

Urgent Treatment Centres – FAQs to support implementation

NHS England and NHS Improvement



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This document articulates the requirement to deliver Urgent Treatment Centres as published in the [Five Year Forward View](#), [Five Year Forward View - Next Steps](#) and the [Long Term Plan](#). It should be read in conjunction with the published [Urgent Treatment Centres – Principles and Standards](#) and is intended to provide enhanced support to providers and commissioners in meeting the standards.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact england.urgentcarereview@nhs.net

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1. Overview

How will urgent treatment centres (UTCs) link with the rest of the urgent and emergency care system?

UTCs provide an opportunity for commissioning a genuine integrated urgent care service, aligning NHS 111, UTC and routine and urgent GP appointments with face to face urgent care (offering co-located provision where appropriate). They should have shared written clinical governance arrangements with the rest of the local Urgent and Emergency Care (UEC) system and Strategic Transformation Partnerships (STPs) should hold responsibility for this. UTCs should meet previously published standards and ensure that they operate effectively as part of a network Primary care interface.

2. Primary Care Interface

How do UTCs fit into the vision for general practice as set out in the GP Forward View?

The [General Practice Forward View](#) set out a vision to invest in and sustain general practice and transform it to deliver more “at scale” services and with view to redesign out of hospital care, strengthen good practice, that will be part of a wider set of integrated services including out of hours and urgent care services.

The benefits include:

- delivery of a more standardised service
- offer value for money
- make it easier for patients to see the right professional at the right time in the right place.
- Step change towards new care models and vision set out in [GP Contract documentation 2018/19](#), [Next steps on the NHS Five Year Forward View](#), [NHS Operational Planning and Contracting Guidance 2019/20](#) and [NHS Long Term Plan](#) .

Clinical commissioning groups (CCGs) have commissioned additional capacity to ensure everyone across the country has more convenient access to general practice, including appointments in the evenings and at weekends. As a minimum this includes access to pre-bookable and same day appointments from 6.30pm – 8:00 pm –each weekday evening and appointments on Saturdays and Sundays based on locally determined demand. Services are being offered alongside access to other primary care and general practice services such as urgent care.

In addition, this includes:

- Access to appointments at a patient’s own practice, a nearby practice or a local ‘hub’ in an NHS premises such as a health centre; (depending on how the service has been commissioned locally)

- Appointments offered with a GP or other healthcare professional including nurses, pharmacists and physiotherapists, as well as collaborative working with other parts of the local healthcare system (e.g. A&E departments, community nursing teams) to offer patients the right care with the right healthcare professional at the right time and in the right location according to their needs.
- Alternative modes of access including telephone and/or online consultations in addition to face to face appointments with a GP or other healthcare professional.

[Improving access to general practice](#) sets out seven core requirements which commissioners must meet in providing extended access to general practice. These include requirements around timing and capacity, inequalities and advertising. Commissioners should secure a minimum of an additional 30 minutes per 1,000 population per week, rising to 45 minutes per 1,000 population per week.

As a minimum, patients should have access to the same types of appointments at evenings and weekends as they would for appointments during core hours. For example, we would expect that a patient accessing a general practice appointment at a hub on a Sunday morning would have access to the same services as would be available within a general practice on a Tuesday morning. The service offered through the hub should be accessible to the whole population, and not targeted at one demographic e.g. with a specific condition or a particular age group.

In commissioning extended access services, there is an opportunity for CCGs to secure integrated care to meet the needs of patients outside of a hospital setting. This can be achieved by bringing together routine and urgent care services, enabling direct booking from NHS 111 into general practice hubs and urgent care settings, and co-locating [Integrated Urgent Care Clinical Assessment Services](#) (CAS) with other elements of urgent care provision, ensuring interoperable IT systems across all stakeholders.

It is increasingly likely that the public will be able to access same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate. This will result in an increasing overlap between services provided through general practice access hubs and those provided by UTCs.

How can commissioners maximise opportunities to integrate wider primary care with UTCs?

The principles below will support commissioners to commission an integrated urgent care offer, whilst following proper procurement processes. There are many opportunities to integrate wider primary care with urgent care, to rationalise the service offer, reduce duplication and flex the workforce to provide urgent and primary care services which meet the needs of the local population.

1. The main route to UTC services should be through an efficient CAS accessed via **NHS 111 calls**, which increasingly includes 111 online and the NHS App.

2. Co-location of the CAS that supports IUC with a UTC or A&E should be encouraged where practical to do so and where the trade off with patient convenience is justifiable.
3. Build on established services by commissioning UTC specifications (e.g. pre-bookable appointments, extended opening) from existing WiCs (Walk in Centres), Minor Injuries Units (MIUs), Urgent Care Centres (UCCs). This will mean sites are already known to patients for urgent care, multi-disciplinary teams are already recruited, and systems are in place, e.g. governance, IT, Care Quality Commission (CQC) approvals, etc.
4. Create additional services to achieve equitable coverage for patients in the local area depending on the population's health needs, access, travel times, and the best use of staff and estates capacity.
5. Create opportunities for closer working through creation of multi-disciplinary teams working across services, e.g. CAS GPs, pharmacy, dental, community nursing, mental health therapist, open access physiotherapy, etc.
6. Where appropriate, use opportunities to make better use of the current workforce and estates for example:
 - There could be opportunities, where appropriately commissioned, for clinical staff be based at a UTC (or A&E) to work across services where necessary e.g. by supporting co-located NHS 111 CAS and extended access hubs.
 - Greater co-location will offer better service efficiency and reduced duplication of provision. Local commissioners will need to consider patient flows, determine what is desirable and achievable within available finances, and patient convenience
7. Commissioners should note that the core requirement to commission a minimum additional 30 minutes per 1,000 population could be partially fulfilled by providing routine pre-bookable and same day general practice appointments at a UTC site.

What do you mean by co-location with GP and clinical assessment services?

UTCs are community and primary care facilities that provide access to urgent care for a local population. There will often be advantages to co-locating UTCs with other primary and community services such as extended access hubs, out of hospital services such as falls teams or the CAS that provides clinical advice to NHS 111 and 999 ambulance services.

Delivering at scale and better integration between primary care and urgent care is one of seven core requirements set out in the [NHS Operational Planning and Contracting Guidance](#) that CCGs must secure as part of agreeing a contract to deliver services.

What does “GP-led” mean - does this mean only general practices can provide the UTC service?

No, services could be provided by acute trusts, community trusts, third sector providers, private sector or GP practices/super practices/networks / federations – commissioners will need to consider a contract for an integrated service that meets local requirements and patient needs. GP led means that GPs should have a clinical leadership role within the UTC . This clearly positions UTCs as a primary and community service and brings consistency throughout the country. This will be supported by a multi-disciplinary workforce.

Does GP-led mean a GP will need to be on site at all times?

No, we understand that it will not always be desirable or practical to have a GP on site at all times. Commissioners will want to consider local demand, be realistic about local supply of workforce, and ensure there is sufficient capacity to meet patient requirements, including bookable appointments with GPs and other clinicians.

Co-location of UTCs with other services, whether that be the CAS that supports IUC (including face to face service) and ambulance services, GP home visiting service or extended access hubs will increase the availability of having a GP on-site and that they are fully utilised. Where commissioners secure an integrated model - including access hubs and UTCs - face to face appointments with a GP should also be available across the area the service is contracted to cover. This could be provided in one or more access hubs or in part through the UTC. Extended access to general practice services must offer, as a minimum, a face to face appointment with a GP. Where demand in the UTC is proven to be low and co-location with other services is not feasible alternative methods such as video consultation may be considered.

What are the expectations of the clinical leadership role played by the GP in a UTC?

This is twofold.

1. To provide clinical oversight in terms of decision making around patient care throughout the full opening hours of the UTC, firmly positioning the UTC as primary and community service This may be provided onsite or offsite such as through the CAS supporting a range of services with appropriate access protocols in place.
2. All UTCs should have a named GP as a core member of the senior team taking responsibility for general oversight, governance, audit, training and the strategic development of the service to ensure that the primary care ethos and culture of the UTC is created and maintained. It is entirely acceptable for a single GP to be involved in the leadership of more than one UTC.

Does GP-led mean that services co-located with emergency departments can't have leadership from an ED consultant?

The emphasis should be that the UTC is a primary and community service rather than an extension of ED. It is entirely sensible for co-located services to have clinical input from an ED consultant or shared leadership between the GP and ED consultant. This reflects the opportunity to work effectively between acute and primary care over one site and will offer opportunities for streaming services at the front door of ED. We recognise this is likely to be the model in place already, particularly where front door clinical streaming has been introduced. It is still important that joint clinical governance arrangements are put in place that demonstrate shared clinical leadership from both ED and general practice, reflecting the opportunity to work effectively between acute and primary care over one site. The GP element of oversight, governance, audit, training and strategy outlined above should be maintained.

N.B a model of the clinical workforce in use within a GP-led UTC is provided as an [annex](#) to this document.

3. Service Logistics / Offer

What specific services should be on offer?

The [Standards](#) set out a minimum expectation of service offer; the exact range of services on offer and opening hours will be dependent upon local need. Commissioners will need to consider the local health needs assessment, the availability of alternative services and any geographical restrictions in determining the exact specification. An urban facility may have call for a dedicated mental health crisis team on site, or a drug and alcohol liaison service; whereas a rural service may find it beneficial to be co-located with a district nursing service. There is no one-size fits all solution and commissioners will need to tailor provision accordingly, acknowledging some services may be available to patients at other sites such as extended access hubs offering additional GP appointments.

To address variation, regions may wish to set additional requirements (e.g. the [London Quality Standards](#)) to ensure a consistent approach across a geographic area.

What communications support is available?

UTCs should be described to patients and the public in a nationally consistent way to avoid any public confusion about the services available and how they should access them. Good communications strategies help patient understand their options and which they should be using first. Communications should be organised locally. In summary communications should:

- Encourage the public to use the NHS 111 service when they have an urgent unexpected health care need.
- NHS 111 - directs patients to the most appropriate service, which may be an urgent appointment or same day appointment at a GP access hub or at a UTC.
- Ensure extended access services are widely advertised in A&E and other community sites.
- In areas where UTCs are being rolled out, local systems, supported by NHS England regions, should promote UTCs as an increasingly common alternative to A&E and providing a high standard offer that simplifies the system for patients.

Regions should ensure that CCGs are communicating to key system participants (GPs, A&E doctors, primary care nurses, NHS 111 providers and ambulance trusts) of the role of the UTC in their patch so every part of the system is joined up. An updated communications guide has been developed and disseminated to regions, this provides messaging about UTCs to local systems. The national comms team are in the process of developing UTC comms materials (videos, infographics and leaflets) and these will be made available when ready.

Where do mental health services fit in?

Mental health should be considered a fundamental part of urgent care services, and pathways should be in place to support those in crisis. Depending on local needs assessment, this may mean liaison mental health services or access to community-based crisis services, as well as signposting to other services such as places of safety, safe havens and sanctuaries, etc. To support appropriate referral from NHS 111, all mental health services should be part of an updated Directory of Service (DoS).

Where does social care fit?

Local systems should ensure there are pathways developed to social care, working in partnership with emerging [Primary Care Networks](#) (PCNs) as appropriate

What IT systems will need to be in place?

UTCs will be expected to have a clinical workflow system with some specific ability including but not limited to:

- The ability to send and receive patient transfers and referrals.
- The ability to share appointment availability and receive direct appointment bookings from other Integrated Urgent Care services.
- The ability to access key patient information, such as the Summary Care Record (SCR), other local care records, care / crisis plans, and key patient flags.
- The ability to offer electronic prescriptions via the NHS Electronic Prescription Service (EPS).

- The ability to submit the [Emergency Care Data Set \(ECDS\)](#) on a daily basis, in line with the applicable [information standard](#).

Clinical workflow systems are expected to make use of nationally-defined interoperability standards where they are available, and to use other locally-available solutions where not. Plans should be in place to adopt national standards once established in the future.

NHS Digital regional delivery teams will support with the planning and roll out of technical solutions where needed.

It should also be noted that the data feed to CDS 010 for Type 3 &4 services will be switched off in December 2019. All current type 3 & 4 services are required to submit emergency care data, including those that will change function in the future. Data should be submitted in Emergency Care Data Set (ECDS) format if possible (or via CDS 010 ([using the Message Exchange for Social Care and Health \(MESH\) mechanism](#)) where this is not possible). Sites that are already UTCs, or are planning to become UTCs, should move to reporting through ECDS as soon as possible. Existing Type 3 and 4 services that do not plan to become a UTC will not be expected to submit ECDS once they change function. They will no longer be considered a national urgent or emergency care service and will be required to submit data through the reporting route that is appropriate to the type of service to which they have transitioned (typically primary or community care). See [NHS Digital webpages](#) for further information.

What options exist to issue a prescription for a patient at a UTC?

UTCs are required to have the capability to prescribe medication throughout the duration of their opening hours. If the prescriber is present at the UTC either paper or EPS prescriptions may be generated. Where a remote consultation takes place (e.g. through a prescriber in the CAS) the prescriber must have access to EPS.

Should UTCs include access to community pharmacy?

It may make sense to have a co-located pharmacy; this would be a commissioner decision based on local need. UTCs should be able to signpost to local pharmacies where there is no facility on site.

There may be benefit in having a pharmacist as part of the multi-disciplinary team. Commissioners may want to consider holding simple medication on site such as analgesics, antibiotics, antivirals, steroids, inhalers, etc.

Sites with electronic prescribing should ensure that they use their own unique cost centre code (not a PGD) when prescribing and that medications are not taken from any internal stock held, even if it is a short supply to support a patient over a few days. This is necessary for cost centre activity to be accurately recorded.

If X-ray facilities are not available on site, what does having clear access protocols in place look like?

X-ray provision should ideally be available at the UTC. Where this is limited or not available, a referral pathway should be identified. This should include arrangements for patients to undergo X-ray in a timely manner and without clinical handover to a new team (unless otherwise clinically indicated).

Where X-rays are not offered on site or are not available on-site at all times, access protocols may include:

- An agreed arrangement for where the X-ray service is provided and at what times.
- The DoS profile for this service must clearly specify the X-ray provision and ensure patients requiring X-ray are signposted appropriately.
- Access via co-located service – e.g. elsewhere on a hospital site.
- Mobile unit offering set hours (recorded in Directory of Services).
- Direct referral to X-ray on an alternative site (not via A&E) – e.g. on an appointment basis. The patient may then conclude treatment at referring site if necessary.

Clear protocols must be in place to manage clinical risk for booking the patient in for the X-ray or if the patient is referred off site. This includes clinical accountability for the patient between the UTC, radiography and who explains the result to the patient; along with follow up should the patient need further investigation. This should also include the electronic transfer/access to clinical records.

Where a patient is referred off site, they should not have to 'start again' in a new setting; they should be given a booked slot or direct referral to the appropriate facility and not have to go through further triage at A&E.

Where available on-site, UTC clinicians should be competent to appropriately request and interpret X-rays. Arrangements should also be in place for routine reporting by a radiologist in line with best practice guidelines. Where appropriate, interpretation of X-ray and other diagnostics may take place off-site with feedback to clinicians within the UTC.

To support localities in implementation, a DoS profile for local adaption has been developed to support appropriate referral, [see section 4](#).

What will happen to patients requiring urgent care outside of the UTC opening hours?

Patients phoning NHS 111 will be given appropriate advice depending on the nature of the complaint and availability of alternative services. This may mean attendance at A&E, booking an appointment with their GP the next day, booking an appointment at the UTC, booking an appointment at an extended access hub, offering self-care advice, etc. Clear signage should be offered to patients who walk up outside of closing hours advising them to phone NHS 111 (or 999 in an emergency).

What options are there for services that may have exceptional reasons for not maintaining the minimum service offer?

Designation as a UTC for services not offering the full specification should be considered exceptional. NHS England and NHS Improvement regional teams will review any requests from localities for such exceptions. To ensure patients have a clear understanding of the service offer expected at an UTC anywhere in the country, these exceptions will not be commonly granted.

There may be opportunities for a limited offer to form part of an alternative community service, or to provide an enhanced offer within, e.g. an extended access hub. All services should be clearly identified within an updated and maintained DoS to enable effective referral from NHS 111 and 999 services.

Is it acceptable for services that do not meet the full UTC standards to operate as a 'spoke' service in hub and spoke model?

Services are expected to meet all the UTC standards; however some localities may wish to explore innovative ways of achieving the standards as part of a networked model of care. This could include shared GP leadership across one or more sites or consultation via video link to clinicians in the CAS. Proposals should stand up to the following checks to ensure the UTC vision is not compromised and demonstrate:

1. How clinical care is improved;
2. How confusion is reduced;
3. How service offer is improved;
4. How patient flow is improved;
5. How the service offer ensures there is consistency of service provision in line with expected standards; and
6. Consistent and fail-safe access protocols are in place where required – e.g. referral and reporting process for X-ray if this is not on site.

Regions should consider proposals on a site by site basis and proposals must be approved through regional governance structures including approval from regional clinical advisor for UEC or clinical senate. If accepted there should be clear sign posting on the DoS to the service offer and ongoing evaluation of patient flow and periodic review to ensure the service continues to pass the checks above.

Do UTCs need to comply with the duty to refer rules (October 2018)?

Yes, all UTCs need to comply with the duty rules. The [Homelessness Reduction Act 2017](#) introduced a duty on certain public authorities to refer service users who they think may be homeless or threatened with homelessness to a housing authority. The service user must give consent and can choose which authority to be referred to. More information is available [here](#).

Do we need to provide a dedicated waiting room for Paediatrics as part of the UTC standards?

A paediatric waiting area should be considered 'good practice' in terms of providing a supportive environment for children and families, but it is impractical and unrealistic to expect this to be the norm. Localities will want to consider the throughput of patients (and specifically the volume of paediatric patients) at the service. Every service would be expected to consider this in the development of new facilities, or alteration of existing services, but it will not be an expected standard that all UTCs would be expected to demonstrate for designation. Regional teams may wish to ask the question about their decision-making regarding provision of a paediatric waiting area or otherwise – and it is possible the CQC would be interested in this decision-making process. The rationale for this is that UTCs are explicitly not an Emergency Department setting; they are community and primary care settings. Not all health centres etc. would be expected to provide a dedicated paediatric waiting area, but some will take the decision to do so, and commonly an area within the waiting area will be more 'child-friendly'. Further specific estates adaption for paediatric requirements should also be considered in line with need.

4. Patients

How will patients understand what's on offer at different services?

It is the function of the system to guide the patient to the correct level of care and to provide clarity as to which services are provided where, along with the pathways to access these services reliably 24/7. NHS 111 should be that guiding service for most urgent care needs. Wherever a patient enters the system they will have consistent access to all services and will, if necessary, be referred on through a process of direct booking whenever possible.

Locally, commissioners will want to consider communication approaches regarding NHS 111, UTCs and other primary and community facilities, including extended access. Services should be clearly signposted when searched through NHS Choices and on practice or CCG websites.

To support localities, the Quick Guide "*Best use of Urgent Treatment Centres*" has been developed to cover the range of conditions that may present to UTCs. As part of ongoing work, a number of templates have been developed that can be adapted for local use to reflect the service offer available.

Your local/Regional DoS Lead or the NHS England National IUC DoS Operations team (england.dos@nhs.net) will be happy to support any specific queries.

What sort of patients would be suitable for referral to a UTC?

Examples of the types of patients suitable for a UTC include:

- Strains and sprains
- Suspected broken limbs
- Minor head injuries
- Cuts and grazes

- Bites and stings
- Minor scalds and burns
- Ear and throat infections
- Skin infections and rashes
- Eye problems
- Coughs and colds
- Feverish illness in adults
- Feverish illness in children
- Abdominal pain
- Vomiting and diarrhoea
- Emergency contraception

This is **not** an **exhaustive list** but it shows some of the minor illness and minor injuries which should be treated at a UTC.

5. Appointments

How will patients get an appointment?

Patients should be encouraged to contact the Integrated Urgent Care service via NHS 111 to access urgent treatment services. A range of clinical professionals such as paramedics, nurses with specialist experience, mental health professionals, pharmacists, dental professionals and doctors will be available to speak to callers who require it, and when a patient needs to see a GP, or needs an appointment at a UTC, a mental health crisis service or other service, this should be booked directly for them (where locally commissioned). UTCs are expected to offer directly booked appointments, direct from NHS 111 calls (and in the future NHS 111 online), from the ambulance service or from their GP practice.

Equally, patients should be able to walk in and get to see a clinician. Access time standards for booked appointments and walk-in patients are given and will all contribute to the local waiting times standard.

UTCs should be described to patients and the public in a nationally consistent way to avoid any public confusion about the services available and how they should access them.

Are UTCs expected to only receive booked appointments in the future?

The UTC guidance states the option to walk in will be retained –as the service progresses, access via NHS 111 will become the default option over time, as walk-in attendances diminish local areas may decide to ‘switch off’ the walk in option. To do this a very clear justification to NHS England will be required

Can we confirm that limited appointment slots are not within the national standards and thus are not acceptable?

We would expect that the UTC offers appointment slots throughout opening hours. Limited slots are not acceptable. However, this may be appropriate as part of a staggered introduction. Sites would need to justify why this was required and seek regional agreement as part of a plan to offer full booking.

6. Assessment, Streaming and Referral

Patients who “walk-in” to an UTC should be clinically assessed within 15 minutes of arrival; in some circumstances UTCs may act as the ‘front door’ to A&E, and stream patients to the most appropriate setting. In all cases [clinical guidance](#) on streaming should be followed.

What ongoing referral pathways could you expect to see from UTCs?

Referrals from UTCs will be dependent on the condition of the patient. Patients could be referred to emergency departments, ambulatory or same day emergency care services, specialist services, GPs, primary and community services or discharged with treatment.

There is an expectation that where the capability exists, the patient should be booked an appointment at the appropriate onward service. Commissioners should work with local services to set up effective and efficient onwards referral pathways.

If patients attend with a minor illness in-hours, is it acceptable to refer them to a different primary care setting?

UTCs are expected to treat both minor injuries and illness, however local demand and other service provision may result in limited requirement for minor illness services in hours. In the first instance patients phoning NHS 111 should be referred and given a booked appointment at the most appropriate setting to meet their needs. Following triage, a booked appointment could be offered at an offsite setting; it is essential that an appointment is made rather than asking the patient to contact the service. NHS Digital are working with IT suppliers to develop direct booking capability and national standards that will support direct booking of appointments between services to enable this to happen, for example, from a UTC to a patient’s GP. Commissioners and providers should note that the governance for this decision lies with the triaging service (i.e. the UTC) until they are actually seen in primary care, so in the event that anything goes wrong the UTC has clinical responsibility for the decision made.

If a patient is booked/transferred to a UTC from IUC (NHS 111) and doesn’t turn up, who is responsible for the patient?

When making a referral, the referring (i.e. 111) service should routinely consider the potential impact of non-attendance (given that patients are generally assumed to have capacity, many problems get better on their own, and appropriate worsening advice has been given). If attendance at a service to which a patient has been referred is considered essential then it is the responsibility of the referring service to

either ensure the patient has been seen as arranged, or to make alternative arrangements to ensure the patient receives appropriate onward care.

Responsibility should be considered as follows:

- with the referring (i.e. 111) service for the correct assessment, worsening advice and appropriate onward referral/advice;
- with the patient (or guardian) to follow such recommendation;
- with the receiving service (i.e. UTC/ A&E/ other face to face setting):
 - for timely management of the patient once they have presented to the service;
 - on the receipt of Interoperability Toolkit (ITK) - or other message - as an agreed method of arranging a call back to a patient.

It should be noted that the receipt of any message to advise of the potential presentation of a patient to a non-bookable service, or the booking of an appointment alone, should not be considered as transfer of responsibility for further care.

In all cases the patient's registered GP should be informed, however this does not imply that the GP is responsible for taking action if a patient does not attend a referral that has been made.

UTC requirements expects that capacity and wait times are available to the local health economy, does this mean that sites should be able to give updates to other providers/commissioners or that the data should be available to the public to understand what waiting times are within UTC sites?

Ultimately this is for local discretion, but we would encourage the more former rather than the latter – although for utility this refers to live information that can inform referrals etc, not retrospective performance information. This is not 'urgent' in the sense that it needs to be in place on day one, but something sites should work towards.

7. Workforce

What sort of health practitioners would you expect to see working in a UTC?

Commissioners will want to consider a multi-disciplinary primary care model team according to local need. This may include GPs, nurse practitioners, paramedics, district nurses, paediatric or geriatric specialists, mental health practitioners, social care, physiotherapist, community mental health, etc. All UTCs should provide appropriate supervision for training purposes including both educational and clinical supervision.

Is it sufficient to have staff trained in basic life support or is there a requirement for all members of staff to be trained in Advance life Support?

We recommend that the level of training gained is Advanced Life Support (ALS); basic life support would be considered insufficient. However, individual areas may

opt for immediate life support training in order to fulfil this requirement, based on a local risk assessment.

Immediate life support is a one day course for both adults and children, run by the Resuscitation Council UK. The courses train large volumes of healthcare staff annually and could be considered suitable for smaller units where resuscitation is infrequent. Immediate life support will therefore be more cost effective and suitable in some locations. More information is available [here](#).

8. Coding

The UTC guidance states: “All urgent treatment centre services will be considered a Type 3 A&E and will contribute to the four-hour access and waiting times target locally - is there guidance on when the ‘clock starts ticking’ for four-hour access and waiting times in UTCs?”

Patients who walk in to UTCs contribute to the four-hour target – the clock starts ticking exactly in the same way it does in an A&E setting.

What service should patients be coded against who initially present to A&E and are streamed to a co-located UTC?

If the UTC is co-located with a main A&E and patients come through one main door and are streamed to the most appropriate place (A&E or UTC) the attendances should be coded against the place they are streamed to.

How should we code patients that did not attend a booked appointment but later present as a walk in?

The current ‘[counting guidance](#)’ explicitly rules out booked appointments from being counted against the four hour target. Currently patients who miss appointments should be coded as a walk in.

It is important that UTCs continue to capture as much data as possible in order to ensure that we have the best possible understanding of activity going through the system, this will help local systems describe how they are best supporting patients to access urgent care conveniently in the best setting for their health needs. In addition, the more we can demonstrate booked activity, the more evidence we can provide to inform future discussions on how best to measure performance (see below).

Localities have raised concerns UEC transformation may have a detrimental impact on A&E performance at a provider level (e.g. existing type 3 services becoming extended access hubs and no longer contributing to A&E performance reporting and the explicit exclusion of NHS 111 booked activity from performance reporting). Is anything being done nationally to address this?

We acknowledge in the short term this may be the case, however, it is expected the Clinical Review of Standards will make fundamental changes to the way performance activity is captured and reported longer term.

In the interim, where wider transformation has an apparent impact on performance, evidence of this should be captured, and where a detrimental effect on A&E performance can be demonstrated, this should be acknowledged in local assessments of overall performance.

9. Designation

What is the formal sign-off process to designate a UTC?

Designation of UTCs is intended to be 'light-touch', reliant on regional assurance that localities have met or have agreed plans in place to meet the key standards for UTCs.

A&E Delivery Board Chairs, or a representative as agreed with the NHS England / NHS Improvement regional teams, should provide assurance that the standards have been met. The following should be considered:

- In cases where digital elements are yet to be met, an agreed plan for implementation with NHS Digital should be demonstrated.
- In cases where the UTC nomenclature will not yet be adopted, an indication of when a name change will take place should be provided.
- In cases where co-located services have clinical leadership from an A&E clinician, assurance should be offered that shared clinical leadership with primary care is to be established.

The regional director, or delegated signatory, should countersign the designation document. Confirmation from the region should be given that the service meets the standards of a UTC. National sign off is not required, but a record of all decisions should be shared with the national team.

Exceptional cases

There is recognition that there will be exceptional cases where there is a justification for offering a service that does not meet the standards; this will typically be in more rural or sparsely populated areas. For these sites a separate form should be completed. Regional teams will need to be assured that local areas have fully considered the impact on patients and other services of offering a limited service, and that local services and patient groups have been involved in decision-making.

What are the Care Quality Commission (CQC) registration requirements for UTCs and is there a process to follow?

This should be a locally managed process, we would expect regions to ensure UTCs alert their local CQC teams when they have been designated, even if this is only a change in nomenclature or a change in service opening hours. It is recommended that regions ask localities to ensure the CQC is notified of change of function/ new

service as part of their designation check list and when the regions sign off designation, they should ensure registration is 'ticked'. Detail on the process for registration for new services/ change of function can be found on the CQC website <https://www.cqc.org.uk/guidance-providers/urgent-care-nhs-111-out-hours>.

Is there a process for closedown or change of use for those sites that are not progressing to become a UTC?

In addition to plans for sites to become UTCs, full regional plans should include information about sites that will close down or change use. As well as providing an audit trail, this will ensure there is clarity around plans for services. Commissioners should follow the guidelines in [planning, assuring and delivering service change](#) for sites that are closing/ changing including public consultation as necessary. We are not being prescriptive in the type of alternative use as sites may become - extended access hubs, alternative non-urgent community services (e.g. community mental health) – there will not be a specification for a non-urgent treatment service that isn't a UTC.

To note - it is expected that 100% (all) Type 3 & 4 services should either meet the UTC standards, become another alternative non-urgent primary or community based service or close by December 2019. Any exceptions to achieving this timeframe should be signed off by the Regional Director.

Is it possible to 'un-designate' a UTC and if so what is the process?

Sites previously designated as UTCs may in the future decide to change function. In many cases this is likely to occur when the UTC has been wrapped up in a wider system reconfiguration.

For any service change commissioners follow the guidelines in [planning, assuring and delivering service change](#). Regional teams should be fully assured that local areas have fully considered the impact on patients, that local services and patient groups have been involved in decision-making and that the service change is clearly communicated.

The undesignation process should be approved through the appropriate regional governance processes. The following is recommended:

- An un-designation document is completed along with any supporting information to support decision-making.
- A&E Delivery Board Chairs, or an agreed representative as agreed with the NHS England regional teams, approves the documentation.
- The regional director, or delegated signatory, should countersign the designation document.

Similar to the designation process, national sign off is not required, but a record of all decisions should be shared with the national team.

If we are not being prescriptive in the types of facilities sites that will not become UTCs should become, will this not lead to further confusion?

The UTC programme vision is to ensure people know they can get the same level of care wherever they are in the country when they need to access a UTC and to eliminate the existing confusion with different nomenclature for urgent care walk-in services. Any site that will not become a UTC should not be providing, or giving patients the impression of providing, type 3 urgent walk-in services. Any alternative non-urgent care services offer at sites not becoming a UTC will be entirely dependent on the local population need, not being prescriptive or setting a specification reflects this freedom.

The [Long Term Plan](#) commits to fully implementing the UTC model by autumn 2020, does this mean there has been an extension to the December 2019 deadline?

As stated in the [NHS Operational Planning and Contracting Guidance 2019/20](#) commissioners should continue to redesign urgent care services outside of A&E, aiming to designate the majority of Urgent Treatment Centres (UTCs) by December 2019, with any exceptions to be agreed with the Regional Director. We know that as services meet the standards there will still be more work to do locally to fully implement the UTC model and embed the new services as part of the whole UEC system and Autumn 2020 reflects this. This means building alignment with all other services across a locality, aiming to fully integrate with pathways into acute emergency services as well as primary and community services such as extended access to general practice community pharmacists, ambulance services, mental health and other community-based services.

10.Nomenclature

Are sites expected to change their name as soon as they start operating as a UTC and meet the standards?

Services operating as UTCs are expected to adopt the name 'Urgent Treatment Centre' – this includes both road signage and onsite signage. Sites already operational as UTCs at December 2018 are expected to have implemented the UTC terminology and remaining sites should implement once designated. Any sites that are already operational and have not adopted the name change or wishing to delay beyond the Dec 19 deadline should put forward a strong local case for delaying adoption of the new name and share their justification for doing so with the NHS England UEC regional office along with a clear plan and timeline for when they expect to implement the UTC name. Other terminology such as Urgent Care Centre, Walk in Centre or Minor Injury Unit will not be supported beyond the final December 2019 date. Any exemption to this must be agreed by the Regional Director.

Once the new nomenclature has been adopted at a service, localities should also ensure that names are updated on relevant websites and other communications about the service accordingly.

What road signage should be used for UTCs?

For UTCs based at hospital sites

The Department for Transport (DfT) authorised the first UTC traffic symbol for signs in Wakefield Council's jurisdiction in October 2018, this can be found [here](#). This involved DfT designing appropriate symbols (see below) for UTCs which are based on hospital sites.

The white 'H' on a red background is a well-recognised symbol for directing road users to hospitals with urgent medical facilities. It is designed to assist road users in finding a destination more easily, rather than acting as a means of describing services.

The design of a 'UTC' supplementary plate to sit underneath, or alongside the 'H' symbol, indicates a UTC facility is present at a hospital (recognising that sites will have formerly hosted an A&E department or a minor injury unit). Both the 'UTC' and 'H' symbols are coloured white on a red background and this should not be varied locally.



Both symbols (UTC and UTC not 24 hrs) shown above are intended for use where the UTC is located at a hospital location and must not be separated from the 'H' symbol. The intent of the symbol is to direct drivers to a hospital.

Where a local authority intends to update signs with this new symbol, they should follow the established traffic sign authorisation application process with DfT to receive local consent for use of the new symbols.

In instances where a UTC is co-located on a hospital site with an A&E department, the H / A&E symbols should be adopted on road signage only, as this would be considered to provide drivers with sufficient signage. The primary intention is to signpost drivers to the hospital rather than list services provided at the destination.

For UTCs at non-hospital sites

UTCs that are based at non-hospital sites, must have text based directional signs only. For example, the name of the site would be displayed as 'Acorn Medical Centre'. In the absence of a specific site name the generic 'Urgent Treatment Centre' should be used (an example below). These signs do not require authorisation from the DfT.

Costs

The local authority is responsible for paying for road signs on their roads, however they may pass this cost onto the locality. Arrangements should be agreed locally for changing signage between the CCG and the Local Authority / Trust.

What is the application process for erecting new UTC road signage?

Local authorities are responsible for placing all traffic signs on their roads and are responsible for contacting the DfT for authorisation to agree any **new** traffic sign that is not prescribed by regulations (['The Traffic Signs Regulations and General Directions 2016'](#)).

The local authority will follow their own decision-making processes and are ultimately responsible for approving or rejecting proposals to signpost to a UTC facility. It is advised the locality contacts the local authority early in the designation process to requirements for road signage, application process and cost.

The CCG should advise the local authority on their preferred signage **before** the local authority makes a request to the DfT (although this is not compulsory or required).

NHS England recommends that CCGs request their local authority to apply for a red road signage for a UTC where it is based within a hospital location.

Local areas will need to manage the implementation process. Please ensure localities make their UTC providers aware of the guidance below when applying for UTC road signage:

1. To begin the process, NHS trusts moving from provision of an A&E service to a UTC should inform their respective local authority.
 - 1.1. For UTCs on hospital sites the local authority takes responsibility for informing the DfT who will then provide the necessary authorisation for this to go ahead.
 - 1.2. Local authorities should raise the request directly with the DfT through a formal application process by contacting Authorisation.Requests@dft.gsi.gov.uk with "UTC symbol" in the email title. The authorisation and approval process can take up to 12 weeks.



2. Where needed, interim arrangements can be put in place, for example, a legacy 'H' and 'A&E' sign can be 'plated over' to cover the 'A & E' plate until a longer-term solution is agreed locally.

What guidance is there on branding for UTCs?

If the UTC is run by an NHS trust or foundation trust then under the NHS Identity guidelines, UTCs should be branded with the NHS organisational logo of the NHS trust / foundation trust that runs them like any other service run by the Trust e.g. A&E. Trusts should not create separate logos for all their different services. The only exception would be if a trust was delivering an UTC outside of its usual geography, where using their trust logo would be confusing to patients, in which case they should create a service logo.

Further information can be found below:

Identity Guidelines – [organisational logos](#)

FAQs - [branding services outside our usual geography](#)

If the UTC is run by third party providers (i.e. private companies) the provider should follow the guidelines for third party providers.

More information can be found [here](#):

An example is available [here](#)

Commissioners are encouraged to work with providers as soon as possible to reach agreement on the branding of an UTC in their locality.

What is the naming convention for sites intending to become extended access services (hubs)?

We have not specified a naming convention for extended access sites however in some areas these have been referred to 'GP access hubs'. Commissioners have the flexibility to use a name that best suits their local arrangements and services available and crucially, which can be easily understood by patients and the public in the local area.

What is specified in terms of appropriate signage for sites intending to become extended access services (hubs)?

We have not specified requirements relating to signage. This is down to local determination.

Is there a specification for an extended access services (hubs)?

There is not currently a national specification for extended access services, however any extended access services must meet the seven core requirements set out in the

NHS Operational Contracting and Planning Guidance 2017-19 Overall, patients should expect to receive the same level of service in extended access as is provided to them during core hours by their general practice. As set out in Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan, NHS England will undertake a review of access to general practice services commencing this year (2019), for full implementation by 2021/22 and it is likely this will be considered as part of the review. Further details will be made available shortly.

11. Tariffs

How should activity in an UTC be reimbursed?

UTCs are classified as a type three A&E service ([NHS Data Dictionary](#)). Under the rules of the [national tariff payment system](#) (NTPS) activity for Type 3 A&E services should be reimbursed as part of the agreed blended payment arrangements for emergency care, the detail of which is set out in the [supporting document](#) published alongside the 2019/20 tariff. The NTPS does allow for local departures from these arrangements. For UTCs this means activity in a UTC may be reimbursed on a different basis if there is local agreement. Full guidance on the rules to follow when agreeing local variations and departures from the blended payment approach for emergency care are set out in sections 6 and 7 of the [NTPS document](#).

Annex: Enhanced definitions of National UTC standardsⁱ

National UTC Standard 10: An appropriately trained multidisciplinary clinical workforce will be deployed whenever the urgent treatment centre (UTC) is open. The UTC will be a GP-led service, which is under the clinical leadership of a GP. There will be an option for bookable appointments with a GP or other members of the multi-disciplinary team. Where the centre is co-located with an emergency department there may be justification for joint clinical leadership from an ED consultant.

GP/ Clinical Leadership is relevant across three different aspects of a UTC:

1. Clinical governance:

Each UTC must ensure there is a named senior clinician, either a GP (on the NHS England Medical Performers List) or an ED consultant, who is responsible and accountable for the clinical governance of the service. Where possible, a joint leadership across Primary & Secondary Care should be developed.

Nurse led services should be making a stepped change to deliver this and ensure that a named senior clinical (as described above) is actively involved in the services, including regular supervision of senior staff and oversight of clinical reviews/audits/development of protocols of the service.

2. Access to Appropriate Clinicians:

The skill mix of services will vary, however services should be commissioned to respond to local need and ensure that patients can receive treatment for both minor illness and minor injuries on site, whilst accepting workforce availability and affordability. Where a GP or an ED Consultant is not available at all times, advice and guidance from the senior clinician (GP on performers list or ED Consultant) should be accessible via phone, skype (or on site) during the opening hours of the UTC.

There is an expectation that prescriptions can be issued during UTC operational hours, ideally through prescribers on either site or through an alternative community service with minimum impact on the patient experience.

Where patients require urgent face to face access to clinicians (i.e. GP) but this clinician is not available on site, patients should be directly booked into appointments at an alternative service. This is particularly important where the service model provides limited minor illness provision (as a strategy to ensure activity does not shift out of core primary care) the service should be on site, in hours, or available on a walk in basis. Where this is the case, the location of directly bookable primary care services should be either co-located, in close proximity with easy public transport links or in a location convenient to the patient. Where services are co-located with improved extended access hubs, access to minor illness service for out of area patients, should also be commissioned.

3. Patient Ownership

Within local governance arrangements, particularly where the patient will transfer between services, it is crucial that local protocols specify which service is accountable for the patient at all points throughout the patient pathway i.e. offsite x-ray, telephone advice on patient care. This should be understood in the case of all inter-agency/shared care arrangements.

ⁱ The enhanced definitions of National UTC standards were initially developed by the South Region in 2018.