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# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

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| **Service Specification No.** | Version 1 |
| **Service** | Summerfield Urgent Treatment Centre |
| **Commissioner Lead** | Sandwell & West Birmingham CCG |
| **Provider Lead** |  |
| **Period** |  |
| **Date of Review** |  |

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| **1. Population Needs** |
| * 1. **National Context**   **1.1.1 Sir Bruce Keogh Urgent and Emergency Care Review**  Sir Bruce Keogh’s review into urgent and emergency care details how models of care can be achieved through a fundamental change in the way urgent and emergency care services are provided to all ages by improving out-of-hospital services so that care can be delivered closer to home and reduce hospital attendances and admissions.  The vision of the review is:   * For adults and children with urgent care needs, the NHS should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families. * For those people with more serious or life threatening emergency care needs, the NHS should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and good recovery.   The review highlighted five elements of change which must be taken forward to ensure success:   1. To provide better support for self-care. 2. To help people with urgent care needs get the right advice in the right place, first time. 3. To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue in A&E. 4. To ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery. 5. To connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.   **1.1.2 Five Year Forward View (5YFW)**  The NHS Five Year Forward View (5YFW) sets out the need to redesign urgent and emergency care services in England for people of all ages with physical and mental health problems  **1.1.3 Next Steps on the Five Year forward view**  In 2017,Next Steps on the Five Year forward was published which reflected on progress in implementing the Five Year Forward View and outlined how the NHS ought to move forward. Of particular relevance to the CCGs plans to commission Same Day Access services are that:   * Urgent and emergency care services must continue to be available to patients and their families 24 hours a day, 7 days a week. * Nationally, up to 3 million A&E visits could have been better dealt with elsewhere. Patients with less severe conditions will be offered more convenient alternatives. * One of the public’s top priorities is to know that they can get a convenient and timely appointment with a GP when they need one. That means having enough GPs, backed up by the resources, support and other professionals required to enable them to deliver the quality of care they want to provide. * As people live longer lives the NHS needs to adapt to their needs, helping frail and older people stay healthy and independent, avoiding hospital attendances and stays where possible. * As well as harnessing people power, the NHS also needs to leverage the potential of technology and innovation, enabling patients to take a more active role in their own health and care while also enabling NHS staff and their care colleagues to do their jobs - whether that is giving them instant access to patient records from wherever they are, or to remote advice from specialists   **1.2.4 Urgent Treatment Centres**  Both nationally and locally it is recognized that there is a need for a more robust community response to urgent care that includes same day access and is strongly integrated with primary care provision. NHS England has focused on a national approach to standardising urgent care via the development and designation of urgent treatment centres (UTCs). There is a defined list of principles and standards (<https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards/>) that must be met for a facility designated as an urgent treatment centre and providers should ensure that the standards are met as part of the Same Day Access model and give due consideration to nomenclature.   * 1. **Patient and Public Feedback**   National consultation with patients and the public has indicated that patients do not distinguish between urgent and emergency health care needs and that the two terms can be used interchangeably. The review states that the judgement of ‘urgent’ and ‘emergency’ is defined by the patient and not by the clinician. Clinicians may choose to distinguish between emergency (time-critical) and urgent (not time-critical) however patients should not be expected to distinguish between the two. Patients and the public have indicated considerable confusion regarding the naming of various facilities and an inconsistent service offer.  Findings from our local patient engagement work are in line with national findings;   * Their main reason for attending an Urgent Treatment Centre is the real and perceived inability to book a same day or a timely routine appointment with their General Practice (GP). * Frustration with current GP booking processes and the simplicity of a walk in service. * Some patients were unaware of the extended service offer available in GP but the majority of patients when asked would be happy to attend an appointment at either their own GP or an alternative GP led service nearby. * Some patients had used the NHS 111 service and found it useful and some were directed to the walk in service. * Many patients using the current walk in services were parents with young children, adults under 35 and unregistered people. * Some patients express their dissatisfaction with recent changes to GP access processes, saying it was nearly impossible to book a routine appointment. * A number of patients were not registered with a GP and Walk in Services were their route (other than A & E) to seek assessment and treatment.   1. **Local Context**       1. **Black Country & West Birmingham CCG**   Black Country & West Birmingham (BCWB) CCG aims is to work across boundaries to improve the health of the communities we serve, and the quality of health and social care services provided to those communities by:   * + - 1. Giving patients and the wider population the opportunity to benefit from healthier lifestyles.       2. Bringing appropriate elements of care closer to home.       3. Designing services to meet the needs of the local population.     1. **Place Based Care**   The West Birmingham geography is part of a bigger place; Western Birmingham. The CCG is working closely with Birmingham and Solihull Clinical Commissioning Group (BSOLCCG) to align commissioning processes and develop shared strategic plans for this footprint.  Our ambition is to create sustainable solutions for the system and the people it serves through a set of new relationships for commissioning and provision. There is recognition that for a system to be fit for the future there must be the opportunity for a flexible provider response to population needs and that this requires strong partnerships with mutual responsibility for population outcomes.  In December 2015 the Final Business Case for the development of a new hospital, Midland Metropolitan, was signed off. The opening of the new hospital will see the closure of both Sandwell General and City Hospital A&Es. City Hospital will be largely closed down with the exception of some intermediate care facilities.    The Midland Metropolitan University Hospital is due to open in 2022 and its business case details that the case for change has become more urgent with the increasing demands upon Providers to raise standards of care against a backdrop of diminishing resources and increasing patient needs. The business case states its reasons for a new single hospital and a change to emergency care as:   1. First and foremost, the Trust cannot sustain services and cannot meet Keogh recommendations on emergency care, operating acute services for adults and children from two sites. 2. The poor health of the residents in the Trust’s catchment area makes the case for change in the model of care to focus on prevention. The Right Care Right Here (RCRH) Programme has developed plans to deliver these changes. A new single site acute hospital is central to successful delivery of these plans. 3. Major changes in primary and community care make the case for development of a new acute hospital with capacity aligned to the activity model agreed by the RCRH Programme. 4. Due to the condition of the current estate the provision of a suitable environment for patients and staff will require investment in new hospital facilities. 5. The preference for care closer to home and expansion of patient choice makes the case for delivering new services closer to home, building state of the art hospital facilities; and developing a high quality workforce.    * 1. **Local System and Service Change**   The following local planned system and service change initiatives have been considered when designing the specification.  **Acute Provision**  Patients are currently provided acute hospital care from Sandwell & West Birmingham Hospitals NHS Trust at Sandwell General Hospital and City Hospital. It is also worth noting that there are patient flows across neighbouring CCG providers. As stated in section1.3.2 above the opening of the new Midland Metroplitan University Hospital will see the closure of both Sandwell General and City Hospital A&Es. City Hospital will be largely closed down with the exception of some intermediate care facilities and an Urgent Treatment Centre facility will remain at the Sandwell site  **Primary Care**  The local Primary Care offer allows for virtual consultations where appropriate and also for patients to book face to face same day appointments, pre-bookable appointments and also allows services such as NHS 111, local Emergency Departments and community services to book appointments directly with a patient’s registered practice.  Primary Care Networks (PCNs) have also been established, to not only ensure the resilience and sustainability of local general practice into the future, but to also offer improved patient pathways as PCNs become effective partners within the emerging Integrated Care System.   * 1. **Population**      * 1. **Patient Feedback**   From 2015- 2020 several listening exercises have been undertaken to understand what our patients want from urgent and emergency care in their local area. Some of the key messages were:   * Improve access to primary care – more appointments, longer opening hours and increased access * More local health and walk-in centres * Better education and information on U&E care services reaching all communities * Better integration   Patients identified the following as the most important for accessing health services:   1. Seeing the right healthcare professional 2. Seeing someone the same day 3. Getting an appointment at a time to suit them 4. Close to where they live/work |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** |  | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** |  | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** |  | | **Domain 4** | **Ensuring people have a positive experience of care** |  | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** |  |   **2.2 Local defined outcomes**   * People are seen, treated and discharged on the same day in an urgent care service close to their own home * Greater integration between community urgent care service and services delivered in the community facilitated by the stronger links with primary care practitioners enabling individuals to be referred more rapidly and seamlessly to relevant pathways, and improving access to community-wide responses to people’s care needs.  * A reduction in travel times (including 999 journey times) for some patients who will be able to access urgent care close to homes * Fewer people will need to travel by ambulance to acute hospital Emergency Departments  Fewer people will need to attend an acute hospital Emergency Department  Fewer people will be admitted at an acute hospital sites, with more people being admitted to a local short stay assessment bed closer to their home * Improved ambulance response times; an urgent treatment centre will improve ambulance service capacity, saving unnecessary journeys and freeing up crews and vehicles to respond to urgent cases. * Greater integration between community urgent care service and services delivered in the community facilitated by the stronger links with primary care practitioners enabling individuals to be referred more rapidly and seamlessly to relevant pathways, and improving access to community-wide responses to people’s care needs. * Increasing the interdependency, networking and mutual support of primary and secondary care practitioners, with a gradual transfer of skills, knowledge and shared competencies creating a more integrated and flexible workforce over time.   **2.2.1 Clinical Outcomes**  All the clinical outcomes listed below will be broadly measurable as part of the contract monitoring process. These generic outcomes cover the service as a whole. For specific clinical outcomes relating to each area of the service specification/pathway, please see section 3.  All the locally defined clinical outcome measures detailed in this specification are developed and used for quality improvement and/or accountability. See Appendix 1 for detailed associated KPI‟s and quality requirements. The following are generic clinical outcomes:  • Patients seen and treated within a maximum of 4 hours  • Patients not returning within 48 hours for the same condition  • Patients will be treated and discharged without the need to refer to other services unless clinically required.  Information and Quality Requirements are detailed in Section 3.9. |
| **3. Scope** |
| **3.1 Aims and objectives of service**  The aims and objectives of the service are in line with the national vision to create an urgent care service that is capable of delivering the right care at the right time seven days a week.  The aim of this service is to provide urgent care services to people closer to their homes and in so doing reduce 999 conveyances, Emergency Department attendances and acute hospital admissions through the provision of high quality care.  The aims and objectives of the service are to:   * Provide timely assessment, intervention and monitoring for patients being treated in the UTC * Streamline the patient episode of care with expedited and safe discharge with the appropriate support * Support flow through the system and reduce pressures on ED through provision of a streamlined pathway from ED and in-reach into ED.   The service must be compliant with the NHSE Urgent Treatment Centre Standards  **3.1.1 Activity**  This service will be based on expected activity of 38,400 attendances per annum  **3.2 Service description/care pathway**  Walk in patients will be assessed and where necessary treated and discharged in line with their presenting health needs. Where possible a discharge summary will be provided to the patient’s registered GP. The service will also provide appointments that are bookable via NHS 111    **3.2.1 Access**  All patients presenting with appropriate conditions should be able to access UTC services.  **3.2.3 Opening Hours**  The UTC will be open from 8am to 8pm, 7 days a week, 365 days a year.    **3.2.4 Patients not registered with a GP**  All patients will be asked at registration if they are registered with a GP practice. Any unregistered patient will be encouraged to register with a GP of their choice.  **3.2.5 Diagnostics**  Pathways will be in place to ensure access to suitably identified diagnostics (bloods, ECG, urinalysis) are available or pathways (X-Ray) are in place and reporting is commensurate with walk in treatment.    **3.2.6 Discharge and onward referral**  Patients being discharged home should be given a summary of their condition, treatment given (if any) and future management plan. This will be discussed with the patient and carer (where appropriate) and a copy sent to their GP.  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 they will be asked to call their own GP practice or NHS111 if out of core GP hours.  The service will agree referral pathways with:     * Local in-hours GP practices including arrangements for temporary residents requiring on the day primary care * Out of Hours GP service * Mental Health services * Local pharmacies   **3.2.7 Supply of Medicines**  The Provider will adhere to all relevant quality standards within the “Commissioning for Quality in Medicines Management”. This includes the CCG formulary.  Medication will be prescribed and administered as required.  **3.2.8 Patient records**  The Provider will ensure all staff and processes follow the patient information and governance arrangements and guidance held by the Department of Health, SWBH and SWB CCG.  Patients being treated at the UTC should, have an episode of care summary communicated electronically to their GP practice within 24 hours of discharge.  Patients may also be given appropriate printed materials relating to their specific condition.  **3.2.9 Workforce**  The Provider’s full staff model for the service will reflect the need for a highly skilled multidisciplinary team presence, with experience of urgent and emergency medicine, from the clinical and non-clinical team doing the rapid initial assessment to the clinicians doing the main assessment/treatment.  Arrangements should be in place for cover in the event of staff absence so not to unreasonably delay pathways and patient outcomes and experience is not adversely affected. The service should be at the required staffing level at all times to be able to see the expected activity volumes and case mix.  **3.2.10 Clinical staff**  The service will be GP led and staffed by a multidisciplinary team including ANPs, Nursing Staff.  **3.2.11 Non-clinical staff**  Sufficient administration and managerial staff will be required to meet the needs of the Commissioner contract and patient demand.  **3.2.12 Locum/ Temporary Staffing**  The Provider is expected to employ permanent staffing for the service. Where locum or temporary staff are required, all staffing will be expected to meet the same compliance requirement as permanent members of staff.  **3.2.13 Workforce planning competency**  The UTC will have a robust and effective workforce plan that demonstrates the ability 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 patients who attend and the competencies of individual staff members. The Provider is expected to demonstrate how staff competencies meet the needs of the expected clinical caseload for each service.  The Provider will be expected to report staffing compliance concerns to the commissioner in real time.  All staff should have competences appropriate to their role in:   * Safeguarding of children, young people and vulnerable adults * Recognising and meeting the needs of vulnerable groups including young people, people with mental health issues, dementia, alcohol and substance misuse problems, learning disabilities and older people * Dealing with challenging behaviour, violence and aggression * Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.   **3.2.14 Overall Management**  The overall operational management of the service will be undertaken by the Provider and a named management lead appointed. The UTC will have an operational policy in place and reviewed on an annual basis. The Provider will be accountable to the Commissioner.  **3.2.15 Clinical Leadership**  The urgent treatment centre should have an identified clinical lead who participates in clinical and non-clinical audit and demonstrates effective engagement in a programme of continuous quality improvement.  The clinical lead will take responsibility for all clinical practitioners who treat patients autonomously. The clinical lead will be responsible for all staffing, training, guidelines, protocols, service organisation’s clinical governance arrangements and for liaison with other services.  **3.2.16 Integration, training and development**  The Provider will be expected to develop the capacity for staff training for all staff or contractors.  The senior management should ensure that there is provision for appropriate supervision for training purposes including both education and clinical supervision for its workforce.  All healthcare practitioners should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.  Arrangements should be in place for competence based induction for all staff including agency, bank and locum and supervision of staff in training and supervision of staff in training.  The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place  In addition it will be an expectation that a core skill of all staff will be good communication and empathy in treating and talking to a wide range of patients and carers (where appropriate)  **3.2.17 Equipment**  The equipment shall be adequate, functional and effective for all the pathways. 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.  The following equipment should be immediately available and checked in accordance with local policy;   * + Resuscitation drugs and equipment   + Defibrillator   + Oxygen   + Emergency drugs (in line with medicines management section)   **3.2.18 Information Technology**  The provider should have an IT system that is secure and fit for purpose.  The urgent treatment centre should collect contemporaneous quantitative and qualitative data, including patient experience. The urgent treatment centre must return the data items specified in the Emergency Care Data Set (ECDS). Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.  A minimum data set on a patient’s demographics needs to be captured and evaluation needs to take into consideration access in line with the EQIA. Data should include:   * + Date of birth   + Postcode   + Gender   + Local patient identifier   + Organisation code   + NHS number   + NHS number status indicator code   + Ethnic category   + Language   + GP practice   + Commissioner   + Date of attendance   + Time of Attendance   + Waiting time   + Service type referred to   + Source of referral   The Provider must ensure that the IT system in use is capable of:   * + Collecting data on activity levels and response time   + Collecting information required to return the data items specified in the Emergency Care Data Set (ECDS).   + Supporting appropriate clinical audits   + Secure transmission of information including PEMS to GP surgeries   + Transfer and acceptance of consultation between services   + Accepting bookings directly from NHS 111   + Facilitating electronic prescribing   + Enabling staff to access an up-to-date electronic patient care record; this may be a summary care record or local equivalent including flags or crisis data where appropriate   + Where available, systems interoperability should make use of nationally defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMEDCT) and nationally-defined record structures   The urgent treatment centre must ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child  **3.2.19 IT system and wider scope and connectivity**  It is preferable that the IT system is ITK accredited to enable the best interoperability with other relevant services.  The IT system should facilitate the transfer of electronic messages relating to a patient’s contact at to the patient’s GP. E.g. post event messages, electronic discharge summary.  **3.2.20 IT Training**  The Provider is responsible for all staff undertaking appropriate 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.  **3.2.21 Interdependency with other services**  The Provider, as part of the wider unscheduled care system, will have a duty to cooperate with other stakeholders in the local healthcare economy. This includes:   * GP practices * Mental Health Services * Community Services * Acute services * NHS 111 * GP Out of Hours services * Social care * Dental * Pharmacy * Voluntary Services   **3.2.22 Quality Standards and Clinical Governance**  A basic requirement for all aspects of service delivery within the UTC 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 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 service 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 qualify of service are raised. More specifically the Provider will:   * Deliver the services in accordance with exemplary clinical practice guidance, exemplary healthcare policies, procedures and legislation as set out in the Standards NHS Contract * Develop and implement mechanisms for managing risk, including disaster recovery, contingency and business continuity plans. * Ensure all incidents (both clinical and non-clinical) will be reported by staff (using Datix Risk Management System) and managed appropriately. * 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 resource   The Provider will keep the Commissioner informed about details 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   **3.2.23 Safeguarding**  The Provider will implement all relevant safeguarding policies including those adopted by the Sandwell & Birmingham Adult and Children Safeguarding Boards. Appropriate disclosure and barring (DBS) checks for all staff will be required and audited.  **3.2.24 Audit**  The data from systematic, robust audits will be a key component of changing the culture of urgent and primary care delivery in SWB. 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 and patient outcomes. The data from these audits will be used to provide recommendations for improvement of the service delivery model and other primary care and acute services.  **3.2.25 Pathways included**  The Services shall include but not be limited to:   * treating injuries and illnesses, including:   + - coughs, colds and flu-like symptoms;     - hay fever, bites and stings;     - skin complaints including rashes, sunburn and head lice;     - stomach ache, indigestion, constipation, vomiting and diarrhoea;     - minor cuts and wounds - care, dressings, suture and stitch removal;     - muscle and joint injuries - strains and sprains;   + provision of information on staying healthy;   + men's health;   + women's health e.g. thrush, menstrual advice, urinary tract infections;   + information on local NHS services, social services and other local     - * + statutory and voluntary services   + contraceptive advice and emergency contraception;   + chlamydia screening;   + investigations including swabs, pregnancy tests and urine dipstick and culture. Near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes should be available. Electrocardiograms (ECG) should be available.   + services seen as minor presentations to A&E;   + nurse-led prescribing in line with joint formulary and other local prescribing policies, including administration or prescribing of medicines using 'Patient Group Directives' or extended formulary for nurses;   + urgent initial treatment relating to:     - Benzylpenicillin for suspected meningococcal disease;     - Salbutamol Nebulizer for Acute asthma; and     - Heimlich Manoeuvre for airway obstruction;     - Unexplained loss of consciousness     - Circulatory collapse     - Respiratory obstruction     - Acute haemorrhage     - Suspected meningococcal meningitis   + a full minor injuries service be available   + medicine stock and dispensing in line with service requirements; and   + travel heath advice.   The presence of senior clinicians will also enable additional cases outside of these pathways to be assessed and treated as appropriate  **3.3 Population covered**  This is a walk-in service and therefore accessible to all including non-Sandwell and West Birmingham residents.  **3.4 Any acceptance and exclusion criteria and thresholds**  Urgent Care is an alternative to accident and emergency (A&E) for a range of minor injuries and urgent medical problems. It is a walk-in service for patients whose condition is urgent enough that they cannot wait for the next GP appointment (usually within 48 hours) but who do not need emergency treatment at A&E. The service is not designed to see walk-in primary care patients who could be seen at an in hours GP practice or by the out of hours primary care service. The service will apply discretion as to whether those who walk-in with a primary care need will be seen, taking into consideration the specific situation, the needs of the patient and the impact on the wider system of turning a patient away. The service’s aim is to improve patient outcomes and reduce attendances at local acute hospital. Therefore, this should always be borne in mind when deciding whether to see a patient presenting with a primary care need. The following are excluded:   * Emergency Care for the ‘5 plus 1 conditions’ (Cardiac chest pain, acute shortness of breath, possible strokes, head injury with loss of consciousness, severe abdominal pain and all severely ill children) * Major Trauma * Specialist referrals e.g. Obstetrics, Gynaecology, Renal, Oncology * The service will not provide repeat prescriptions. · * The service will not provide care for patients who request Private Healthcare   At times of pressure, the Provider will be expected support the urgent care system by providing a service to those patients conveyed by ambulance who have been categorised as a “category Green” conveyance. ·  **3.5 Communication**  **3.5.1 Internal stakeholders**  The Provider will ensure that all internal stakeholders are aware of the services provided and the agreed pathways to other services.  **3.5.2 Commissioner internal stakeholders & external stakeholders**  The Provider and CCG will work closely together to ensure excellent continued communication throughout the duration of the contract.  **3.5.3 Patient and public engagement**  Throughout the care episode, 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). Patients will be advised during their treatment on the best source of ongoing care most appropriate to their need or self-care options.  **3.6 Patient Feedback and Experience**  Feedback from patients and their carers is essential to developing a quality service. Family and friends test survey will be carried out on an on-going basis and analysis reported back to commissioner at least 3 times per year and through the quality reporting routine reporting process.  The Provider will log all comments, complaints and compliments received by the service to be used when reviewing standards as part of clinical audit, used to inform service improvements and when reviewing commissioning arrangements.  All untoward incidents will be logged by the Service Provider and should be reported to the commissioner as soon as possible and in any event within three working days. This does not negate responsibility to input onto datix.  The Service Provider should put in place and maintain throughout the episode of care, an effective representation and Complaints Procedure and have systems in place, which monitor any incidents and the outcome of all complaints and investigations regarding the service.  Complaints will be reported to the commissioner three times per year in addition to local quality reporting requirements.  **3.7 Finance**  The agreed contract value per annum (pro rata where applicable).  **3.8 Contract**  **3.8.1 Main contract**  There will be an NHS Standard Contract between the CCG (Commissioner) and the Provider  **3.8.2 Contract duration**  The Contract duration is as detailed in the NHS Standard Contract  **3.9 Performance**  Reports to be provided on the following Local Information and Quality Requirements   | Local Quality Requirement | Threshold | Method of Measurement | Consequence of breach | Timing of application of consequence | Service Spec No | | --- | --- | --- | --- | --- | --- | | Monthly activity | 3200 | Activity Reports | Nil | Nil | Nil | | Number of Unregistered patients accessing service | N/A | Activity Reports | Nil | Nil | Nil | | Number patients walking out before being seen | >5% | Activity Reports | Nil | Nil | Nil | | Number of patients who “walk-in” that are clinically assessed within 15 minutes of arrival | >95% | Activity Reports | Nil | Nil | Nil | | Number of ‘walk in’ patients who following clinical assessment, patients need a face to face appointment will be seen within two hours of the time of arrival | 95% | Activity Reports | Nil | Nil | Nil | | Number of patients who have a pre-booked appointment made by NHS 111 that are seen and treated within 30 minutes of their appointment time | 95% | Activity Reports | Nil | Nil | Nil | | Average Waiting Time | < 4 hours | Activity reports | Nil | Nil | Nil | | Number and % prebookable appointments utilised | N/A | Activity Reports | Nil | Nil | Nil | | Top 10 Presenting Conditions | N/A | Quarterly Service Reports | Nil | Nil | Nil | | Referral routes | N/A | Quarterly Service Reports | Nil | Nil | Nil | | Complaints | N/A | Quarterly Service Reports | Nil | Nil | Nil | | Compliments | N/A | Quarterly Service Reports | Nil | Nil | Nil | | Incidents | N/A | Quarterly Service Reports | Nil | Nil | Nil | | Patient Satisfaction | >95% | FFT/ patient satisfaction survey | Nil | Nil | Nil |   **3.9.1 Performance Management**  The Provider and the Commissioner will meet on a quarterly basis under the same terms of reference as Contract Review Meetings.  **3.9.2 Activity reporting**  The Provider is required to report activity in line with national NHSE/I reporting requirements. The Provider and Commissioner will work together to agree any additional local activity reporting requirements.  **3.10 Policy and 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 ambulatory care.  Policies and procedures should be up to date and include but not be limited to the following:   * Business Continuity and Emergency Planning * Operational Policy * Health & Safety * Critically ill patient conveyance * Safeguarding policy * Trust related policies * Medicine Management policy in place covering at least   + Links to national and local formularies   + Arrangements for monitoring individual clinicians prescribing   + Patient group directives to support the treatment of common presenting conditions   + Arrangements for access to pharmacist advice   + Medicines reconciliation   + Record keeping   + Disposal and movement of drugs   + Access to palliative care drugs   + A complete, document audit trail for controlled drugs, including those administered in the patient’s home and drugs returned for destruction. * Guidelines for the care of vulnerable children, young people and adults should be in use in particular   + Identification of vulnerable people   + Individualised care plans for people identified as being particularly vulnerable   + Restraint and sedation   + Missing patients   + Consent, mental capacity act and the deprivation of liberty safeguards   + Safeguarding   + Information sharing   + Palliative care   + End of life care   **3.11 Innovation**  The Commissioner is committed and has desire to adopt innovation positively. We are keen to advocate for the greater adoption of technology and new approaches to the provision of urgent and emergency care. Locally we have a proven track record of innovation and the Provider must commit to work with the Commissioner to embrace future best practice and guidance and use of digital solutions to ensure that the service is continuously future fit. |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (e.g. NICE)**     * The national Emergency Department 4 hour standard will apply * Department of Health A&E Clinical Indicators. * Applicable Legal Duty – Equality Act 2010 and Reasonable Accessible Information Standard (DCB1605 Accessible Information) * In line with the Equality Act 2010 the service will make reasonable adjustments to ensure that services are accessible to disabled people along with everyone else. The service will also adhere to The Accessible Information Standard (DCB1605 Accessible Information) to ensure the service meets the communication needs of patients, carers and those with a disability.     The following are from the national specification:     * Following clinical assessment, patients will be given an appointment slot, which will not be more than two hours after the time of arrival. * All urgent treatment centres should collect contemporaneous quantitative and qualitative data, including patient experience. * From October 2018 all urgent treatment centres must return the data items specified in the Emergency Care Data Set (ECDS). Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.   **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**   * Resuscitation Council (UK) ‘Quality Standards for cardiopulmonary resuscitation practice and training’. |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-D)** |
| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:**  Summerfield Urgent Treatment Centre |
| **7. Individual Service User Placement** |
| N/A |