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Setting up NHS 111 direct booking efficiently

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How to set up NHS 111 direct booking to help your practice

The 2019/20 GMS contract requires GP practices to make arrangements, technology permitting, for NHS 111 to book GP appointments directly on behalf of patients. Practices will only be required to make a limited number of appointments available for booking each day.

GPs have always seen the appointment book as the ultimate means of controlling workload. Scheduling, planning surgery templates, allocating appointments and the dreaded embargoes all make up a key part of the practice culture. So intrusion from a third party, in this case NHS 111, into your tried and trusted system will understandably create unease.

But this is a contractual change and one that could even help, if managed correctly.

What happens from 2019/20?

The new contract states that from this year, where functionality exists, every practice will need to make a minimum number of appointments available for direct booking by NHS 111.

According to the BMA, practices should make the appointments available from 1 July 2019 – although implementation will clearly depend on the IT being ready.

The appointments will come from NHS 111 calls that have reached clinician triage and are deemed to need to see their usual GP team for the sake of continuity. In such cases patients will still have the option to make their own appointment, so this should only apply in a limited number of cases.

Most importantly, it is up to the practice to decide how to deal with any patient booked in. The appointments are nominally face to face, but patients will be told that they may be contacted by the practice ahead of the appointment.

The contract does not specify GP appointments, so if you have a nurse practitioner routinely seeing undifferentiated presentations and acute work, it may be appropriate for them to see patients.

You are at liberty to contact the patients and triage them in the way you would normally deal with this sort of booking.

How many appointments do we need to make available?

The contractual requirement is one appointment per day 'per whole 3,000 patients' (practices with less than 3,000 patients offer one appointment) as follows:

Patient numbers	Minimum appointments per day
< 3,000	1
3,001-5,999	1
6,000-8,999	2
9,000-11,999	3

And so on, increasing in 3,000 patient steps

How should we allocate the appointment slots?

First, identify which clinician will take these appointments. Most practices run a duty system and you may find it easier to allocate slots in your duty/urgent access surgery template. Make these easily identifiable. Most clinical systems will allow colour coding or flagging of appointment slots, so make them consistent in both timing and how they are displayed. This will also allow you to audit and feed back to NHS 111 should you wish to.

When should they be made available?

The stipulation is that they should be allocated throughout the day. Obviously if you are only providing one or two appointments this is difficult. But be pragmatic; if you have the opportunity to triage and deal with the patient by telephone in advance, then make the appointments later in the day to allow you time to contact the patient. Perhaps consider allocating one of your clinical team to review any bookings made.

Will we get details of the reason for the appointment?

Currently this is not supplied. However, according to the BMA, NHS 111 will add a note to the patient's record indicating their rationale for booking the appointment so that the practice 'has all relevant information prior to the appointment'.

NHS England contract information also states: 'Clear post-event information will be automatically added to the patient record along with the appointment, so that the practice can easily see the reason for the appointment and any relevant clinical summary.

'NHS England will provide guidance for practices and NHS 111 outlining how system configuration can be optimised to make this information as clear and accessible as possible.'

What if the appointments are unused?

Another advantage to having appointments later in the day is that if they are not used by a reasonable time beforehand, you can release them for general use. Based on the assumption that the main booking is likely to come from out of hours, you can assume that slots still free mid-morning are unlikely to be booked.

It's important to note here that the BMA has advised that appointments may be freed up 'if not booked within a set period before the appointment' and that 'further information about the set period will be provided in due course'.

If you are worried about wasting time when an appointment slot is unbooked, make sure the nurse or doctor on duty has a set of non-urgent tasks to do to fill the time (eg, simple medication reviews or QOF work).

How will it impact on our practice?

Around 40% of practices have already been involved in pilots, including those in my area in the North East. We have been making these appointments available for two to three years now and the impact has been minimal. Usage has varied; some practices rarely if ever have the appointments booked, while others (mainly those in more deprived areas with high acute demand) are finding they are regularly booked.

As LMC Secretary I have been involved with discussions with our practices about the service. None of them has raised any serious objections and they that the clinical problems are generally appropriate. Also, with good LMC and CCG support they can feed back if the system is not working. As practices are able to triage the patients, inappropriate use by 'frequent flyers' can be addressed.

Overall you will have several fewer phone calls from patients directed to you from out of hours each week, and the services of a clinician to do a first pass on the problem.

Guide URL:
http://preview.pulse-intelligence.co.uk/guide/how-to-set-up-nhs-111-direct-booking-to-help-your-practice/