Appendix B

Accident and Emergency Department Classifications

Currently Accident and Emergency Departments are classified by Type: -

- Type 1 is consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

- Type 2 is consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.

- Type 3/Type 4 is another type of department currently classified as minor injury units (MIUs) or Urgent Care Centre. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A crucial distinguishing aspect of a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. An appointment based service is not a type 3 A&E service even though it may treat a number of patients with minor illness or injury.

Standards for Urgent Treatment Centres (NHS England – July 2017)

Urgent treatment centres must conform to the following minimum standards. Sustainability and Transformation Partnerships and commissioners may also choose to build upon or add to these, according to their requirements.

(1) Urgent treatment centres should be open for at least twelve hours a day seven days a week, including bank holidays, to maximise their ability to receive streamed patients who would otherwise attend an A&E department. Typically this will be an 8-8 service, but commissioners will wish to tailor to local requirements based on locally determined demand.

(2) Urgent treatment centres should provide both pre-booked same day and “walk-in” appointments, however patients and the public should be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.

(3) Urgent treatment centres, and NHS 111, should support patients to self-care and use community pharmacy whenever it is appropriate to do so. Urgent treatment centres should promote and record the numbers of patients offered self-care management and patient education.

(4) The urgent treatment centre should ensure that there is an effective and consistent approach to primary prioritisation of “walk-in” and pre-booked appointments, and the allocation of pre-booked routine and same day appointment slots.

(5) For patients who require an appointment in the urgent treatment centre this should be booked by a single phone call to NHS 111; locally patients should be encouraged to use NHS 111 as the primary route to access an appointment at an urgent treatment centre.

(6) Patients who “walk-in” to an urgent treatment centre should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary.

(7) Following clinical assessment, patients will be given an appointment slot, which will not be more than two hours after the time of arrival.

(8) Patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time.

(9) Protocols should be in place to manage critically ill and injured adults and children who arrive at an urgent treatment centre unexpectedly. These will usually rely on support from the ambulance service for transport to the correct facility. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance 'Quality standards for cardiopulmonary resuscitation practice and training’, should be immediately available. At least one member of staff trained in adult and paediatric resuscitation present in the urgent treatment centre at all times. This should all be part of an approach of ‘design for the usual, and plan for the unusual’.

(10) An appropriately trained multidisciplinary clinical workforce will be deployed whenever the urgent treatment centre is open. The urgent treatment centre will usually 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.

(11) The scope of practice in urgent treatment centres must include minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries.

(12) All urgent treatment centres should have access to investigations including swabs, pregnancy tests and urine dipstick and culture. Near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes should be available. Electrocardiograms should be available, and in some urgent treatment centres near-patient troponin testing could also be considered.

(13) Bedside diagnostics and plain x-ray facilities, particularly of the chest and limbs, are desirable and considerably increase the assessment capability of an urgent treatment centre, particularly where not co-located with A&E. Where facilities are not available on site, clear access protocols should be in place. Commissioners will need to consider patient throughput in their cost benefit analysis where capital investment will be required.

(14) All urgent treatment centres should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (e-prescribing should be in place in all sites by June 2019).

(15) All urgent treatment centres should be able to provide emergency contraception, where requested.

(16) All urgent treatment centres must have direct access to local mental health advice and services, such as through the on-site provision of 'core' liaison mental health services where services are co-located with acute trusts or links to community-based crisis services.

(17) All urgent treatment centres should have arrangements in place for staff to access an up-to-date electronic patient care record; this may be a summary care record or local equivalent. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient's best interests in an emergency situation where the patient lacks capacity to consent.

(18) There must be the ability for other services (such as NHS 111) to electronically book appointments at the urgent treatment centre directly, and relevant flags or crisis data should be made available for patients.

(19) A patient's registered GP should always be notified about the clinical outcome of a patient's encounter with an urgent treatment centre via a Post Event Message, accompanied by a real-time update of the electronic patient care record locally. For children the episode of care should also be communicated to their health visitor or school nurse, where known, within two working days.

(20) Where available, systems interoperability should make use of nationally defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology and nationally-defined record structures.

(21) Urgent treatment centres should make capacity and waiting time data available to the local health economy in as close to real-time as is possible for the purposes of system-wide capacity management; relevant real-time capacity information should also be made available for use across Integrated Urgent Care nationally.

(22) Urgent treatment centres should refer to and align with the Integrated Urgent Care Technical Standards to ensure effective service and technical interoperability.

(23) Urgent treatment centres should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.

(24) Where appropriate, patients attending an urgent treatment centre should be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).

(25) All urgent treatment centres should collect contemporaneous quantitative and qualitative data, including patient experience. From October 2018 all urgent treatment centres must return the data items specified in the Emergency Care Data Set. Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.

(26) All healthcare practitioners working in urgent treatment centres should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.

(27) All urgent treatment centres to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan, looked after child or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.