Section 13. Activity). It is also anticipated that the staff skill mix may change and include a wider range of practitioners with varying competencies as the UCC becomes established.

As part of the development of an integrated service, the Provider will work closely with partner organisations to develop an appropriate skill mix of staff to ensure patients are seen, treated and redirected back to primary care core services for on-going care. The Provider will ensure there is a named clinical streamer and clinical assessment/ treatment clinicians with paediatric/ parental support skills.

7.21.2 General Practitioners

GPs will be deployed to meet the needs of presenting patients to the UCC, it is recognised that the GPs will need to move fluidly between UCC appointments to meet patient demand and utilise their skills in the best possible way. The Provider will be encouraged to explore innovative ways of working and this will include offering opportunity for Dudley GPs and GP Trainees to work in the UCC to maintain skills in urgent care, towards their revalidation or appraisal requirements.

7.21.3 Non-Clinical Staff

Sufficient administration and managerial staff will be required to meet the needs of the UCC Commissioner contract and patient demand. No dedicated security staff will operate in the UCC. If security staff are needed, they will be provided by the general DGNHSFT security services.

7.21.5 Navigators

The Navigators will be available 9am to 10pm daily and at other peak activity times as and when required. The Navigators are non-clinical roles but nevertheless will play a crucial role in helping patients who are identified for redirection by the streaming/ reception or assessment/ treatment staff (see Section 7.6). This includes advising and helping:

- Unregistered patients to register at a GP Practice of their choice;
- Helping registered patients to book a GP Practice appointment;
- Supporting patients to access other community services or resources e.g. dentists, optometrists;
- By using the 111 Directory of Service (DOS) or Dudley Community Information Directory, leave patients with details of alternative clinical pathways of care; or
- Signpost to other non-clinical key services such as welfare rights advice, social services, expert patient programmes, drug and alcohol advice services, virtual wards, local authority homeless service and other voluntary agencies etc.

The Navigators will have the required training and information tools to provide the above help and advice and will be responsible for keeping up-to-date details (e.g. opening hours, telephone numbers etc.) of all these community based services. The Navigators will not offer clinical advice to a patient, however general health promotion advice is within the scope of the role.

Clinicians delivering the streaming/ registration and other clinical staff in the UCC will direct patients to the Navigators if the patient needs help or advice or assistance for any of the above.

The Navigators will be responsible for recording details of all help and advice they provide. In particular, they will be responsible for recording details (e.g. time, date, name, age, presenting complaint, GP Practice, the reason why a GP Practice appointment could not be made etc.) of all successful and unsuccessful attempts to book a GP Practice appointment. These details will be collated on a monthly basis and fed back to the CCG and GP Practices in question.

The Provider shall produce a monthly report which details successful and unsuccessful patient redirection attempts by the Navigators. This shall be in a format suitable to be emailed to local GP Practices. For example, this may include for the GP Practice:

- Patient details (name, DOB, presenting condition, GP Practice);
- Time and date of redirection attempt by the Navigators during the month;
- Outcome of redirection attempt by the Navigators;
- If redirection was unsuccessful, the reason for this; and
- Attempts to register unregistered patients and outcome.

7.22 Workforce planning and competency

The Provider will have a robust and effective workforce plan that demonstrates the ability of the Provider to operate and manage the range of services outlined in this specification, ensuring that patients are seen by the most appropriate healthcare professional. The workforce model should reflect the multidisciplinary nature of urgent care delivery from different healthcare professionals. The Provider will provide evidence of a robust urgent care workforce, through clinical and performance audits to ensure the service meets high quality clinical outcomes. The appropriate staffing model for the services will be shaped by the clinical needs of the patients who attend and the competencies of individual staff members. The Provider is expected to demonstrate how the staff competencies meet the needs of the expected clinical caseload for each service.

The Provider will have arrangements in place for the UCC staff to access support and advice from consultants in emergency medicine without requiring patients to be transferred to ED. This will be defined through clear protocols agreed between the Provider and DGNHSFT.

GPs working in the services must have a minimum of three years experience of working in primary care and experience of working in urgent/ emergency care. They must be included on a Medical Performer's List and should continue to work in general practice and demonstrate a commitment to their continuing professional development in urgent care.

7.22.1 Overall Management of UCC

The overall management of the UCC (including the OOH provision) will be undertaken by the Provider.

7.22.2 UCC Clinical leadership

The Provider will be expected to develop a model for clinical leadership and clinical governance, consistent with the existing DGNHSFT internal clinical governance arrangements. As part of this, a designated Primary Care Clinical Lead (one of the GPs working in the UCC) will be assigned by the Provider for the UCC. The Primary Care Clinical Lead will take responsibility for all clinical practitioners working in the UCC who treat patients autonomously. The Primary Care Clinical Lead will also take responsibility for the development, approval and implementation of care pathways and protocols within the UCC. The Primary Care Clinical Lead will be responsible for all clinical governance arrangements identified by DGNHSFT.

7.22.3 Integration, Training and Development

The Provider will be responsible for successfully integrating the UCC staff into all applicable existing DGNHSFT practices and protocols. The Provider will be expected to develop the capacity for staff training for all staff or contractors operating in the UCC.

7.23 Estates and Facilities

Appropriate premises will be available for the Provider to deliver the UCC, these may prove to be interim premises in light of the broader medium to long term capital estates plan of DGNHSFT to redesign the urgent and emergency care hub of RHH.

7.23.1 Existing WiC and OOH at Holly Hall Clinic

The existing WiC and OOH service (currently based at Holly Hall Clinic) will be closed and replaced by the UCC on the RHH site.

7.23.2 Physical Layout

The proposed layout of the UCC is summarised in the accompanying UCC schedule of accommodation and floor plan. The centre will provide capacity and specification commensurate to primary care treatment and the patient numbers expected to be seen within the UCC. The Provider will need to follow all current NHS guidance on primary care premises and equip the UCC consulting rooms for primary care consultation and treatment. The Provider will be responsible for all appropriate infection control measures to be in place and all current NHS associated infection control, primary care treatment regulated guidance and DGNHSFT standards and practices must be followed.

7.23.3 Equipment

The Provider shall provide medical and surgical equipment, medical supplies including medicines, drugs, instruments, appliances and material necessary for primary care delivery. The equipment shall be adequate, functional and effective for all the UCC services. The Provider shall also provide non-medical equipment to furnish the UCC and other services including computers, telephones, desks, desk chairs, couches, trolley, etc. The Provider shall establish and maintain a planned preventative programme for its equipment and make adequate contingency arrangements for emergency remedial maintenance, equipment failure and business continuity.

7.24 Information Technology

This section should be read in conjunction with the UCC IT Requirements document which is currently in development and will be released for information when complete. The requirements will include the NHS Interoperability Toolkit (ITK Specification) to ensure links are attained with NHS 111.

7.24.1 IT System

All GP practices within Dudley utilise EMIS Web as their main primary care system. Using appropriate data sharing agreements, this is a key enabler for the efficient utilisation of primary care patient information for all Dudley CCG member practices.

The primary patient system for use within the Urgent Care Centre will also be EMIS Web. This will enable the provider to access and utilise the 'live' patient record for Dudley registered patients upon presentation to the UCC. This will facilitate a safer and more efficient clinical model with the benefit of accelerating the patient journey through the UCC. Patients presenting at the UCC from non-Dudley Practices will access the patients' Summary Care Record (if 'turned on' by their registered GP Practice).

7.24.2 IT System wider scope and connectivity

The IT system will also have the ability, via shared record protocols, to present to UCC staff key information, drawn from partner organisations health systems, including Dudley and Walsall Mental Health Partnership Trust, Dudley Social Services, DGNHSFT Community Services and private providers where relevant.

EMIS will be fully interoperable with partner systems, such as the RHH Patient Administration system, to ensure the seamless transfer of patients from the UCC into ED, other locations within DGNHSFT and to support interventions by partner agencies. Transactions throughout the patient's interaction with the UCC will be updated automatically within partner organisations' patient records. It is intended to work with the Provider, in conjunction with partner agencies, to jointly design the functionality and protocols within the UCC EMIS system. The provider will also be a key member of the CCG's shared record working group.

7.24.3 Training

The Provider is responsible for all staff undertaking appropriate UCC IT system training. The Provider will also need to ensure all staff have access to appropriate clinical supervision for training purposes and ensure a system of continuing professional development. Clinicians in the services will have access to advice and expertise (such as a mental health crisis intervention team and social services emergency duty team). The staffing model should be based on workforce competency, which will allow staff to flex across all settings of the UCC service to provide cover 24 hours a day, 7 days week.

8 Interdependency with other services

The Provider of the UCC, as part of the wider unscheduled care system, will have a duty to cooperate with other stakeholders in the local healthcare economy. The provider will be expected to attend meetings of the local urgent care operations group and urgent care working group. The Provider will also cooperate with, but not be limited to the following agencies summarised in sections 8.1 to 8.7.

8.1 DGNHSFT

The Provider will be required to agree clinical, information governance, data sharing and operational governance processed with DGNHSFT. The Provider will be required to implement with DGNHSFT direct referral pathways from the UCC to additional specialist services and clinics within DGNHSFT. Where an admission is required this will be made directly from the UCC to the specialty concerned. Patients will not be referred back to, for example, ED for diagnostics or admission.

8.2 GP Practices

GP Practices in Dudley Borough are critical to the success of the UCC service and in particular its ability to redirect patients (see Section 7.6.1). GP Practices will need to make sufficient appointments available to patients being redirected from the UCC. The Provider will develop a GP Practice engagement plan which will be a key part of the external stakeholder engagement plan referred to in Section 16.4.

8.3 WMAS patient handovers

The Provider will be required to agree clinical and operational governance to ensure an efficient, safe and robust handover process between patients conveyed by ambulance by West Midlands Ambulance Service to the UCC staff for streaming/registration. As a result of robust implementation (WMAS Transfer of and Discharge from Care Protocol) streaming and registration protocol, patient handover delays will be required to be kept to a minimum. 2013/14 ambulance conveyance activity is captured in Table 5. below.

Table 5. **Current WMAS Conveyances to A&E and Walk in Centre (2013/14)**

Destination	Annual Conveyances	Resuscitation Unit
A&E	28,886	1226
WIC	110	-
Total	**28,996**	**1,226**

8.3.1 WMAS Placements

The Provider will, when deployed by WMAS, work alongside the Hospital Ambulance Liaison Officer (HALO) within the UCC to resolve delays in ambulance turnaround.

8.4 Dudley and Walsall Mental Health Partnership Trust

The streaming clinicians must have a process in place for quickly identifying patients with a potential mental health disposition. The provider will then have in place (when applicable) an alert and handover process with Dudley and Walsall Mental Health Partnership NHS Trust to ensure exemplary treatment and care of these patients. Headline activity data where mental health was recorded as the presenting condition for 2013/14 is presented in Table 6. below:

Table 6. **WiC and ED activity where Mental Health is the presenting reason**

Destination	Annual
Walk In Centre	75
A&E	976
Total	**1051**

8.4.1 Adults

The Provider must ensure UCC staff have competencies to make initial assessments of patients suspected of mental health issues. Patients with suspected mental health problems who present at the UCC will be initially streamed to primary care and assessed by a nurse using the "Mental Health Risk Assessment Matrix". If appropriate the patient is then referred directly to the Psychiatric Liaison Team (provided by Dudley and Walsall Mental Health Partnership NHS Trust) based at RHH ED. Those patients who require a physical assessment/ treatment in addition to a psychiatric assessment will be assessed by an appropriate clinician prior to, or concurrently with referral to the Liaison team. The Psychiatric Liaison Service currently operates within RHH ED 24 hours a day, 7 days a week, 365 days per year. All UCC staff must have training in appropriately managing people with mental illness.

8.4.2 Children

The Provider will ensure paediatric health and mental health training awareness is a key component of the clinical and non-clinical UCC staff team. The Provider will ensure there is a named clinical streamer and clinical assessment/ treatment clinicians with mental health/ parental support skills. The current Psychiatric Liaison Service is an adult service and does not see children. Furthermore there is currently no out of hours CAMHS service for children. Both of these issues however are under consideration following a full service review commissioned by Dudley CCG which will conclude in 2014/15.

8.5 Community Services

The Provider will work closely with DGNHSFT, Dudley Social Services and other community providers to ensure a one step, referral process for supported discharge from the UCC (e.g. community nursing, intermediate care, specialist nurses, community matrons and virtual wards etc.). The one step referral process will also support referrals to routine and preventative community health services e.g. falls service, primary care therapy teams etc. Community staff from the virtual wards may attend the UCC on a planned basis to facilitate identification of patients suitable for discharge to community services. Community health staff will provide training on a planned basis for UCC staff to develop improved understanding of community services.

8.6 Substance Misuse Services

The Provider will work with the Integrated Substance Misuse Service to ensure a one step, referral process for supported discharge from the UCC. The Provider will also have service arrangements in place with Dudley Drug and Alcohol Liaison Service and coordinate any other relevant services for this patient group.

8.7 Emergency Care Network

The Urgent and Emergency Care Review published in November 2013 by NHS England stressed the importance of Emergency Care Networks in transforming urgent and emergency care. More specifically, to make the whole urgent and emergency care system operate as effectively and efficiently as possible, and become more than just the sum of its parts, a networked approach will be introduced in which patients, along with all relevant information, flow smoothly between the different components. The Provider will be expected to participate fully in any such network developed across Dudley Borough or Birmingham and the Black Country.

8.8 Health Protection Cooperation

As detailed in the NHS Standard Contract the Provider will be available and prepared to deliver general health protection, incident and emergency services necessary to achieve the aims of local Emergency Resilience Preparedness and Response plans. The Provider will also under the direction of the Commissioner, provide screening/ treatment of patients with known or suspected infection diseases if required. Details of this can be found in the document 'Dudley Health Protection Co-operation Agreement 2013-15'.

9. Quality Standards and Clinical Governance

A basic tenet for all aspects of service delivery within the UCC is that the Provider will ensure consistent high quality care for all users of the service.

The Provider will deliver care that is compliant with national quality and professional standards. All staff working in the UCC must comply with the NHS Constitution and individual professional regulations and standards. The Provider will be expected to clearly state the clinical governance framework under which the UCC will operate and the surveillance/ monitoring mechanisms in place to provide assurance that issues will be identified, escalated and resolved quickly if concerns about the quality of service are raised. More specifically the Provider will:

- Deliver the services in accordance with exemplary clinical practice guidance, exemplary healthcare practice, and will comply with all clinical standards, recommendations, policies, procedures and legislation as set out in the DGNHSFT Standard NHS Contract;
- Develop and implement mechanisms for managing risk, including disaster recovery, contingency and business continuity plans as set out in the DGNHSFT Standard NHS Contract;
- Ensure all incidents (both clinical and non-clinical) will be reported by staff (using the DGNHSFT Datix Risk Management System) and managed appropriately as set out in the DGNHSFT Acute Contract; and
- Ensure that clinical risk management is an integral part of the daily service and use this to improve decision-making, share learning and encourage the continued improvement of service delivery and best use of resources.

The Provider will keep the Commissioner informed about detail of the risk management structures and processes that exist, and how they are implemented. The Commissioner will seek assurance that services delivered are:

- Safe;
- Effective;
- Caring; and
- Well led.

9.1 Policies & Procedures

The Provider will be required to have in place policies and procedures which comply with general NHS legislation and any relevant NHS guidance in the delivery of primary care, OOH and urgent care.

9.2 Safeguarding

The Provider will implement all relevant safeguarding policies including those adopted by the Dudley Adult and Children Safeguarding Boards. Appropriate disclosure and barring (DBS) checks for all staff will be required and audited.

10. Service Commencement

The target full service commencement date for a fully operational UCC within the RHH site adjacent to ED is 1st April 2015.

11. Performance Management

11.1 UCC Performance Management Group (PMG)

It is very important to the Commissioner that the service model in the UCC is regularly and effectively evaluated and refined over time where necessary. There will be an operational management team consisting of the responsible managers from the UCC, ED and DGNHSFT. This team will report to an overall PMG chaired by the Commissioner. The PMG will be responsible for monitoring and managing overall performance and deciding how the UCC service model will develop over time.

11.2 Activity Reporting

The Provider is required to report UCC activity in line with national DH reporting requirements.

The Provider and Commissioner will work together to agree any additional local activity reporting requirements. The Commissioner requires that there is the ability to separate overall data reporting between the UCC and ED (See attached UCC Commissioning Standards V0.3).

11.3 Performance Measurement

In addition to the PMG process there will be Commissioner and Provider quarterly and annual contract review meetings. The Commissioner requires that the performance and success of the UCC service will be measured against a series of operational and quality indicators and be reported to the Commissioner (see attached UCC Commissioning Standards FINAL Version). A major component of the UCC service will be the requirement for the three main components of the UCC pathway (streaming, assessment and treatment/ advice) to meet different performance standards.

11.4 Audit

The data from systematic, robust UCC audits will be a key component of changing the culture of urgent and primary care delivery in Dudley. A major component of the Providers responsibilities will be the requirement to undertake systematic audits of for example: patient activity, presenting conditions, case notes, complaints, redirection outcomes and patient reasons for using the UCC. The data from these audits will be used to provide recommendations for improvement of the UCC delivery model and other primary care and acute services. A key outcome of these audits will be to ensure inappropriate referrals into the UCC pathway from other Providers are captured and when appropriate, used by the Commissioner to challenge these Providers. The audit requirements can be found in Dudley UCC Commissioning Standards V.03. It is expected that the audit will be a key function of the daily service delivery model of the UCC and as a result it will require dedicated staffing and capacity identified for this purpose.

12. Payment Model

The payment model for the Urgent Care Centre will comprise of three elements for patients who are registered with a Dudley GP Practice. Patients who are registered with a practice responsible to another CCG shall be charged on a cost per case basis. A summary of the key elements is provided below.

12.1 Core Element

There shall be a core payment made for the expected level of activity for patients registered with Dudley GPs:

- 122,000 of the 164,700 patients streamed
- 74,000 of the 99,500 patients seen within Primary Care Area

12.2 Volume Element

There shall be an adjustment to the core payment based on a risk share arrangement to be proposed by the Provider and agreed by the Commissioner. This is required in order to mitigate the risk to the Commissioner and Provider of the volume of redirections and the percentage of activity seen within each of the shadow tariffs outlined below. Any activity undertaken on behalf of other CCGs outside of the Dudley Borough will be charged wholly on a cost per case basis. Therefore tariffs will need to be developed for the following:

- Streaming Only (65,300 patients);
- Streaming and Primary Care Assessment (99,400 patients);
- OOH Home Visit (4,075 patients); and
- OOH Phone Consultation (28,000 patients. Including 13,675 that result in face-to-face attendances at the UCC, and 4,075 home visits).

These prices will also be used as shadow prices for comparison against the core payment for patients registered with Dudley GPs.

12.3 Performance Element

10% of the core element will be withheld and paid on achievement of the following key performance indicators:

- In year 1 of the contract, the Provider will undertake two audits (month 6 and month 12) to publishable standard, which details the clinical appropriateness of the streaming decision making for all presenting patients to the UCC. The data from this audit will used to define KPI's for year 2 of the contract;
- Less than 5% of patients re-attending the UCC within 7 days;
- 70% of all patients streamed for primary care assessment/ treatment, whose condition could have been deferred to the next available GP appointment, are seen by the Navigator and offered information/ advice on appropriate use of the UCC;
- Less than 3% of UCC streamer dispositions to the primary care element of the UCC requiring immediate transfer to ED; and
- Less than 10% of UCC streamer dispositions to ED are discharged from ED with no treatment given.

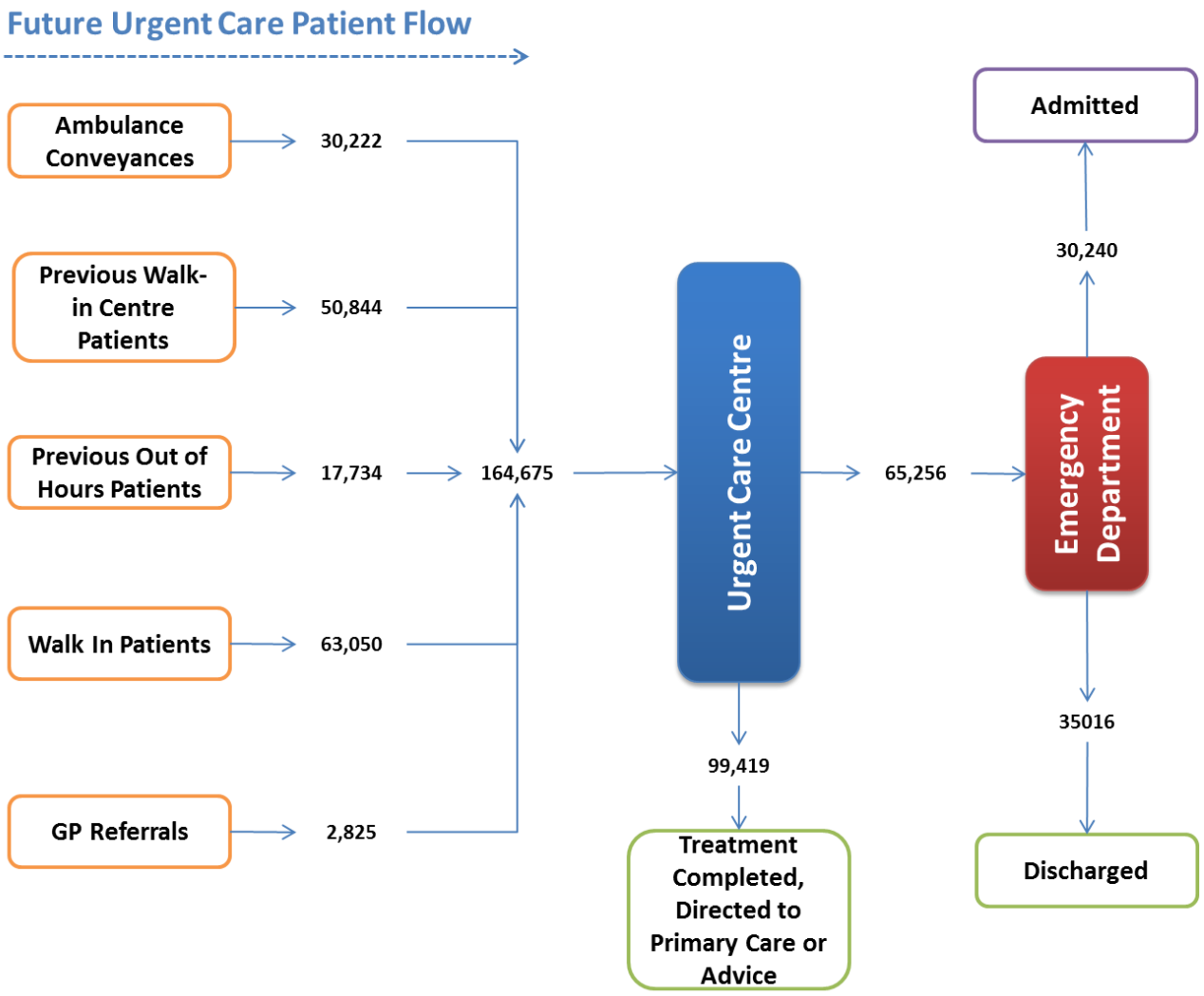
13. Activity

13.1 By Geography

The diagram below sets out an example of the potential distribution of patients between the UCC and ED (it should be assumed that the UCC (excluding resuscitation redirections) = ED minors + current WiC and OOH activity). The anticipated average yearly, weekly and daily figures are also included.

13.2 By Total Activity – Current ED, WIC & OOH per annum and daily average (2013/14)

Annual patient attendances within the existing urgent care configuration are **164,700** (combined ED, WiC and OOH attendances) approximately **450** patients per day. The illustration below provides further detail on these assumed numbers and there disposition within the UCC pathway.



13.3 Current RHH ED Activity – Per annum and daily average (2013/14)

	Total Activity Per annum								
Time Band	**Monday**	**Tuesday**	**Wednesd**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**	**%**
00:00 - 01:00	324	287	266	319	266	336	405	2,203	2.29%
01:00 - 02:00	263	230	217	248	230	314	365	1,867	1.94%
02:00 - 03:00	205	199	181	183	182	234	268	1,452	1.51%
03:00 - 04:00	172	166	165	157	164	214	257	1,295	1.35%
04:00 - 05:00	160	133	143	158	168	173	209	1,144	1.19%
05:00 - 06:00	179	161	142	149	155	177	191	1,154	1.20%
06:00 - 07:00	196	220	204	173	188	186	218	1,385	1.44%
07:00 - 08:00	326	294	292	273	316	278	263	2,042	2.12%
08:00 -09:00	614	501	472	488	467	446	424	3,412	3.55%
09:00 - 10:00	1,081	875	861	800	779	654	738	5,788	6.02%
10:00 - 11:00	1,076	888	845	787	777	803	890	6,066	6.31%
11:00 -12:00	997	847	837	843	811	865	974	6,174	6.42%
12:00 - 13:00	1,021	820	786	844	812	810	985	6,078	6.32%
13:00 - 14:00	959	824	835	814	749	802	924	5,907	6.15%
14:00 - 15:00	869	794	837	803	746	810	888	5,747	5.98%
15:00 - 16:00	838	749	798	701	712	801	818	5,417	5.64%
16:00 - 17:00	818	774	731	715	729	727	796	5,290	5.50%
17:00 - 18:00	915	801	809	777	781	753	809	5,645	5.87%
18:00 - 19:00	973	891	892	850	752	691	756	5,805	6.04%
19:00 - 20:00	932	852	829	884	759	686	754	5,696	5.93%
20:00 - 21:00	875	776	774	752	668	654	743	5,242	5.46%
21:00 - 22:00	689	683	663	691	638	609	657	4,630	4.82%
22:00 - 23:00	555	569	529	577	493	531	558	3,812	3.97%
23:00 - 00:00	410	373	394	393	411	440	423	2,844	2.96%
Total	15,447	13,707	13,502	13,379	12,753	12,994	14,313	96,095	
%	16.07%	14.26%	14.05%	13.92%	13.27%	13.52%	14.89%		

	Average Daily Activity							
Time Band	**Monday**	**Tuesday**	**Wednesd**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**
00:00 - 01:00	6.21	5.50	5.10	6.12	5.10	6.44	7.77	42
01:00 - 02:00	5.04	4.41	4.16	4.76	4.41	6.02	7.00	36
02:00 - 03:00	3.93	3.82	3.47	3.51	3.49	4.49	5.14	28
03:00 - 04:00	3.30	3.18	3.16	3.01	3.15	4.10	4.93	25
04:00 - 05:00	3.07	2.55	2.74	3.03	3.22	3.32	4.01	22
05:00 - 06:00	3.43	3.09	2.72	2.86	2.97	3.39	3.66	22
06:00 - 07:00	3.76	4.22	3.91	3.32	3.61	3.57	4.18	27
07:00 - 08:00	6.25	5.64	5.60	5.24	6.06	5.33	5.04	39
08:00 -09:00	11.78	9.61	9.05	9.36	8.96	8.55	8.13	65
09:00 - 10:00	20.73	16.78	16.51	15.34	14.94	12.54	14.15	111
10:00 - 11:00	20.64	17.03	16.21	15.09	14.90	15.40	17.07	116
11:00 -12:00	19.12	16.24	16.05	16.17	15.55	16.59	18.68	118
12:00 - 13:00	19.58	15.73	15.07	16.19	15.57	15.53	18.89	117
13:00 - 14:00	18.39	15.80	16.01	15.61	14.36	15.38	17.72	113
14:00 - 15:00	16.67	15.23	16.05	15.40	14.31	15.53	17.03	110
15:00 - 16:00	16.07	14.36	15.30	13.44	13.65	15.36	15.69	104
16:00 - 17:00	15.69	14.84	14.02	13.71	13.98	13.94	15.27	101
17:00 - 18:00	17.55	15.36	15.52	14.90	14.98	14.44	15.52	108
18:00 - 19:00	18.66	17.09	17.11	16.30	14.42	13.25	14.50	111
19:00 - 20:00	17.87	16.34	15.90	16.95	14.56	13.16	14.46	109
20:00 - 21:00	16.78	14.88	14.84	14.42	12.81	12.54	14.25	101
21:00 - 22:00	13.21	13.10	12.72	13.25	12.24	11.68	12.60	89
22:00 - 23:00	10.64	10.91	10.15	11.07	9.45	10.18	10.70	73
23:00 - 00:00	7.86	7.15	7.56	7.54	7.88	8.44	8.11	55
	296	263	259	257	245	249	274	1,843

13.4 Current WiC Activity – Per annum and daily average (2013/14)

	Total Activity Per annum								
Time Band	**Monday**	**Tuesday**	**Wednesd**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**	**%**
00:00 - 01:00								-	
01:00 - 02:00								-	
02:00 - 03:00								-	
03:00 - 04:00								-	
04:00 - 05:00								-	
05:00 - 06:00								-	
06:00 - 07:00								-	
07:00 - 08:00								-	
08:00 -09:00								-	
09:00 - 10:00	321	585	432	488	335	1,171	990	4,321	8.50%
10:00 - 11:00	599	739	571	627	516	976	655	4,683	9.21%
11:00 -12:00	488	502	335	432	335	1,213	836	4,139	8.14%
12:00 - 13:00	711	418	516	460	348	850	836	4,139	8.14%
13:00 - 14:00	613	544	446	348	516	599	697	3,763	7.40%
14:00 - 15:00	544	767	516	669	599	753	683	4,530	8.91%
15:00 - 16:00	530	460	544	446	571	599	739	3,889	7.65%
16:00 - 17:00	585	530	613	502	488	697	781	4,195	8.25%
17:00 - 18:00	599	669	585	627	599	585	627	4,293	8.44%
18:00 - 19:00	683	627	906	822	544	613	641	4,836	9.51%
19:00 - 20:00	711	892	808	920	530	544	530	4,934	9.70%
20:00 - 21:00	544	488	432	488	613	362	195	3,122	6.14%
21:00 - 22:00								-	
22:00 - 23:00								-	
23:00 - 00:00								-	
Total	6,927	7,220	6,704	6,829	5,993	8,962	8,209	50,844	
%	13.62%	14.20%	13.19%	13.43%	11.79%	17.63%	16.15%		

	Average Daily Activity							
Time Band	**Monday**	**Tuesday**	**Wednesd**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**
00:00 - 01:00								-
01:00 - 02:00								-
02:00 - 03:00								-
03:00 - 04:00								-
04:00 - 05:00								-
05:00 - 06:00								-
06:00 - 07:00								-
07:00 - 08:00								-
08:00 -09:00								-
09:00 - 10:00	6.15	11.23	8.29	9.36	6.42	22.45	18.98	83
10:00 - 11:00	11.49	14.17	10.96	12.03	9.89	18.71	12.56	90
11:00 -12:00	9.36	9.62	6.42	8.29	6.42	23.25	16.04	79
12:00 - 13:00	13.63	8.02	9.89	8.82	6.68	16.30	16.04	79
13:00 - 14:00	11.76	10.42	8.55	6.68	9.89	11.49	13.36	72
14:00 - 15:00	10.42	14.70	9.89	12.83	11.49	14.43	13.10	87
15:00 - 16:00	10.16	8.82	10.42	8.55	10.96	11.49	14.17	75
16:00 - 17:00	11.23	10.16	11.76	9.62	9.36	13.36	14.97	80
17:00 - 18:00	11.49	12.83	11.23	12.03	11.49	11.23	12.03	82
18:00 - 19:00	13.10	12.03	17.37	15.77	10.42	11.76	12.30	93
19:00 - 20:00	13.63	17.11	15.50	17.64	10.16	10.42	10.16	95
20:00 - 21:00	10.42	9.36	8.29	9.36	11.76	6.95	3.74	60
21:00 - 22:00								-
22:00 - 23:00								-
23:00 - 00:00								-
	133	138	129	131	115	172	157	975

13.5 Current OOH Activity – Per annum and daily average (2013/14)

	Total Activity Per annum								
Time Band	**Monday**	**Tuesday**	**Wednesd**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**	**%**
00:00 - 01:00	105	85	88	61	116	34	24	512	2.89%
01:00 - 02:00	86	70	72	50	95	45	36	452	2.55%
02:00 - 03:00	70	56	58	41	77	22	24	347	1.96%
03:00 - 04:00	63	51	53	37	70	11	-	286	1.61%
04:00 - 05:00	56	45	47	33	62	22	12	276	1.56%
05:00 - 06:00	56	46	47	33	62	56	-	299	1.69%
06:00 - 07:00	65	53	54	38	71	34	-	315	1.77%
07:00 - 08:00	99	80	83	58	109	189	-	619	3.49%
08:00 -09:00						556	631	1,187	6.69%
09:00 - 10:00						546	690	1,236	6.97%
10:00 - 11:00						567	524	1,091	6.15%
11:00 -12:00						579	428	1,007	5.68%
12:00 - 13:00						434	500	934	5.26%
13:00 - 14:00						512	190	702	3.96%
14:00 - 15:00						378	393	771	4.35%
15:00 - 16:00						256	214	471	2.65%
16:00 - 17:00						301	321	622	3.51%
17:00 - 18:00						234	357	591	3.33%
18:00 - 19:00						212	190	402	2.27%
19:00 - 20:00	275	223	230	160	303	167	190	1,550	8.74%
20:00 - 21:00	252	204	211	147	278	156	179	1,425	8.04%
21:00 - 22:00	215	174	180	125	237	123	71	1,126	6.35%
22:00 - 23:00	178	144	149	104	196	11	48	829	4.68%
23:00 - 00:00	137	111	114	80	151	56	36	684	3.86%
Total	1,658	1,343	1,385	966	1,826	5,498	5,057	17,734	
%	9%	8%	8%	5%	10%	31%	29%		

	Average Daily Activity							
Time Band	**Monday**	**Tuesday**	**Wednesd**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**
00:00 - 01:00	2.01	1.63	1.68	1.17	2.22	0.64	0.46	10
01:00 - 02:00	1.65	1.33	1.38	0.96	1.81	0.85	0.69	9
02:00 - 03:00	1.34	1.08	1.12	0.78	1.47	0.42	0.46	7
03:00 - 04:00	1.22	0.99	1.02	0.71	1.34	0.21	-	5
04:00 - 05:00	1.07	0.87	0.89	0.62	1.18	0.42	0.23	5
05:00 - 06:00	1.08	0.88	0.90	0.63	1.19	1.07	-	6
06:00 - 07:00	1.24	1.01	1.04	0.72	1.37	0.64	-	6
07:00 - 08:00	1.90	1.54	1.59	1.11	2.10	3.63	-	12
08:00 -09:00						10.67	12.10	23
09:00 - 10:00						10.46	13.24	24
10:00 - 11:00						10.88	10.04	21
11:00 -12:00						11.10	8.22	19
12:00 - 13:00						8.32	9.58	18
13:00 - 14:00						9.82	3.65	13
14:00 - 15:00						7.26	7.53	15
15:00 - 16:00						4.91	4.11	9
16:00 - 17:00						5.77	6.16	12
17:00 - 18:00						4.48	6.85	11
18:00 - 19:00						4.06	3.65	8
19:00 - 20:00	5.28	4.28	4.41	3.08	5.82	3.21	3.65	30
20:00 - 21:00	4.83	3.92	4.04	2.81	5.32	2.98	3.42	27
21:00 - 22:00	4.13	3.34	3.45	2.40	4.55	2.35	1.37	22
22:00 - 23:00	3.41	2.77	2.85	1.99	3.76	0.21	0.91	16
23:00 - 00:00	2.63	2.13	2.19	1.53	2.89	1.07	0.69	13
	32	26	27	19	35	105	97	340

13.6 Anticipated UCC Activity – Per annum and daily average.

Developed from 2013/14 activity data and key findings from the May 2014 streaming audit of **3000** patients:

	Total Activity Per annum								
Time Band	**Monday**	**Tuesday**	**Wednesda**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**	**%**
00:00 - 01:00	429	372	354	380	382	370	429	2,715	1.65
01:00 - 02:00	349	300	289	298	325	359	401	2,319	1.41
02:00 - 03:00	275	255	239	224	259	256	292	1,799	1.09
03:00 - 04:00	235	217	218	194	234	225	257	1,581	0.96
04:00 - 05:00	216	178	190	191	230	195	221	1,420	0.86
05:00 - 06:00	235	207	189	182	217	233	191	1,453	0.88
06:00 - 07:00	261	273	258	211	259	220	218	1,700	1.03
07:00 - 08:00	425	374	375	331	425	467	263	2,661	1.62
08:00 -09:00	614	501	472	488	467	1,002	1,055	4,599	2.79
09:00 - 10:00	1,402	1,460	1,293	1,288	1,114	2,370	2,418	11,345	6.89
10:00 - 11:00	1,675	1,627	1,416	1,414	1,293	2,346	2,069	11,840	7.19
11:00 -12:00	1,485	1,349	1,172	1,275	1,146	2,657	2,239	11,321	6.87
12:00 - 13:00	1,732	1,238	1,302	1,304	1,160	2,094	2,321	11,151	6.77
13:00 - 14:00	1,572	1,368	1,281	1,162	1,265	1,913	1,811	10,372	6.30
14:00 - 15:00	1,413	1,561	1,353	1,472	1,345	1,941	1,963	11,048	6.71
15:00 - 16:00	1,368	1,209	1,342	1,147	1,283	1,657	1,771	9,776	5.94
16:00 - 17:00	1,403	1,304	1,344	1,217	1,217	1,725	1,898	10,107	6.14
17:00 - 18:00	1,514	1,470	1,394	1,404	1,380	1,572	1,793	10,529	6.39
18:00 - 19:00	1,656	1,518	1,798	1,672	1,296	1,516	1,587	11,043	6.71
19:00 - 20:00	1,918	1,967	1,867	1,964	1,592	1,397	1,474	12,179	7.40
20:00 - 21:00	1,671	1,468	1,417	1,387	1,559	1,172	1,117	9,789	5.94
21:00 - 22:00	904	857	843	816	875	732	728	5,756	3.50
22:00 - 23:00	733	713	678	681	689	542	606	4,641	2.82
23:00 - 00:00	547	484	508	473	562	496	459	3,528	2.14
	24,032	22,270	21,591	21,174	20,572	27,454	27,580	164,673	
%	14.59	13.52	13.11	12.86	12.49	16.67	16.75		

	Average Daily Activity							
Time Band	**Monday**	**Tuesday**	**Wednesd**	**Thursday**	**Friday**	**Saturday**	**Sunday**	**Total**
00:00 - 01:00	8.23	7.14	6.78	7.29	7.32	13.12	13.91	64
01:00 - 02:00	6.69	5.75	5.54	5.72	6.23	11.49	12.03	53
02:00 - 03:00	5.27	4.90	4.59	4.29	4.96	8.92	9.22	42
03:00 - 04:00	4.52	4.17	4.18	3.72	4.49	8.14	8.64	38
04:00 - 05:00	4.14	3.42	3.64	3.65	4.40	6.87	7.28	33
05:00 - 06:00	4.51	3.96	3.63	3.49	4.16	6.98	6.96	34
06:00 - 07:00	5.00	5.23	4.95	4.04	4.98	7.70	7.98	40
07:00 - 08:00	8.16	7.18	7.19	6.34	8.16	11.65	10.85	60
08:00 -09:00	17.92	20.83	17.34	18.71	15.37	31.01	27.11	148
09:00 - 10:00	32.23	30.95	27.47	27.37	24.83	31.25	26.72	201
10:00 - 11:00	29.99	26.65	22.62	23.38	21.32	38.65	33.11	196
11:00 -12:00	32.75	24.26	25.94	24.99	22.24	32.89	34.72	198
12:00 - 13:00	31.34	26.15	23.63	22.87	25.46	27.03	32.26	189
13:00 - 14:00	28.82	30.50	25.90	28.44	25.86	29.81	30.82	200
14:00 - 15:00	26.82	24.05	26.48	23.95	25.27	27.03	31.20	185
15:00 - 16:00	27.30	24.52	27.06	23.07	23.01	28.73	30.66	184
16:00 - 17:00	27.18	27.67	25.25	25.74	25.47	25.17	27.29	184
17:00 - 18:00	30.65	27.39	32.89	30.67	25.40	26.20	27.81	201
18:00 - 19:00	32.29	34.19	32.61	33.94	24.58	23.68	24.66	206
19:00 - 20:00	33.58	29.97	28.60	29.38	32.13	37.62	34.32	226
20:00 - 21:00	21.61	18.80	18.88	17.24	18.13	28.57	28.99	152
21:00 - 22:00	17.34	16.44	16.16	15.66	16.78	25.37	25.19	133
22:00 - 23:00	14.06	13.68	13.00	13.05	13.21	21.51	21.12	110
23:00 - 00:00	10.49	9.28	9.75	9.07	10.78	17.15	16.13	83
	461	427	414	406	395	527	529	3,158

13.7 Anticipated UCC Primary Care Assessment and Treatment Activity – Per annum and daily average (Inc OOH activity).

EXPECTED VOLUME TO BE STREAMED TO UCC PRIMARY CARE AREA									
Time Band	Monday	Tuesday	Wednesd	Thursday	Friday	Saturday	Sunday	Total	%
00:00 - 01:00	159	151	88	107	116	146	24	790	2.02
01:00 - 02:00	130	300	72	50	95	123	182	951	1.69
02:00 - 03:00	70	156	149	86	107	22	24	614	1.33
03:00 - 04:00	63	118	53	37	111	11	-	393	1.20
04:00 - 05:00	56	106	47	78	62	22	64	434	1.06
05:00 - 06:00	176	99	118	70	217	144	-	824	1.07
06:00 - 07:00	212	163	156	124	134	127	73	988	1.26
07:00 - 08:00	192	241	216	194	173	282	66	1,363	1.88
08:00 -09:00	307	167	222	122	187	556	800	2,362	4.70
09:00 - 10:00	910	864	818	919	335	1,760	1,944	7,548	6.36
10:00 - 11:00	1,045	1,002	853	994	602	1,694	1,521	7,711	6.20
11:00 -12:00	820	737	669	896	450	2,080	1,619	7,271	6.26
12:00 - 13:00	1,119	699	853	952	602	1,400	1,599	7,224	5.98
13:00 - 14:00	1,024	904	717	697	516	1,325	887	6,070	6.34
14:00 - 15:00	963	1,208	874	937	972	1,499	1,075	7,529	5.85
15:00 - 16:00	965	744	721	691	730	928	1,444	6,224	5.84
16:00 - 17:00	814	850	979	800	904	1,288	1,367	7,003	5.82
17:00 - 18:00	896	817	865	886	741	894	984	6,085	6.36
18:00 - 19:00	1,100	1,045	1,352	1,126	920	1,319	1,020	7,881	6.52
19:00 - 20:00	1,273	1,530	1,265	1,326	1,165	1,054	908	8,521	7.14
20:00 - 21:00	1,026	803	944	750	891	910	522	5,846	4.82
21:00 - 22:00	445	385	489	224	450	351	144	2,488	4.21
22:00 - 23:00	317	286	325	219	415	210	327	2,099	3.47
23:00 - 00:00	171	140	213	316	185	56	121	1,200	2.62
	14,255	13,514	13,057	12,601	11,078	18,201	16,715	99,419	100

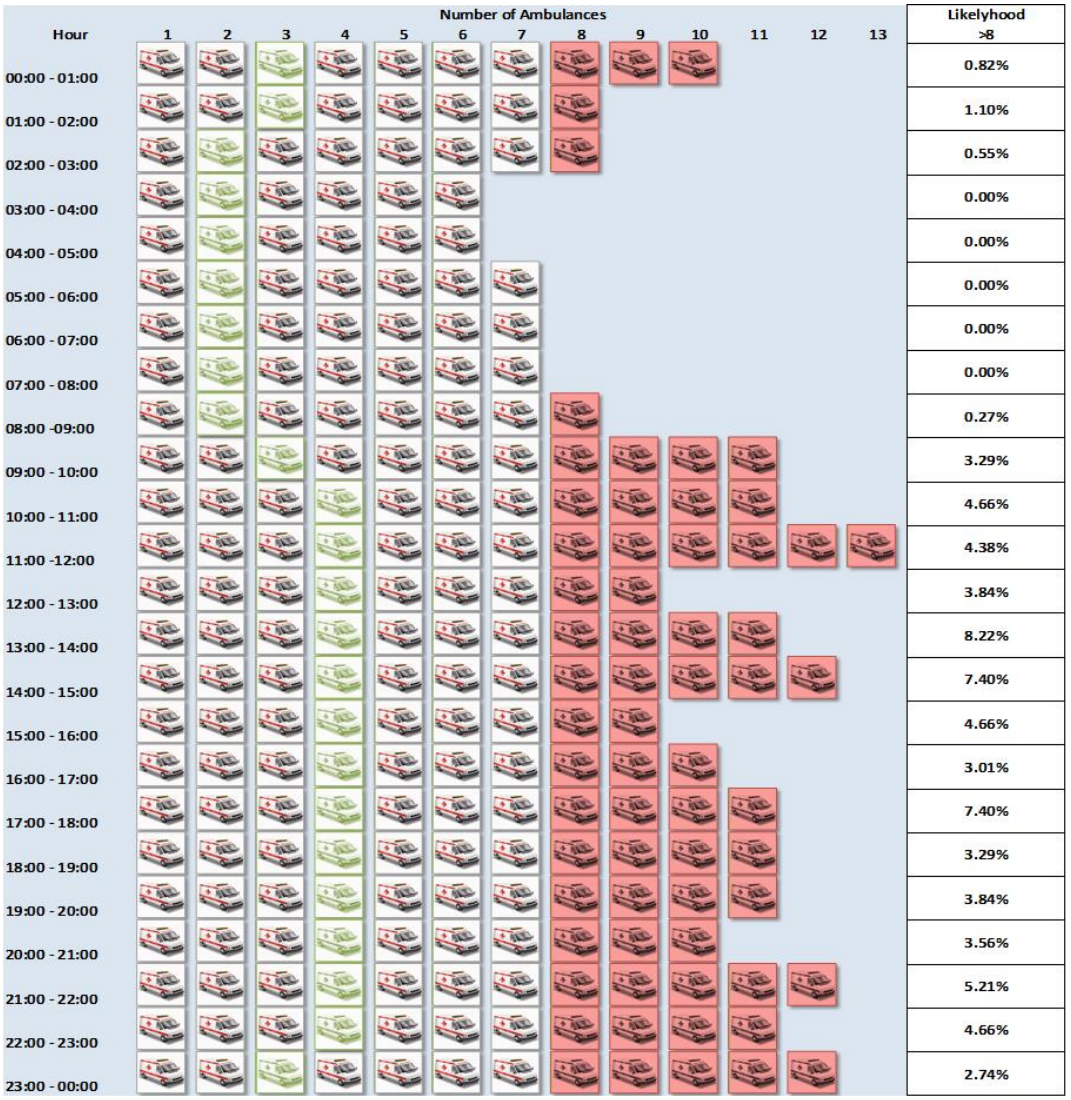
	Average Daily Activity							
Time Band	Monday	Tuesday	Wednesd	Thursday	Friday	Saturday	Sunday	Total
00:00 - 01:00	3.05	2.90	1.68	2.05	2.22	2.79	0.46	15
01:00 - 02:00	2.49	5.75	1.38	0.96	1.81	2.36	3.49	18
02:00 - 03:00	1.34	2.99	2.85	1.66	2.05	0.42	0.46	12
03:00 - 04:00	1.22	2.26	1.02	0.71	2.13	0.21	-	8
04:00 - 05:00	1.07	2.03	0.89	1.49	1.18	0.42	1.23	8
05:00 - 06:00	3.37	1.90	2.26	1.34	4.16	2.76	-	16
06:00 - 07:00	4.06	3.12	3.00	2.38	2.57	2.43	1.39	19
07:00 - 08:00	3.69	4.62	4.14	3.73	3.31	5.40	1.26	26
08:00 -09:00	5.89	3.20	4.26	2.34	3.58	10.67	15.35	45
09:00 - 10:00	17.46	16.57	15.69	17.62	6.42	33.75	37.27	145
10:00 - 11:00	20.05	19.21	16.36	19.07	11.55	32.48	29.17	148
11:00 -12:00	15.73	14.13	12.84	17.18	8.64	39.89	31.05	139
12:00 - 13:00	21.46	13.41	16.35	18.26	11.55	26.84	30.66	139
13:00 - 14:00	19.64	17.34	13.75	13.37	9.89	25.41	17.01	116
14:00 - 15:00	18.47	23.16	16.77	17.96	18.65	28.75	20.62	144
15:00 - 16:00	18.51	14.27	13.83	13.26	13.99	17.80	27.69	119
16:00 - 17:00	15.62	16.30	18.77	15.34	17.34	24.71	26.22	134
17:00 - 18:00	17.18	15.67	16.60	17.00	14.22	17.15	18.88	117
18:00 - 19:00	21.09	20.04	25.93	21.59	17.64	25.29	19.57	151
19:00 - 20:00	24.41	29.35	24.25	25.43	22.34	20.21	17.42	163
20:00 - 21:00	19.67	15.40	18.10	14.39	17.08	17.46	10.02	112
21:00 - 22:00	8.53	7.37	9.38	4.30	8.62	6.73	2.77	48
22:00 - 23:00	6.08	5.49	6.23	4.20	7.96	4.03	6.26	40
23:00 - 00:00	3.28	2.68	4.08	6.05	3.55	1.07	2.31	23
	273	259	250	242	212	349	321	1,907

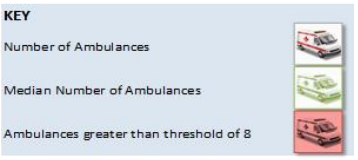
13.8 Anticipated Activity to be streamed to RHH ED – Per annum and daily average.

EXPECTED VOLUME TO BE STREAMED TO A&E DEPARTMENT									
Time Band	Monday	Tuesday	Wednesd	Thursday	Friday	Saturday	Sunday	Total	%
00:00 - 01:00	270	221	266	273	266	539	702	2,536	2.02
01:00 - 02:00	219	-	217	248	230	476	445	1,835	1.69
02:00 - 03:00	205	100	91	137	152	443	457	1,584	1.33
03:00 - 04:00	172	100	165	157	123	414	451	1,581	1.20
04:00 - 05:00	160	73	143	113	168	336	315	1,308	1.06
05:00 - 06:00	60	107	71	112	-	220	363	932	1.07
06:00 - 07:00	49	110	102	87	125	275	343	1,091	1.26
07:00 - 08:00	233	134	159	137	253	325	500	1,741	1.88
08:00 -09:00	628	919	682	854	615	1,060	613	5,371	4.70
09:00 - 10:00	770	750	614	509	960	- 130	- 550	2,923	6.36
10:00 - 11:00	518	388	326	225	509	322	205	2,494	6.20
11:00 -12:00	888	528	683	407	709	- 365	191	3,042	6.26
12:00 - 13:00	515	664	379	240	726	10	83	2,617	5.98
13:00 - 14:00	478	687	634	786	833	229	720	4,366	6.34
14:00 - 15:00	436	46	506	312	345	- 90	551	2,107	5.85
15:00 - 16:00	458	535	690	511	470	569	155	3,389	5.84
16:00 - 17:00	603	593	338	543	424	24	56	2,580	5.82
17:00 - 18:00	702	611	850	713	583	472	466	4,396	6.36
18:00 - 19:00	584	738	348	644	362	- 84	265	2,858	6.52
19:00 - 20:00	478	33	227	206	511	908	881	3,243	7.14
20:00 - 21:00	101	177	41	148	55	579	990	2,092	4.82
21:00 - 22:00	459	473	354	592	425	972	1,169	4,445	4.21
22:00 - 23:00	416	427	353	462	274	911	775	3,617	3.47
23:00 - 00:00	376	344	296	157	377	839	720	3,109	2.62
	9,777	8,756	8,535	8,573	9,494	9,254	10,866	65,256	100

	Average Daily Activity							
Time Band	Monday	Tuesday	Wednesd	Thursday	Friday	Saturday	Sunday	Total
00:00 - 01:00	5.18	4.23	5.10	5.24	5.10	10.33	13.45	49
01:00 - 02:00	4.20	-	4.16	4.76	4.41	9.13	8.54	35
02:00 - 03:00	3.93	1.91	1.74	2.63	2.91	8.50	8.76	30
03:00 - 04:00	3.30	1.91	3.16	3.01	2.36	7.93	8.64	30
04:00 - 05:00	3.07	1.39	2.74	2.16	3.22	6.45	6.04	25
05:00 - 06:00	1.14	2.06	1.36	2.14	-	4.21	6.96	18
06:00 - 07:00	0.94	2.11	1.96	1.66	2.40	5.27	6.59	21
07:00 - 08:00	4.47	2.56	3.05	2.62	4.85	6.24	9.59	33
08:00 -09:00	12.04	17.63	13.08	16.37	11.79	20.33	11.76	103
09:00 - 10:00	14.77	14.38	11.78	9.75	18.41	- 2.50	- 10.56	56
10:00 - 11:00	9.94	7.44	6.26	4.31	9.77	6.17	3.94	48
11:00 -12:00	17.02	10.13	13.11	7.81	13.60	- 7.00	3.67	58
12:00 - 13:00	9.88	12.74	7.28	4.61	13.91	0.18	1.60	50
13:00 - 14:00	9.17	13.17	12.16	15.07	15.97	4.40	13.81	84
14:00 - 15:00	8.35	0.89	9.71	5.99	6.62	- 1.72	10.57	40
15:00 - 16:00	8.78	10.25	13.24	9.81	9.02	10.92	2.96	65
16:00 - 17:00	11.56	11.37	6.47	10.40	8.13	0.46	1.08	49
17:00 - 18:00	13.46	11.71	16.29	13.68	11.19	9.05	8.93	84
18:00 - 19:00	11.20	14.16	6.68	12.35	6.94	- 1.61	5.09	55
19:00 - 20:00	9.17	0.63	4.35	3.96	9.79	17.41	16.90	62
20:00 - 21:00	1.94	3.40	0.79	2.85	1.05	11.11	18.98	40
21:00 - 22:00	8.81	9.07	6.78	11.36	8.16	18.64	22.43	85
22:00 - 23:00	7.98	8.18	6.76	8.85	5.25	17.48	14.85	69
23:00 - 00:00	7.21	6.60	5.67	3.01	7.23	16.09	13.82	60
	188	168	164	164	182	177	208	1,251

13.9 Anticipated WMAS ambulance conveyances to RHH ED – Daily average.





The table opposite captures the current daily (by hour) average ambulance conveyances to the A&E department for 2012/13. The data highlights periods of the day with a high likelihood of >8 ambulances within a one hour period.

	Total Activity Per annum								
Time Band	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total	%
00:00 - 01:00	161	133	130	167	122	185	210	1,108	3.84
01:00 - 02:00	153	135	115	147	129	177	205	1,061	3.67
02:00 - 03:00	108	122	90	108	89	133	158	808	2.80
03:00 - 04:00	88	98	89	83	76	121	136	691	2.39
04:00 - 05:00	88	74	81	86	88	96	122	635	2.20
05:00 - 06:00	101	97	81	86	85	104	118	672	2.33
06:00 - 07:00	68	96	74	70	92	80	105	585	2.03
07:00 - 08:00	92	94	99	73	115	97	82	652	2.26
08:00 -09:00	126	137	109	117	138	123	115	865	2.99
09:00 - 10:00	229	188	164	176	200	169	185	1,311	4.54
10:00 - 11:00	211	226	218	182	203	221	190	1,451	5.02
11:00 -12:00	224	200	194	212	218	230	244	1,522	5.27
12:00 - 13:00	215	186	196	232	213	204	241	1,487	5.15
13:00 - 14:00	240	223	219	206	207	236	272	1,603	5.55
14:00 - 15:00	223	224	262	233	240	209	257	1,648	5.71
15:00 - 16:00	202	200	235	200	207	243	221	1,508	5.22
16:00 - 17:00	194	191	190	183	195	222	203	1,378	4.77
17:00 - 18:00	263	219	211	227	245	234	223	1,622	5.62
18:00 - 19:00	192	207	201	193	165	178	216	1,352	4.68
19:00 - 20:00	202	189	193	194	188	196	176	1,338	4.63
20:00 - 21:00	244	198	193	204	213	215	195	1,462	5.06
21:00 - 22:00	204	219	206	219	221	210	230	1,509	5.22
22:00 - 23:00	215	192	185	200	184	206	221	1,403	4.86
23:00 - 00:00	167	164	177	150	190	198	169	1,215	4.21
	4,210	4,012	3,912	3,948	4,023	4,287	4,494	28,886	
%	14.57	13.89	13.54	13.67	13.93	14.84	15.56		

	Average Daily Activity							
Time Band	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
00:00 - 01:00	3.1	2.6	2.5	3.2	2.3	3.6	4.0	21
01:00 - 02:00	2.9	2.6	2.2	2.8	2.5	3.4	3.9	20
02:00 - 03:00	2.1	2.3	1.7	2.1	1.7	2.6	3.0	16
03:00 - 04:00	1.7	1.9	1.7	1.6	1.5	2.3	2.6	13
04:00 - 05:00	1.7	1.4	1.6	1.7	1.7	1.8	2.3	12
05:00 - 06:00	1.9	1.9	1.6	1.7	1.6	2.0	2.3	13
06:00 - 07:00	1.3	1.8	1.4	1.3	1.8	1.5	2.0	11
07:00 - 08:00	1.8	1.8	1.9	1.4	2.2	1.9	1.6	13
08:00 -09:00	2.4	2.6	2.1	2.3	2.7	2.4	2.2	17
09:00 - 10:00	4.4	3.6	3.2	3.4	3.8	3.3	3.6	25
10:00 - 11:00	4.1	4.3	4.2	3.5	3.9	4.3	3.7	28
11:00 -12:00	4.3	3.8	3.7	4.1	4.2	4.4	4.7	29
12:00 - 13:00	4.1	3.6	3.8	4.5	4.1	3.9	4.6	29
13:00 - 14:00	4.6	4.3	4.2	4.0	4.0	4.5	5.2	31
14:00 - 15:00	4.3	4.3	5.0	4.5	4.6	4.0	4.9	32
15:00 - 16:00	3.9	3.8	4.5	3.8	4.0	4.7	4.3	29
16:00 - 17:00	3.7	3.7	3.7	3.5	3.8	4.3	3.9	27
17:00 - 18:00	5.1	4.2	4.1	4.4	4.7	4.5	4.3	31
18:00 - 19:00	3.7	4.0	3.9	3.7	3.2	3.4	4.2	26
19:00 - 20:00	3.9	3.6	3.7	3.7	3.6	3.8	3.4	26
20:00 - 21:00	4.7	3.8	3.7	3.9	4.1	4.1	3.8	28
21:00 - 22:00	3.9	4.2	4.0	4.2	4.3	4.0	4.4	29
22:00 - 23:00	4.1	3.7	3.6	3.8	3.5	4.0	4.3	27
23:00 - 00:00	3.2	3.2	3.4	2.9	3.7	3.8	3.3	23
	81	77	75	76	77	82	86	556

14. Procurement and Contracting

14.1 Main Contract

There will be an NHS Standard Contract between Dudley CCG (as Lead Commissioner) and the Provider for the UCC service.

14.2 Contract Duration

The Contract will be for a term of 5 years, with the possibility of extending the term by 2 year(s) beyond the initial contracted duration by mutual agreement.

14.3 Sub-Contracting

Any consideration on the part of the Provider to commission an independent third party to provide any element of the UCC will first be discussed with the Commissioner. If the Commissioner agrees to the sub-contract, Department of Health Procurement Guide for Commissioners of NHS-Funded Services (July 2010) will need to be followed in respect of the procurement of this.

15. Public consultation and engagement

From 1st October 2013 to 24th December 2013 a formal public consultation took place on the reconfiguration of urgent care within Dudley. The outcome of the public consultation is detailed in the post consultation report received at the Dudley CCG Board meeting on the 9th January 2014. http://www.dudleyccg.nhs.uk/board-meeting-dates-and-papers/

16. Communication and Stakeholder Engagement

16.1 Provider Internal Stakeholders

As part of the medium to long term premises solution for the UCC within the term of the contract (see Section 7.23), there will be a capital development scheme led by DGNHSFT. The Provider therefore have a duty to cooperate with DGNHSFT to ensure they are informed and contribute actively to this plan and its developments.

16.2 Commissioner Internal Stakeholders

The Provider will produce an external stakeholder engagement and communication plan throughout the mobilisation phase and to cover the term of the contract. This will be developed in consultation with the Commissioner Communications Team.

16.3 Local and National Media

Communication messages will be developed to deal with media interest in the UCC and its on-going performance and development. It is a requirement of the contract that all media communication regarding the UCC are authorised before publication by Dudley CCG Communication Team and not the Provider directly.

16.4 External Stakeholders

A communication plan for healthcare stakeholders will need to be developed by the Provider. Guidance on which key stakeholders the Provider should engage with will be issued by the Commissioner. Key formal communication links will as a minimum need to include:

- Dudley GP Practices;
- DGNHSFT;
- Dudley Metropolitan Borough Council;
- Dudley and Walsall Mental Health Partnership Trust;
- WMAS;
- NHS 111;
- Dudley Healthwatch;
- Dudley Health Overview and Scrutiny Committee;
- Other CCGs who have patients that use the UCC;
- Dudley Council for Voluntary Services; and
- Neighbouring Acute Trusts and Local Authorities.

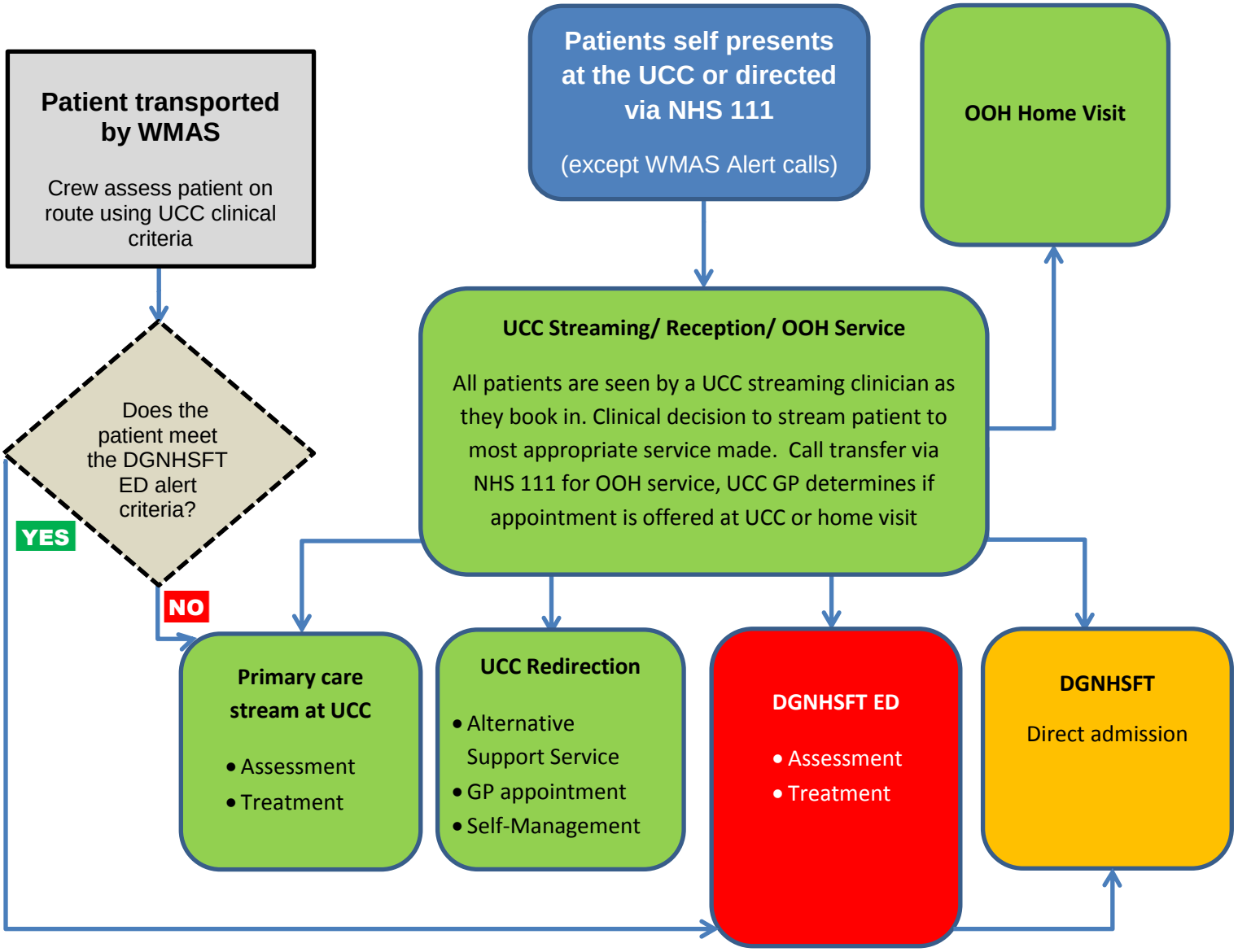
16.5 Patient and Public engagement

The commissioner will continue to communicate and engage with patients and the public throughout and beyond the period leading to the opening of the UCC to ensure that the local community has a clear understanding of the way their urgent care services are changing.

Throughout the patient experience at the UCC, patients will be educated on other healthcare services in the community and actively encouraged to use their own GP Practice (or register with a GP Practice if they are unregistered). Once patients do present at the UCC there will be a series of communication and information materials produced by the Provider in partnership with the Commissioner (for example leaflets, waiting room TV screens) to explain how the UCC operates.

The Provider will be expected to encourage and sustain meaningful and robust patient feedback and patient engagement. Patient feedback on the UCC will form a key component of the performance management of the service. The Provider will be required to facilitate the initiation and maintenance of an UCC patient participation panel and secure patient representation for the UCC Management Board.

APPENDIX 1. – Patient flow through UCC



APPENDIX 2. UCC Streaming Protocol for all presenting patients

ESI Score	Criterion	Interventions/ Resources		Factors	Paediatric Specific Factors (if applicable)	Outcome
1	Does the Patient Require Immediate Life-Saving Intervention?		**Life-saving - on booking**	**Examples of ESI level 1:** • Cardiac arrest • Respiratory arrest • Severe respiratory distress • Signs of cyanosis and respiratory distress • Critically injured trauma patient who presents unresponsive • Overdose • Severe respiratory distress with agonal or gasping type respirations • Reported Severe bradycardia or tachycardia with signs of hypoperfusion • Hypotension with signs of hypoperfusion • Trauma patient who requires immediate crystalloid and colloid resuscitation • Chest pain, pale, diaphoretic, Weak and dizzy, nauseous. • Weak and dizzy with palpitations or racing heart rate described • Signs and Symptoms of Anaphylactic shock • Baby that is flaccid • Unresponsive patient with a strong odor of alcohol • Hypoglycaemia with a change in mental status • Intubated head bleed with unequal pupils • Child that suffered trauma, falls from height and/or is unresponsive to painful stimuli	Respiratory arrest and/or Cardiopulmonary arrest and/or Respiratory failure Major head trauma with hypoventilation Active seizures an/or Unresponsiveness Peticheal rash in a patient with altered mental status (regardless of vital signs) Hypoventilation and/or Cyanosis Decreased muscle tone and/or Decreased mental status Reported Bradycardia (late finding, concerning for impending cardiopulmonary arrest) Signs of Shock/sepsis with signs of hypoperfusion Reported Tachycardia Obvious or reported Tachypnea Alteration in pulses: diminished or bounding and/or Cold extremities Alteration in skin appearance: cool/mottled or flushed appearance Widened pulse pressure and/or Hypotension (often a late finding in the prepubescent patient) (Weak and dizzy and/or alterations in mental state) Anaphylactic reaction (onset in minutes to hours) Respiratory compromise (dyspnea, wheeze, stridor, hypoxemia) Reduced systolic blood pressure Signs of Hypoperfusion (eg, syncope, incontinence, hypotonia) Skin and/or mucosal involvement (hives, itch-flush, swollen lips, tongue or uvula Persistent gastrointestinal symptoms	A&E
		Airway/breathing	BVM ventilation			
			Intubation			
			Surgical airway			
			Emergent CPAP			
			Emergent BiPAP			
		Electrical Therapy	Defibrillation			
			Emergent cardioversion			
			External pacing			
		Procedures	Chest needle decompression			
			Pericardiocentesis			
			Open thoracotomy			
			Intraoseous access			
		Hemodynamics	Significant IV fluid resuscitation			
			Blood administration			
			Control of major bleeding			
		Medications	Given Naloxone			
			Given Dextrose 50%			
			Intervention with Dopamine			
			Intervention with Atropine			
			Intervention with Adenosine			
2	1. Is this a high-risk situation? 2. Is the patient confused, lethargic or disoriented? 3. Is the patient in severe pain or distress?		**Not life-saving - on booking**	**Examples of high-risk situations:** • Active chest pain, suspicious for acute coronary syndrome but does not require an immediate life-saving intervention, stable • A needle stick in a health care worker • Signs of a stroke, but does not meet level-1 criteria • Severe Abdominal Pain in Pregnant Women or women of child bearing age (removed signs of ectopic) • A patient on chemotherapy and therefore immunocompromised, with a fever • A suicidal or homicidal patient **Examples of patients who are confused, lethargic, or disoriented:** • New onset of confusion in an elderly patient • The 3-month-old whose mother reports the child is sleeping all the time • The adolescent found confused and disoriented **Determining Severe Pain:** This is determined by clinical observation and/or a self reported pain rating of Severe or Unbearable That discontinues normal day a to day activity . When patients report pain ratings of 7/10 or greater, the triage nurse may triage the patient as ESI level 2, but is not required to assign a level-2 rating. Pain to be assessed by clinical observation - Distressed facial expression, grimacing, crying, Diaphoresis, Body posture & Changes in vital signs – hypertension (HTN), tachycardia, and obvious increases in respiratory rate Physical responses to acute pain that support the patient's rating. For example, the patient with abdominal pain who is diaphoretic, tachycardic, and has an elevated blood pressure or the patient with severe flank pain, vomiting, pale skin, and a history of renal colic are both good examples of patients that meet ESI level-2 criteria. **Determining Severe distress:** Can be physiological or psychological. Examples of distress include the sexual assault victim, the victim of domestic violence, the combative patient, or the bipolar patient who is currently manic	Syncope Immunocompromised patients with fever Haemophilia patients with possible acute bleeds • Joint pain or swelling • History of fall or injury • Vital signs and/or mental status outside of baseline Febrile infant <28 days of age with a reported fever ≥38.0°C rectal or hot to touch on the chest Hypothermic infants <90 days of age with a reported temperature <36.5°C rectal or cold to touch on the chest Suicidality Rule out meningitis (headache/stiff neck/fever/lethargy/irritability) Seizures--prolonged postictal period (altered level of consciousness) Moderate to severe croup Lower airway obstruction (moderate to severe) • Bronchiolitis and/or Reactive airway disease (asthma) • Respiratory distress – Obvious or reported Tachypnea – Tachycardia – Increased effort (nasal flaring, retractions, see-saw actions with breathing) – Abnormal sounds (grunting) – Altered mental status Signs of Distress Requiring further Assessement Reported bad cough or wheezes Appears pale and appears unwell Reported cries or screams and is unable to be settled or calmed Develops an unusual cry for one hour or more Child Cries, grizzles and pulls or rubs their ears Develops a runny ear Reported no wet nappies for six hours, during the day, or 8 hours at night Not eat or drink normally or has been vomiting for more than 6 hours or has trouble swallowing or uncontrolled dribbling or has vomiting and diarrhoea together Vomiting is described as green or has blood in it Adult reports several runny, dirty nappies (diarrhoea) in 1 or 2 hours or diarrhoea that lasts longer than 24 hours or reports blood in their poo Adult reports skin or eyes are a yellow colour (jaundice)	A&E
		Airway/breathing	Oxygen administration			
			Nasal cannula			
			non-rebreather			
		Electrical Therapy	Cardiac Monitor			
		Procedures	Diagnostic Tests			
			• ECG			
			• Blood taken for Labs			
			• Referred for Ultrasound			
			• FAST (Focused abdominal scan for trauma)			
		Hemodynamics	Fluids administered IV access			
			Patient has a Saline Locked Cannula for medications			
		Medications	Received Asprin from Medical Professional			
			Received Nitro-glycerine from a Medical Professional			
			Not responding to Antibiotics			
			Patient on Heparin			
			Not responding to Pain medications			
			Respiratory treatments with beta agonists			
3	Are there Danger Zone Baseline Observations?	**Danger Zone Baseline Obs**	Presenting Adult describes in Children/ or observed - Respiratory Retractions, Grunt, Apnoea Moderate or severe chest indrawing. and/or central cyanosis	**Danger Zone Vital Signs** - Consider up-triage to ESI 2 if any vital sign criterion is exceeded. **Paediatric Fever Considerations (associated with Danger Obsevations for Children)** 1 to 28 days of age: assign at least **ESI 2** if temp reported as >38.0 C (100.4F) 1-3 months of age: consider assigning **ESI 2** if temp reported as >38.0 C (100.4F) 3 months to 3 yrs of age: consider assigning **ESI 3** if temp reported as >39.0 C (102.2 F), incomplete immunizations, or no obvious source of fever.	**Examples of Situations That May Warrant Sedation in Pediatric Patients:** Fracture/dislocation repair in A&E Complicated lacerations, such as: Complex facial/intraoral lacerations, Lacerations across the vermillion border, Lacerations requiring a multilayered closure, Extremely dirty or contaminated wounds CT/MRI procedures or image-guided procedures (e.g. joint aspirations under bedside ultrasound, fluoroscopy) Lumbar punctures (except in infants) and/or Chest tube insertions	A&E
			Any Jaundice, Cyanosis, Unresolved Nausea, Dizziness or Breathlessness (abnormal to them)			
	Non UCC Resources	**Resources from any of the following**	Labs (blood, urine) ECG, X rays CT-MRI-ultrasound angiography IV fluids (hydration) Saline or heplock IV, IM or nebulized medications Specialty consultation Difficult Procedure or Wound Care i.e.. Facial Lac Repair , complex burn dressing Complex procedure = (conscious sedation)			
4	UCC Resources	**Resources from any of the following**	Simple procedure = 1 (lac repair, Foley cath), Simple wound care (dressings, recheck) Crutches, splints, slings	From a clinical standpoint, ESI level 4 and 5 patients are stable and can wait several hours to be seen by a provider. However, from a customer service standpoint, these patients are perhaps better served in a fast-track or urgent care area.		UCC
		Presentation	Any presentation >48hrs old and non-life or limb threatening should be diverted to UCC.			
5	No ILT, Non Urgency, No Resources	**No Resources**	History & physical (including pelvic) Point-of-care testing PO medications, Tetanus immunisation, Prescription refills Phone call to Primary Care Provider Elderly with Increased number of falls with no Physical Injuries or Level 1- 3 conditions		**Examples of ESI Level 5:** Medication refills Ear pain in healthy school-age children Contusions and abrasions URI symptoms with normal vital signs - ie.2 year-old with runny nose, mild cough and a reported temp of 38°C (100.4°F), active and drinking during triage Poison ivy on extremities	UCC
Social	Social Aspects for referral	**No Resources**	Reported not coping with activities of daily living (especially in elderly with care) could be either physically or a cognitive decline. A 3rd party struggling to manage with increase in care needs and demands. Change in care category residential to nursing Described Social related issues eg alcohol with no physical injuries, medical complications & mental health exacerbation. Also self neglect. Ambulance services referral via emergency department with reports of poor living conditions	Reason for admission is not for any medical, trauma or mental health related issues, however could be for place of safety due to increased social needs and categorised in the listed social concerns.		UCC

Please note the appointed Provider will be expected to work in partnership with the Commissioner and DGNHSFT on this service protocol and therefore following joint review it may be subject to some change.

Figure 1: National drivers for change

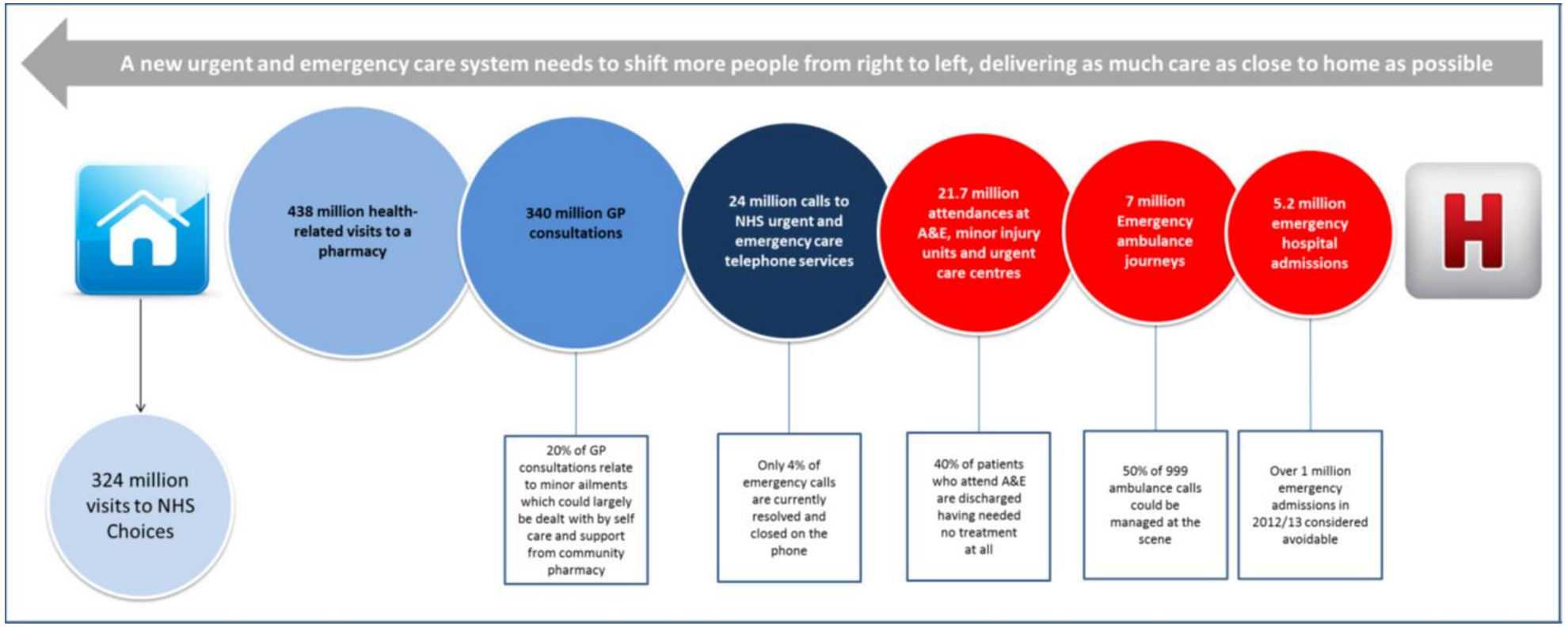
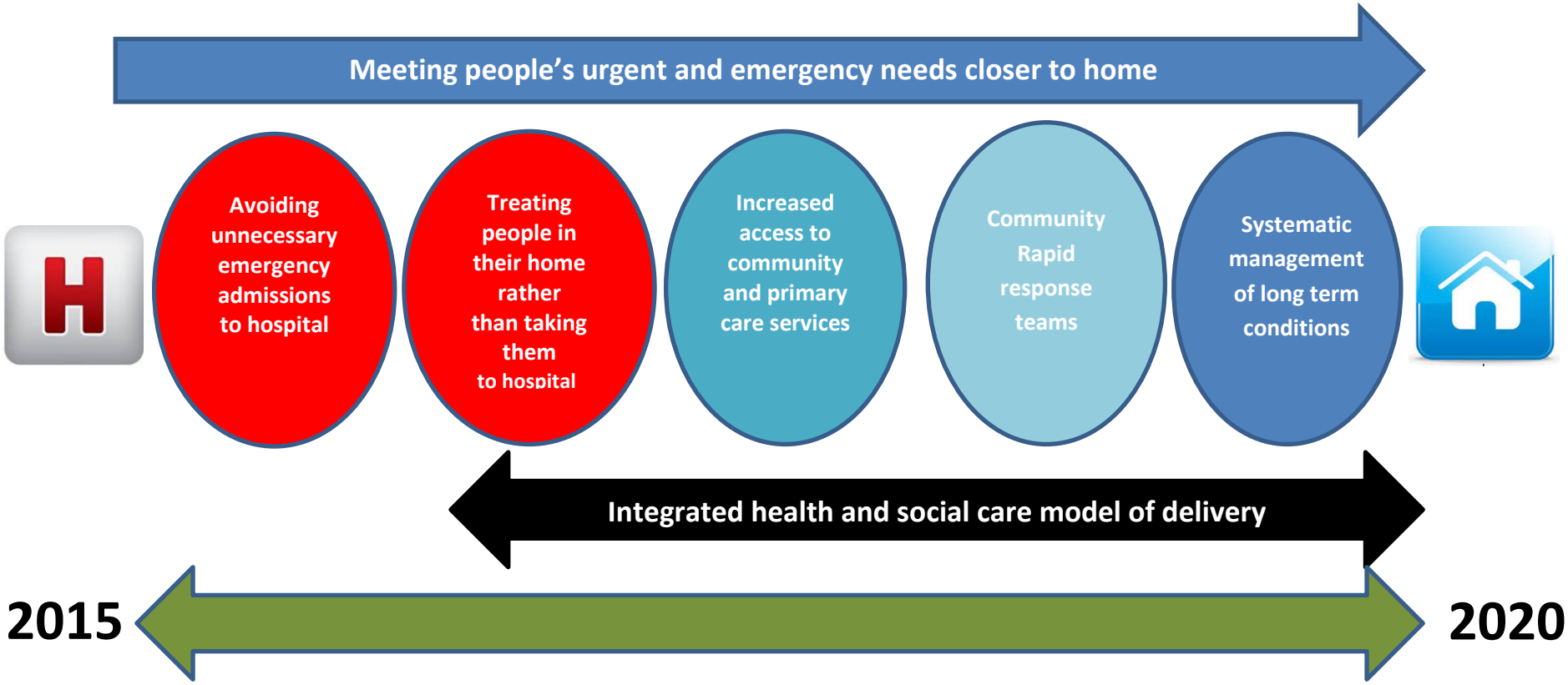


Figure 2: Urgent care vision for Dudley



Agenda Item No. 8

Health Scrutiny Committee – 22nd September 2014

Report of the Chief Accountable Officer, Dudley CCG

The Better Care Fund (BCF)

1.0 Purpose of Report	
	To advise the Committee on the current position in relation to the Better Care Fund.
2.0 Background	
	The Committee will recall that the Better Care Fund (BCF) was originally announced in June 2013 as an "opportunity to transform local services so that people are provided with better integrated care and support".
	In effect, this involves the creation locally of a pooled budget (the local BCF) using powers contained in Section 75 of the NHS Act 2006. The total minimum value of this for Dudley is £23.84m in 2015/16. This total amount is derived from 3 sources as follows:- • Dudley CCG - £13.533m • NHS England - £7.157m • Dudley Council - £3.151m This report sets out the current position in terms of developing our local BCF Plan which at the time of writing (10 September) was due to be submitted to NHS England on 19 September 2014
3.0 Report	
	At the time of writing this report, work was taking place to finalise the submission and brief the Chair of the Health and Wellbeing Board which has responsibility for its ultimate oversight. An update on the detail of the final submission will be made at the meeting. **Impact on CCG** The CCG's contribution to the BCF shown above will be a direct reduction from its budgetary allocation in 2015/16. This means that the CCG will have £13.533m less to commission services than it has in 2014/15 – an amount more or less equivalent to 50% of the contract value for commissioning mental health services for the population of Dudley.

The way in which the BCF is designed to deal with this is through services being transformed to reduce the level of emergency hospital admissions by an equivalent amount. This is to be achieved through the integration of health and care services locally, as well as investing in new services to prevent directly unnecessary admissions.

Service Integration

The notion of integrating local services to reduce admissions to hospital, reduce admissions to care homes and enable people to continue living their lives independently in their communities is something that was identified as a priority by the Health and Wellbeing Board in the Joint Health and Wellbeing Strategy. This predates the advent of the BCF and in this sense ensuring we have a BCF that is in balance and delivers on a series of key performance measures is a sub-set of a wider service integration programme.

The service integration model we are working towards is based upon creating integrated teams at practice, locality and borough levels.

The basic integrated team at practice level will consist of:-

GP
community nurse
mental health link worker
practice based pharmacist
social care link worker.

They will be led by the GP with appropriate input from a virtual ward case manager. There will be a "congruence of case load" for each member of the team - they will each have responsibility for serving the same group of patients. Some team members may additionally serve patients of other practices and be members of other teams (in which case there will be a similar congruency with workers serving those patients from other services). At any time the team members will all serve the same patients. There will be clear links from these teams to services at Locality and Borough level.

Under the leadership of the GP they will:-

hold primary care multi-disciplinary team (MDT) meetings on a regular basis;
review key performance data relating to the population they serve including admissions, avoidable admissions, delayed transfers of care, care home admissions and virtual ward status (in effect a sub set of the BCF performance framework).

At Locality level the team will consist of:-

GP
lead community nurse
lead social care link worker
lead mental health link worker

all the above are drawn from those working at practice/community of practices level. In addition, this team will consist of:-

Community Rapid Response Team rep
Virtual ward rep.
CVS Locality Link Development Officer

They will be led by a GP Clinical Leader

The team will be responsible for:-

holding a multi-disciplinary team (MDT) meeting of all those individuals identified above;
reviewing the collective performance of all the teams in their locality, through an aggregated performance report;
reporting on performance to the CCG locality meeting, in accordance with an agreed process;
ensuring that pathways from practice to Locality to Borough wide services function effectively.

A key principle behind this approach is that of shared responsibility – teams working together serving the same population and holding themselves to account for their performance.

To provide the appropriate level of capacity, in order to support the integrated practice teams to function effectively the CCG has commissioned a number of further community services. The main service of this nature is the Community Rapid Response Team which is designed to act as an alternative intervention for those frail elderly patients who would ordinarily have been admitted to hospital.

This service will be supported by a number of other services, including nurse practitioners and a community psychiatric nurse working specifically with care homes.

It is anticipated that this service will be the main contributor to reducing emergency admissions to the level required for the BCF to achieve financial balance.

Implementation of the Integrated Service Model

5 “early implementer” sites have been established and have begun to meet as multi-disciplinary teams. The lessons from these sites will be used to support the roll out of the model across all Dudley practices over the coming weeks. This is being supported by an extensive organisational development programme to build effective team working.

The Community Rapid Response Team is operational and once appropriate clinical governance arrangements have been finalised, this team will begin to deal with emergency calls which have traditionally been dealt with by the ambulance service. Other associated services have been recruited to.

The performance framework and reporting arrangements for individual teams is being put in place.

Revised BCF Guidance

Following publication of revised guidance on the BCF in July 2014, discussion shave

	taken place with regard to its implications for existing plans and the budgetary positions of both the Council and the CCG. The most significant change from the previous guidance is that the element of the fund that is payable on meeting performance targets is now solely related to reducing emergency admissions by an agreed amount. The financial value of this element of the BCF is £5.96m. This creates a level of financial risk greater than existed previously. **Timetable for Completion** At the time of writing this report, these discussions are still taking place. The final submission date to NHS England is 19 September 2014. Arrangements are being made to brief the chair of the Health and Wellbeing Board prior to submission and the Health and Wellbeing Board will receive a full report at its meeting on 30 September 2014. A verbal update on progress will be given to the Committee.
4.0 Financial Implications	
	The contributions to the BCF are as set out in paragraph 4. Above. The value of the performance element of the BCF is £5.9m
5.0 Legal Implications	
	The pooled budget to be used to facilitate the creation of the BCF will be created using powers contained in Section 75 of the NHS Act 2006.
6.0 Equality Impact	
	The integrated services model is designed specifically to respond to health inequalities identified in the Joint Strategic Needs Assessment and the CCG's Operational Plan
7.0 Recommendation	
	That the position in relation to The Better Care Fund be noted

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