NHS

IT System Requirements and Direct Booking Frequently Asked Questions (FAQs)

These FAQs have been produced to respond to a range of questions from both IT system suppliers on the requirements for UTC IT systems and from commissioners on the operational expectations for bookable appointments in UTCs.

The document should be read in conjunction with the published Urgent Treatment Centres – Principles and Standards and **updated FAQs** (due for publication in May 2019). It will be addended to the updated UTC FAQs in the next six month refresh.

1. One of the standards states that urgent treatment centres (UTCs) must ensure relevant flags or crisis data are made available for patients, what does this mean?

When patients book an appointment via another service (such as NHS 111), the UTC must ensure relevant patient information, including patient care and/or crisis plans, Summary Care Record (SCR), any local care records, and key patient flags are accessible.

This is usually accessible via the SCR, which can provide access to special patient notes (including any red flags), medicines and contra-indications, and allergies. Increasingly, the SCR can be enhanced with additional information including significant medical history, communications requirements, and end of life care (advance care plans) to better support care. See Quick Guide to Sharing Patient Information for Urgent & Emergency Care.

Key patient flags refer to the electronic flag applied to a patient's electronic record to highlight vitally important clinical, social or safety factors that may need to be considered for individual patients. These fall into four categories:

1. *Clinical Alerts* – which ensure any allergies, sensitivities or significant clinical patient information is immediately noticeable. This should include patients subject to Community Treatment Orders, Mental Health Act detentions, etc.

2. *Administrative Alerts* – which make staff aware of any special requirements or patient circumstances e.g. Impaired Hearing, disabilities, Care Programme Approach status and inform users of any historical alerts. These also ensure that staff are aware of patients whose capacity to give informed consent diminishes as a result of their condition.

3. *Staff and Public Safety Alerts* – which highlight safety/security issues. These generally relate to the risk of aggression or violence, ownership of weapons, sexually inappropriate behaviour, risks from known patient associates, police alerts, registration on the sex offenders register, etc.

4. *Safeguarding* – which highlight potential risks of harm to the patient or an individual linked to the patient. These also include if a child has been placed on a Child Protection Plan; this alert may appear on the child's records as well as the parents (if known to the Trust). All UTCs must be able to access Child Protection Information Sharing (CP-IS) which is recorded on the NHS Spine and presented as a flag indicating the patient is a vulnerable child. Access should either be integrated into the Host System or through logging into a different system.

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2. **Where can UTC clinicians access information regarding a patient's mental health plan?**

UTCs must be able to electronically access mental health information. At the most basic level this is a non-structured mental health note. Optimally the full mental health care plan should be available electronically. This is a plan developed between the person, their carer and the appropriate mental health and social care professionals to support them to manage their mental health problem. The plan will include information on the specific needs of the person. A crisis plan (sometimes referred to as a 'safety plan') is usually part of a mental health care plan and is prepared in advance to help a person plan for a future mental health crisis should it occur. It provides guidance to the person experiencing a crisis as well as to family members, carers and others involved in the person's care. Information on early warning signs, seeking help in crisis, providing support and contact details for mental health services is also included. See Guidelines on Service User Experience in Adult Mental Health Services.

There should be an agreed and consistent means of sourcing further mental health information about a patient for example through summary care record with additional information.

There should also be an agreed point of contact to a mental health clinician for further information where available for the UTC to contact. Consideration may be given to link back to the mental health team in IUC CAS service.

3. **Where can UTC clinicians access information regarding a patient's and end of life care plan.**

There are a range of systems including Palliative Care Systems, EPaCCs, My Right Care or Summary Care Record with Additional Information. Either the patient's own GP or their palliative care lead will identify patients receiving end of life care during the out-of-hours period and pass the information to NHS 111 providers for the out of hours period of time.

4. **Where can UTC clinicians access patient Primary Care Records?**

Clinicians can access patient Primary Care Records via the Summary Care Record (SCR) or Local Shared Records that are in place including MiG, SLIP, Graphnet or GP connect etc.

5. **Where will the capacity and waiting time data be published for the local health economy and also nationally?**

Standards and specifications will be published shortly. The information will initially be presented to the 111 (CAS) service when they are making a referral to the UTC.

6. **One of the standards is for all UTCs to be able to issue repeat prescriptions. Who is responsible in ensuring the GP system is up to date with repeat issues?**

It is important to ensure that repeat prescription is clearly recorded on the system to keep medications in check.

The Electronic Prescription Service (EPS) system developed by NHS Digital is accredited for implementation into urgent care (both IUC CAS and UTCs). UTCs will be able to issue one-off prescriptions for patients who have run out of repeat medication using the urgent care EPS system.

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The EPS system does not currently have the capability to issue a repeat prescription or update the GP system. UTCs that have issued a repeat medication should provide a discharge summary via a post event message (PEM), which includes an update on the prescriptions issued including any medications given under a patient group directive, or short supply such as GP Out of Hours short supply pack. The GP is responsible for ensuring this is updated on the patient's record as per their protocol. Commissioners should ensure there is has a clearly defined route in place and that system functionality exists so this is feasible and monitoring can take place.

7. If a patient needs to be referred on to another service, is the UTC expected to book the onward appointment?

Referrals from UTCs will be dependent on the condition of the patient and must be clinically appropriate. Patients could be referred to emergency departments, ambulatory emergency care services, specialist services, GPs, primary and community services, or discharged with treatment. There is an expectation that where the capability exists, the UTC should book the appropriate onward service for the patient. NHS Digital are working with IT suppliers to develop direct booking capability and national standards that will support direct booking of appointments between services, for example, from a UTC to a patient's GP. However, at present this capability does not currently exist between every service type and commissioners should work with local services to set up the most effective and efficient onwards referral pathway possible. If necessary, patients can also be referred back to NHS 111.

8. Where the UTC needs to provide 'bookable appointments' from NHS 111, are these appointments expected to be within the UTC itself or within a GP practice within the area that the UTC provides services for?

NHS 111 should be able to book appointments with the UTC directly and the multidisciplinary team would see the patient. The UTC IT system should be able to provide this functionality.

The UTC should be operating a 'consult and complete' model, but we understand that in certain circumstances patients need to be referred onto more appropriate services.

9. Should walk in patients be provided an appointment after being clinically assessed?

Following clinical assessment walk in patients should be given an appointment slot if appropriate, this should be no longer than two hours after the time of arrival in line with locally agreed procedure

10. For UTCs that are only open for 12 hours, how will the end of sessions be managed?

Arrangements in respect of closing hours will be subject to local commissioning decisions. Most services will not take patients from a certain time to allow waiting patients sufficient time to be clinically treated.

In cases where patients have not been seen by the time the site closes the patient should be transferred to another service in line with local commissioning arrangements under the same Episode of Care. It is expected this number would be minimal.

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11. Should bookable appointments be available for booking 7 days a week?

UTCs should offer appointments 7 days a week throughout opening hours.

12. Is there a minimum number of appointments a UTC should offer?

The number of appointment slots a service can offer will be determined locally based on local demand and capacity as part of commissioning arrangements. There must also be flexibility from UTCs to release slots to meet the demand of patients referred from NHS 111.

Local agreement will include:

1. How far in advance the appointment slots are eligible to be booked by NHS 111/IUC
2. How the UTC can utilise the appointment slot if it is not booked by NHS 111/IUC within a certain timeframe before the appointment
3. Timing of appointments released for NHS 111 use
4. Booking processes - whether clinicians and non-clinical Health Advisors are able to book into the appointments

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Regular review should be undertaken by the UTC and commissioner to ensure appointment slots are appropriately utilised, capacity is not be over-whelmed by appointment requests but at the same time appointment slots are not underutilised. Continuous review may include analysis of unmet need, review of pathways and dispositions within NHS 111, DoS profile, and trend analysis i.e. peaks and troughs in the day/month/year.

Also refer to IUC Key Performance Indicator and Quality Standards 2018. KPI 5: **50% of Primary Care Cases booked to an Urgent Treatment Centre**

Local examples:

1. **Lancashire and South Cumbria** – The number of appointments available every day varies across sites. This has been locally determined between the CCG and the UTC provider based on local assumptions, demand and capacity modelling, and staffing models. Providers and NHS 111 undergo regular reviews.

The following examples are specific to implementing direct booking to GP extended access but are useful also for UTCs.

2. In the **North East**, it was agreed that practices would release one appointment per 2,000 patients to NHS 111, which was considered enough to not overwhelm the practice. If a service believes a referral is inappropriate, the DoS team should be made aware and the case be reviewed to determine whether the service was offered appropriately. If the DoS clinical coding all appears to be appropriate, the call in details will be passed to NHS 111 to review.

3. When implementing direct booking to GPs **North East Ambulance Service (NEAS)** found that the clear enabler to direct booking utilisation is not the number of appointments released but the timing of the appointments. The highest booking rates are achieved when NHS 111 appointments are split across the whole day with an appointment available in each of the typical four GP sessions (early morning, late morning, early afternoon, late afternoon).

13. If a service is short-staffed and unable to cope with demand, is there a process to ''block out' or stop appointment booking for a certain period?

Exceptional circumstances may arise when services have to block out appointment slots for example during very short periods of high demand from walk ins or A&E diverts. This is so the UTC can deal with the backlog and to ensure they continue to operate safely and patient satisfaction is maintained. If necessary, providers can ask NHS 111 to divert

patients to an alternative UTC or alternative appropriate service during this time in line with local commissioning arrangements.

Commissioners and providers should regularly monitor trends to ensure there are sufficient appointment slots for patients calling NHS 111 and workforce available to treat both directly booked patients and walk ins.

Local example: **Lancashire and South Cumbria** - UTCs have ability to access and manage their own diaries and the appointments they offer to 111. NHS 111 can only see the appointments that are available at any given time. Operationally, services could block appointments out if they are having a particularly busy period but cancelling slots would generally only happen if there is a technical issue.

14. How far ahead should UTC appointments be shown?

Bookable appointments should be shown for the remainder of the day and the following day. Slots made available beyond this would indicate less than urgent need, so more appropriate for a primary care appointment. Consideration should be given to appointment slots beyond regular time frames to accommodate patients' individual circumstances, for instance when a carer is unable to attend be able due to duties overnight but needs an appointment in the morning. This would enhance patient convenience and experience.

Local example: **Lancashire and South Cumbria** - Appointments will show based on both the availability of slots and the disposition the site will accept. Staff within 111 will then book based on the disposition that is reached with the patient. All the UTCs accept 2 & 6-hour dispositions and therefore do not currently offer next day appointments.

15. What is the process for patients requiring an appointment very quickly within a specified time period, e.g. 1 or 2 hours, and no appointment slots are available at that time?

If no appointment slots are available the patient should be advised to attend the UTC as a walk in. Overbooking existing appointment slots is not permissible as this will compromise clinical safety and the satisfaction of other patients. In this situation an ITK message should be sent from NHS 111 to the UTC to indicate the patient has been advised to walk in due to a lack of available appointment slots, and they should be prioritised on arrival according to clinical need. Regular and timely reviews are expected to take place to monitor trends with and report back to commissioners to manage the availability of appointment slots and resources (ref above).

Local example: 1. **Lancashire and South Cumbria** – For any 'reds' (1-hour dispositions) with a G.P surgery outcome the UTC should fit patients in and they should be prioritised on arrival based on clinical need. This process is used for both walk-in and pre-booked patients (i.e. appointments made via NHS 111 directly or after an Out of Hours telephone triage). Appointments are not held back for emergencies as it may result in failure to maximise capacity. In addition, implementing a process whereby slots are reserved for emergencies would be problematic as it will vary for each service and provider. Fylde Coast have a complex model with 8 integrated services, holding appointments for specific DX codes would be difficult for service to manage.

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2. **Durham, Durham Dales and Sedgefield and Darlington** sites have open ledgers for 111. If there is not a slot available the call handler will be directed to the next appropriate service on the DoS.

Darlington, Durham, Peterlee, Shotley Bridge and Bishop Auckland provide 111 with open access to their ledger throughout opening times. Patient's GP will rank above UTC on DoS. If no slot is available in the recommended disposition timeframe the call handler will select the next appropriate service on the DoS. This ensures the full system capacity of that area is used.

3. **Hartlepool and Stockton-on-Tees CCG (HAST)** release appointments throughout opening hours (24/7). In the unlikely event where there is not an appropriate appointment the patient is advised to walk in and they will be prioritised on arrival based on clinical need. The UTC still receives an ITK for the patient even if no slot available to book so they are expected. This would the same process for 1-hour dispositions.

16. If a patient needs to be referred elsewhere for an X-ray for example (to continue treatment), what type of attendance will this be recorded as in the 'referred to location'? Will it be categorised as an 'Unplanned follow up for another Emergency Department' or a 'New visit'?

Patients referred off site should not have to 'start again' in a new setting both from a record and clinical patient journey perspective. They should be given a booked slot or direct referral to the appropriate facility and not have to go through further triage at the emergency department. For example, if they are referred directly to an X-ray department, they should bypass the emergency department and not be counted as an A&E attendance. The patient may then conclude treatment at the referring site if necessary.

If the patient *has* to go to the emergency department at the new site, they should be reported as an unplanned follow up for another emergency department, for example, if their condition deteriorates during the x-ray.

17. Should walk in patients be included in Emergency Care Data Set (ECDS) submissions?

Yes, all patients attending UTCs should be included in Emergency Care Data Set submissions on a daily basis, in line with the applicable information standard (see also technical output specification).

18. A number of the attributes within the Emergency Care Attendance Activity Characteristics Data Group implicitly assume that the patients are walk ins. How can we differentiate between walk ins and those who booked through NHS 111?

The Emergency Care Attendance Activity Characteristics provides a range of options to capture the type of attendance under '11.2 attendance source', including '111 / NHS telephone advice'.

To ensure the patient journey is recorded accurately, one of the following Emergency Care Attendance Category national codes should be used:

1 - Unplanned First Emergency Care Attendance for a new clinical condition (or deterioration of a chronic condition), this is often the most common code for both walk- in and booked appointments

2 - Unplanned Follow-up Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance at this Emergency Care Department

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3 - Unplanned Follow-up Emergency Care Attendance for the same or a related clinical condition and within 7 days of the First Emergency Care Attendance at another Emergency Care Department

4 - Planned Follow-up Emergency Care Attendance within 7 days of the First Emergency Care Attendance at this Emergency Care Department

19. When reporting on the 'Emergency Care Arrival Date and Time' to the Emergency Care Data Set (ECDS), does this refer to when the patient presents to the UTC, as opposed to the actual appointment time?

Reporting to ECDS should capture when the patient arrives at the UTC **and** the time they are seen.

20. Do patients booked through NHS 111 count towards the four-hour standard?

The A&E four-hour performance standard applies **only** to **walk-in** cases (unplanned attendances) – see A&E Attendances and Emergency Admissions Monthly Return Definitions.. The current A&E four hour performance standard does not apply to booked appointments[1]. It would however be beneficial to understand the number of patients who follow this pathway and that activity for booked UTC appointments is counted and reported as a standalone item alongside other A&E performance data. This could be either through an automated report from the UTC IT system or manual data collection.

21. When should the clock start and stop for walk-in patients (i.e. do not have a pre-booked appointment)?

For patients that are applicable for inclusion within the four-hour standard reporting, the clock starts at their time of arrival and stops when the patient leaves the department on admission, transfer from the hospital or discharge (see section 3 of A&E Attendances and Emergency Admissions Monthly Return Definitions).

22. If the patient's condition deteriorates resulting in the need to be transferred to A&E, does the overall 4-hour limit apply across the whole stay?

This depends on whether the UTC is co-located on the same site and if the patient is booked in or not (as above patients given a pre-booked appointment via NHS 111 are currently not counted within the four-hour performance standard).

If the patient walks in to a UTC that is co-located with an A&E the clock should keep running and be counted as a single attendance and reported by the department the patient ends their attendance in.

If the second department is not on the same site then the first attendance stops when they leave the first unit and a new attendance (and clock) starts on arrival at the second unit.

23. If the patient's condition deteriorates resulting in a need to be transferred to A&E, will this be considered as under the same Episode of Care?

[1] The four hour standard only applies to patients who walk into UTCs and booked appointments are explicitly excluded; this was to exclude outpatient appointments, out of hours services, GUM services etc. contributing to the target.

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When a patient is transferred from the care of a UTC to another department e.g. an A&E department, then this is classed as a referral if the UTC has carried out investigations on the patient, otherwise it is classed as streaming. In either case, under ECDS there will be a separate episode of care – one for the UTC care episode capturing the initial assessment details, and one for the A&E care episode capturing the subsequent assessment details.

For the SitRep and Monthly A&E return, this scenario should be counted as a single attendance.

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