Service Specification for Urgent Primary Care Services at the Walk-in Centres at Edgware Community and Finchley Memorial Hospitals

Appended to the service level agreement / community services contract agreed between Barnet PCT and Barnet Community Services

For the years 2009-10 and 2010-11

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1. Introduction

1.1 This service specification is written as an appendix to the service level agreement agreed between Barnet PCT as the commissioner and Barnet Community Services (BCS) as the provider.

1.2 The service described in this specification is that provided at the current walk-in centres (WICs) at Edgware Community Hospital (ECH) and Finchley Memorial Hospital (FMH). These are urgent primary care services available as unscheduled care, without a booked appointment, to all patients who walk into the WICs.

1.3 The WICs will remain named as WICs and be provided as agreed in this service specification by BCS for two years and / or until such time as ECH services are redesigned and FMH is redeveloped. The plan then is for urgent primary care services to continue to be provided from both ECH and FMH but for their commissioning and delivery to be more streamlined with routine primary care services (scheduled care by booked appointment). The service specification will be rewritten in line with the primary care strategy for primary care centres and the PCT will agree a new commissioning process.

2. Negotiation Process

2.1 A service specification for urgent primary care services both at the WICs and during the out of hours (OOH) period was agreed by the PCT and negotiated with current providers, BCS and BarnDoc respectively, between March and September 2008.

2.2 The urgent care service specification sits underneath the primary care strategy and was designed in the urgent care plan. The PCT decided not to tender the services as current provision by local providers is both cost efficient and of good quality. Furthermore the services are fully integrated and the providers have a functioning partnership. As described above, services will necessarily be redesigned and re-commissioned as part of the implementation of the primary care strategy in about two years time.

3. Service Principles

3.1 In line with general NHS and local PCT principles, and specific guidance from the Department of Health (DH), the following principles underpin the provision of all urgent care services:

- Patient access should be as simple and straightforward as possible with equity of access for all.

- Patients should be able to access the clinically most appropriate professional, in the most appropriate place, in a timely fashion.
- Professionals and other personnel involved in the delivery of urgent care services should work together to deliver the best possible service to patients, to make the most effective use of resources and to share the clinical and financial risk at the 'boundaries' of their work.
- Information gathering should take place only once and a timely and efficient flow of information should ensure continuity of care for the patient.
- Services should meet all clinical governance criteria and national quality and performance requirements with regular monitoring informing improvements to the service.
- Services should be patient focused with mechanisms for patient involvement and choice.
- Services should be flexible and scalable to all changes in demand and, at all times, ensure clinical effectiveness and best value for money.
- Professionals and other personnel involved in the delivery of urgent care should have good local knowledge and be aware of local issues and need.
- Services should be provided on a needs basis.

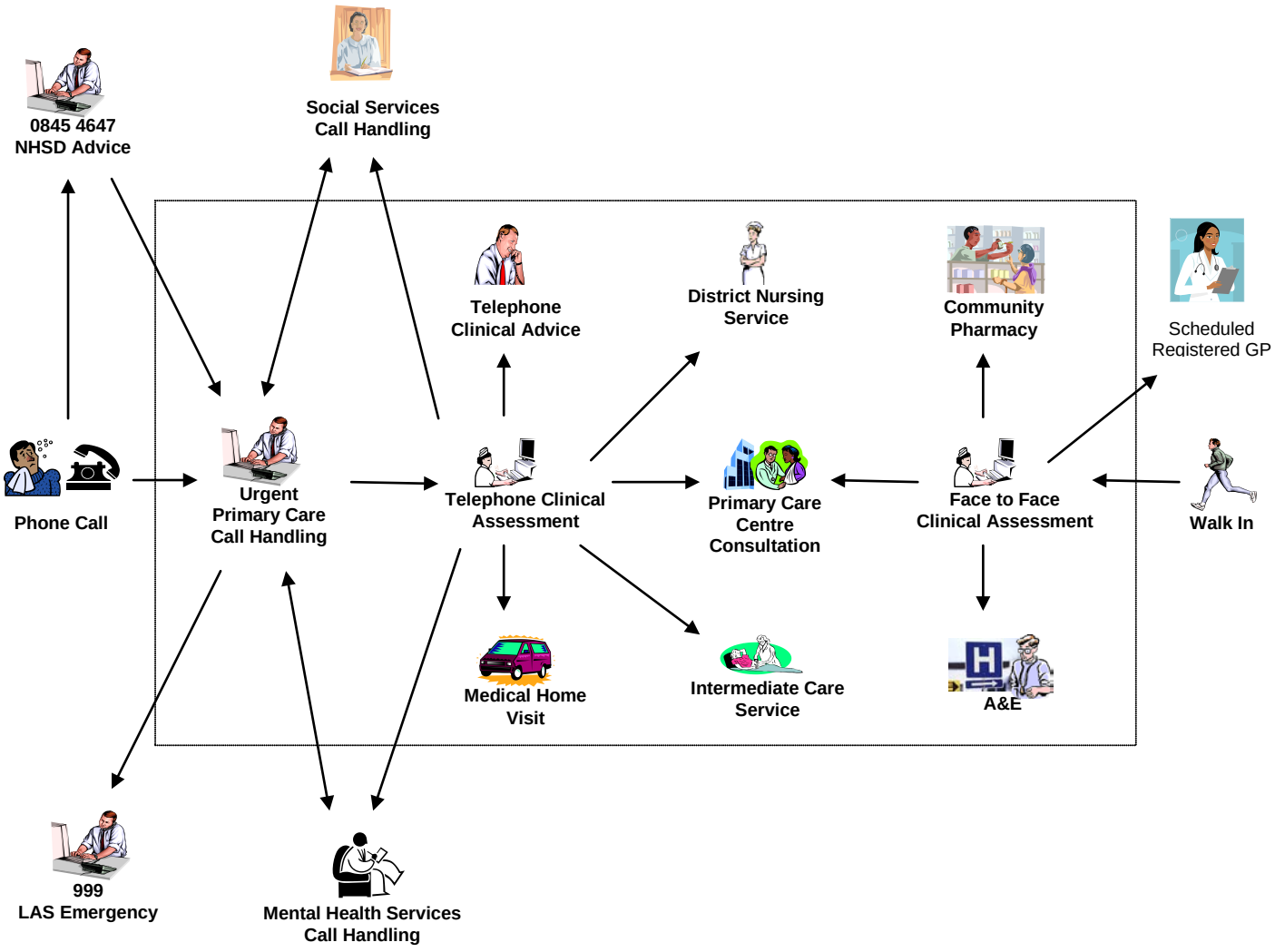
4. Service Model

4.1 Premise

The model for urgent primary care services is based on the following premises:

- single telephone number access to services for patients and clinicians
- appropriate referral between services irrespective of telephone number called
- patient demographic information collected only once
- initial clinical assessment of patient carried out only once
- patient information flow between services on referral
- flagging of case managed patient needs eg palliative care, long term conditions, within urgent care service systems
- feedback to patient case manager eg GP, health visitor, community matron, from urgent care services
- information to patients regarding different urgent care services and more appropriate scheduled care services

4.2 Model



4.2.1 The model for urgent primary care recognises that there are two ways people access services, either via a telephone call or by walking in to a centre. Either way they need to receive timely and consistent clinical assessment in order to consider the urgency of their need and the most clinically appropriate service to provide advice or treatment.

4.2.2 Currently, people are able to walk in to services provided at Barnet hospital A&E and at Finchley and Edgware WICs. The model moves these services on in two ways, one recognising that many of those that use A&E do not require emergency treatment and could be seen elsewhere and / or by primary care clinicians. The other, bringing WICs into the new urgent care arena and positioning them as urgent care centres more appropriate for some of the urgent, but not emergency, cases currently using A&E. This in turn puts emphasis on GP practices to have capacity and competency to see, treat and maintain many of their own patients in their own surgeries. This is especially important in the light of long term conditions, continuity of care and the current lack of availability of complete patient records outside the GP practice. Likewise, pharmacies take their place in the model with minor ailment schemes enabling patients to seek non-complex urgent advice and treatment without first requiring a GP appointment and prescription.

5. Service Specification

Urgent Care Centres

5.1 In the current unscheduled care environment, a shift in the role of the WICs is required. With increasing attendance across the emergency and urgent care system, A&Es need to re-focus on the emergency cases for which they have the resources and expertise, and WICs need to deliver along the lines of urgent care centres. The WICs are currently set up to deal appropriately with urgent primary care in terms of expertise, diverse staffing, access, opening hours, waiting room space, integration, diagnostics, pharmacy and so on.

5.2 Although WICs are not currently linked to GP practices or streamlined with routine care, proximity already plays a large part in their attending caseload. Relationships can be further developed with local GP practices and pharmacies.

5.3 The WICs provide a co-located and integrated service with the OOH services provided by BarnDoc. Patients who telephone the OOH service and are assessed as needing a face to face consultation are given an appointment at one of the WICs. Patients walking into the WICs or coming in for an OOH appointment are received by the same reception and use the same waiting area. An integrated team of BCS and BarnDoc employed staff treat both sets of patients by competence and within clinical priority and waiting time targets or at appointed times. LAS emergency care practitioners also work within the WICs to enhance both their skills and complement the skill mix of the team.

Urgent Primary Care Services

5.4 The WICs provide primary care assessment, advice and treatment to all patients who present at the centres. Patients walk in without appointment. Services are provided by GP trained doctors, health care assistants, nurses and nurse practitioners trained in minor illnesses and minor injuries.

5.5 Patients are assessed within either 20 minutes or 60 minutes of arrival at the centre depending on categorised urgency of clinical need. This is in line with national quality requirements for OOH services and ensures standardisation of clinical assessment timings for both telephone access and walk in access to urgent primary care services.

5.6 Patients are treated within 1, 2 or 3 hours of assessment depending on categorised urgency of clinical need. Again this is in line with requirements for OOH services. Those treated within 3 hours of assessment must be treated within 4 hours of arrival at the centre to comply with the national 4 hour waiting time target for A&Es and WICs.

5.7 Patients assessed as having a life-threatening condition are transferred to the London Ambulance Service (LAS) via a 999 call within 3 minutes of arrival at the centre or deterioration in condition. Other patients may be transferred to the LAS within 1 hour for transportation to A&E. This is via a local ambulance station number.

Patient Information

5.8 Patient information, both demographic and for initial clinical assessment, is collected only once per visit and uploaded on to the WICs' Adastra software system. Information can be viewed by all clinicians. Past patient history information is also linked and available to be viewed by all clinicians. Warning flags are in place for frequent attenders, particularly those who have attended with the same condition within the past 4 days.

5.9 Information regarding patient consultations is automatically transferred to the patient's GP before 8am the following morning.

5.10 For patients with special needs, or who are case-managed elsewhere in the healthcare system, Adastra is uploaded and continually updated with flags and care plan details to assist with clinical assessment and treatment. This includes child protection cases, those with long term conditions managed by the community matrons, those known to the acute mental health services and others with special needs or conditions identified by their GP or health visitor. Contacts with any such patients are fed back to the appropriate service the next morning. Automatic transfer of notes is preferred, but secure faxes are the next best option. If systems and procedures are sufficiently shared with BarnDoc, only one provider needs to update these flags and notes, although both have to feedback on their consultations.

5.11 Contact with children under 18 is recorded by children's centre or school and reported back to the children's services liaison officer on a monthly basis. Any child protection or 'trigger' issues are reported immediately through the child protection procedures to the lead or social services, or to the children's services liaison officer respectively. 'Trigger' issues are those agreed as needing individual and immediate follow up by the children's services liaison officer but that do not fall into the child protection category.

Patient Referrals

5.12 Referral of patients back to their GP, on to A&E or into any other service is recorded as a referral / external outcome. The WICs should bear in mind that the GP is the best place of care for those with chronic or long term conditions and inform the patient and GP accordingly. Likewise, the WICs can refer into other BCS provided community care services but must adhere to best practice in terms of patient choice and the GP being the gatekeeper of other NHS services.

5.13 In-hours, unregistered patients with a Barnet postcode are processed by a front of WIC health care assistant who fills in application forms, registers patients with local GPs and carries out pre-registration health checks. Outside these hours, the PCT should be kept aware of such contacts and information passed to PALS or patient services for follow up.

5.14 The WIC system should note patients who have been advised to continue care with their GP or who have been registered by the WIC with a GP and such patients should not be given inappropriate care at the WICs a second time but referred directly to their GP instead.

5.15 The PCT is in the process of designing a minor ailments scheme whereby pharmacies will be enabled to see, diagnose, treat and medicate a list of minor ailments with an agreed list of drugs. These will be available as through a GP

prescription either free of charge, on a prescription charge or with an over the counter payment. The WICs are expected to participate in the design and use of the minor ailments scheme as appropriate.

5.16 The WICs can receive referrals from the LAS of patients assessed by ambulance crews as requiring WIC as opposed to A&E services. Patients are conveyed to the WICs by ambulance or car.

Diagnostics

5.17 Sufficient and appropriate diagnostic capability is available at each WIC site from 9am to 10pm. This includes equipment, skilled staffing, result feedback and quality checking procedures.

5.18 It is the responsibility of BCS to sub-commission the provision of diagnostic capacity and capability from a suitably qualified provider. In the first instance the current service from Barnet and Chase Farm Hospitals (BCF) diagnostics department can be extended, although re-commissioning the full service from any provider is an option within the timescale of this service specification and beyond.

5.19 It is expected that working relationships with local GP practices regarding access to diagnostics and results for their patients will continue and improve. Patients should not be assessed by more than one healthcare professional nor travel or wait unnecessarily for access to diagnostics, results or treatment.

Pharmacy

5.20 The following services and procedures are in place:

- there is a comprehensive pharmacy policy covering the agreed drug formulary, dispensing, patient group directions (PGDs), FP10 prescribing, palliative care patients, stocking and re-stocking, handovers, repeat prescriptions, clinician prescribing reviews, monitoring and so on
- drugs are dispensed to patients treated at the WICs from the WIC drug cupboard with payment, where eligible, through the WIC machines
- FP10 prescribing is kept to a minimum and regularly monitored
- where possible, patients are given medication at the time and place of consultation, where not, the inconvenience to the patient is minimised in terms of amount, time and travel

5.21 It is the responsibility of BCS to sub-commission the provision of sufficient and high quality pharmacy services from a suitably qualified provider. This includes both the supply of drugs and also the provision of pharmacy advice. In the first instance the current services from BCF pharmacy department can be enhanced, although re-commissioning the full service from any provider is an option within the timescale of this service specification and beyond.

5.22 BCS and BarnDoc will work together to ensure the smooth and fair usage of, and payment for, the WIC drug cupboards.

6. Service Scope

6.1 This service specification is for the time period 1 April 2009 to 31 March 2011 and is appended to the current service level agreement between Barnet PCT and BCS.

6.2 The population served is any patient who walks into, or who is conveyed by ambulance or car into, either WIC. However, Barnet PCT is only responsible within the service level agreement for payment to BCS for patients who are either registered with a Barnet GP or who are unregistered but have a Barnet postcode. Barnet PCT is currently also responsible for payment to BCS for patients registered or residing outside the London boroughs as well.

6.3 The WICs are open daily at ECH from 7am to 11pm with the last walk in at 10pm and at FMH from 8am to 11pm with the last walk in at 10pm. GPs are available amongst the mix of staff daily from 9am to 11pm, although some are provided during the OOH period by BarnDoc.

6.4 Telephony and IT are the responsibility of BCS but must meet reporting, quality and integration requirements.

6.5 The services are provided from Edgware and Finchley WICs and integrated with the OOH services provided by BarnDoc.

7. Service Activity

7.1 The average monthly activity for WIC services for 2007-8 was:

Service	Total Monthly Attendances
Edgware WIC	4,563
Finchley WIC	3,193

7.2 BCS will monitor both the monthly activity during the service specification time period and the daily and hourly distribution of these attendances. This will inform both staffing capacity and any required changes to service or financial planning.

8. Service Quality

8.1 The WICs must meet the national Healthcare Commission target to see and treat 98% of attendees within 4 hours of registration. This is reported weekly to commissioners and the DH.

8.2 The national OOH quality requirements for face to face assessment and treatment should also be met and monitored. This requires:

- assessing patients immediately for life threatening conditions and referring these appropriately to the LAS within 3 minutes
- clinically assessing patients within 20 minutes or 60 minutes depending on assessed categorised urgency (requirement 10)
- treating patients within 1, 2 or (so as not to breach the Healthcare Commission target) 3 hours depending on clinically assessed categorised urgency (requirement 12)

8.3 The WICs should ensure they follow guidance and best practice on access to medicines including that in the DH's '*Delivering the out-of-hours review: securing proper access to medicines in the out-of-hours period*' from December 2004:

http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4134235

and more recently in July 2007 in '*Delivering urgent access to medicines outside 'normal' hours*' by the medicines management network.

8.4 BCS should meet the full access requirements of the Disability Discrimination Act (DDA) including having in place services to assist with language interpretation and for those who are hard of hearing. The waiting room and treatment areas also need to be child friendly.

8.5 Receptionists and clinicians should listen carefully, speak clearly, assess fully, be reassuring and be clear in their diagnosis. They should be clear with patients and those accompanying them about any further steps, booked appointments or referrals.

9. Service Monitoring

9.1 Barnet PCT commissioner and BCS WIC staff will meet quarterly to monitor the WIC services. Quarterly reports will include:

- monthly activity by PCT
- activity by Barnet GP practice
- activity analyses by week, day, hour, postcode, age, ethnicity or presenting condition as required to highlight any issues
- arrival by LAS referral
- outcome by diagnosis and by onward referral
- achievement of assessment and treatment timing quality requirements
- patient complaints
- patient surveys
- staff audits
- any other service, staffing or integration issues

9.2 BCS will also meet with Barnet PCT as part of the higher level monitoring of the overall SLA, this will not include as much detail and will focus on the overall activity and cost levels of the WIC services.

10. Service Cost

10.1 The WICs will charge each responsible PCT by patient activity. In the case of Barnet PCT this will form part of the budget and payment for the overall SLA.

10.2 The activity tariff will be agreed as part of the overall SLA based on full BCS service reference costs. With a full WIC service in place from April 2009, it is advised that three levels of tariff are agreed as appropriate for the level and complexity of advice or treatment given. These tariffs must firstly be appropriate within the unscheduled care system and fit with those paid at A&E and for the minor ailments scheme, and secondly be adjusted should any London or national guidance come into force regarding WIC or urgent care centre tariffs.

11. Contacts

11.1 This service specification is agreed between the Barnet PCT commissioner:

- Annette Alcock, urgent care commissioning manager, 020 8349 7572

and the BCS WIC manager:

- Brenda Persaud, urgent care general manager, 020 8732 6694

11.2 The SLA is agreed between Barnet PCT and BCS at chief executive / chief operating officer level.