NHS England

Integrated Urgent Care Service Specification

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Integrated Urgent Care Service Specification

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Executive Summary

1.1. Introduction

Each year the NHS provides around 110 million urgent same day patient contacts. Around 85 million of these are urgent GP appointments and the rest are A&E or minor injuries-type visits. Some estimates suggest that between 1.5 and 3 million people who attend A&E each year could have their needs addressed in other parts of the urgent care system.

Earlier this year, NHS England and NHS Improvement published the *Next Steps on the NHS Five Year Forward View* which highlighted the importance of delivering a functionally integrated urgent care service to help address the fragmented nature of out-of-hospital services. Our aim is to provide care closer to people's homes and help tackle the rising pressures on all urgent care services (primary and hospital) and emergency admissions.

The opportunity to improve the patient's experience of, and clinical outcomes from, urgent care is huge. NHS England has worked to develop a new national service specification for the provision of an integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call-handling and former GP out-of-hours services. This new specification is just the starting point to revolutionise the way in which urgent care services are provided and accessed.

Around the country, commissioners have adopted a range of models for the provision of NHS 111, GP out of hours and urgent care services in the community. In some areas a more comprehensive model of integration has already been implemented. More often, however, there are separate working arrangements between NHS 111 and GP OOH services, and a lack of interconnectivity with community, emergency departments and ambulance services. This position is entirely understandable given the way that primary care, OOH and NHS 111 policy has evolved; but it no longer fully meets the needs of patients or health professionals. This service specification supersedes the previous commissioning standards, moving from an advisory set of recommendations to mandatory requirements, to ensure a consistent service across the country.

This document provides a national service specification for the provision of a functionally integrated 24/7 urgent care access, clinical advice and treatment service (incorporating NHS 111 and OOH services), referred to here as an IUC Clinical Assessment Service. It outlines the steps that commissioners must take in delivering an essential part of this transformation – and to move from an 'assess and refer' to a 'consult and complete' model of service delivery.

1.2. Key elements of an Integrated Urgent Care Service - Action required by all NHS 111 and OOH commissioners

Moving to a functionally integrated service which incorporates those elements that were previously described in separate NHS 111 commissioning standards and OOH services guidance and requirements is a considerable commissioning task. The OOHs National Quality Requirements will be superseded by this service specification once fully implemented.

The key elements of an Integrated Urgent Care Service - action required by all NHS 111 and OOH commissioners are:

1. Deliver 'Consult and Complete' by increasing clinical consultation in to calls in 2017/18 (see Section 5.4)
2. Develop Lead Commissioner Arrangements by 30th September 2017 (see section 5.20)
3. Develop a Collaborative Provider Arrangement (see section 5.20)
4. Model the Financial and Workforce Impacts (see section 5.7)
5. Undertake an Immediate Gap Analysis (all sections)
6. Initiate immediate contract variations or re-procurements to deliver the new service specification by 31st March 2019 (see section 5.20)
7. Roll-out of NHS 111 Business Intelligence Tool - Disposition and Outcome monitoring (see section 7.6)

This national service specification describes how the existing and new service elements - call-handling, clinical assessment and treatment services should be commissioned, provided and measured. For these reasons the national service specification is more extensive than its predecessor documents.

1.3. The Clinical Assessment Service – present and future

The vision for an Integrated Urgent Care Clinical Assessment Service (IUC CAS) offers a transformational opportunity to deliver a model of urgent care access that will streamline and improve patient care across the urgent care community, through the implementation of "consult and complete" model.

The present NHS 111 service available across England is staffed by fully trained Health Advisors - non-clinicians who use the NHS Pathways triage tool. The final decisions reached by the Health Advisor mean that approximately 70%-80% of patients are advised to have contact with a clinician in one setting or another (February 2017 snapshot show ambulance 11.4%, A&E 8%, speak-to GP 10.2%, contact GP 36.6%, Dental/Pharmacy 4.9% and other services 3.5%). These clinicians at present work in service providers outside of the NHS 111 call handling service, which merely signposts patients to them.

The introduction of an IUC CAS will will fundamentally change the way patients access health services. **It will mean patients will receive a complete episode of care concluding with either: advice, a prescription, or an appointment for further assessment or treatment.**

This means as many clinically appropriate calls to NHS 111 as possible should be closed following consultation with an appropriate clinician, negating the need for onward secondary care referral or additional signposting. By the end of 2017/18 it is expected that more than 50% of all calls to NHS 111 will involve a clinical consultation over the phone. The service specification provides underpinning evidence of how early clinical consultation into calls improves outcomes for patients and the system alike – with more patients offered self-care advice, fewer A&E attendances and ambulance dispatches and conveyances.

The IUC CAS will contain a multidisciplinary clinical team. Each IUC CAS will have at least one senior responsible GP available 24/7 with additional GPs rostered according to demand. Working with them, also rostered according to demand and local need will be specialist clinicians such as advanced nurse practitioners, pharmacists, dental nurses, mental health nurses, palliative care nurses.

The Health Advisors will be assisted by a triage tool to identify which clinician needs to assess the patient in a timely manner. This call streaming is expected to identify approximately 75% of patients who need/want clinical consultation. The other 25% are often calling for simple health information/provider information (e.g. local pharmacy location and opening times) and will not be forwarded to clinicians in line with the “consult and complete” model.

The model for an IUC CAS requires the following offer for patients:

- access to urgent care via NHS 111, either a free-to-call telephone number or online;
- triage by a Health Advisor;
- consultation with a clinician using a Clinical Decision Support System (CDSS) or an agreed clinical protocol to complete the episode on the telephone where possible;
- direct booking post clinical assessment into a face-to-face service where necessary;
- electronic prescription; and
- self-help information delivered to the patient.

All these alternatives need to be in place in order to complete the consultation.

In the transition to a fully delivered IUC Service – including a full Clinical Assessment Service - commissioners must ensure that the call-handling and clinical assessment functions:

- clinical validation of 'low acuity[1] ambulance dispositions from the Clinical Decision Support System (CDSS);
- clinical validation of all A&E dispositions from the CDSS;
- offer rapid access to a GP for all community health care professionals – through the 'star-line' system described in the service specification;
- ensure that the speak-to GP dispositions from the CDSS are dealt with by a GP co-located in the NHS 111 service (either physically or virtually) enabling 40% of calls to speak to a clinician by December 2017; and
- enable NHS 111 and local clinicians to work closely together so that the achievement of 50% of calls receiving a clinical consultation is reached by 31st March 2018.

Face-to-face services will vary according to local service commissioning and patient need. These could include Urgent Treatment Centres (UTCs), which will be standardised to a consistent service specification; primary care, including new extended access services and direct booking of appointments with a patient's own GP where required; and services co-located on A&E sites, offering 24/7 access to urgent primary care or where necessary to emergency departments. Patients will be referred to locations of care using the Directory of Service (DoS). Wherever possible, this referral will involve an appointment, including with an Urgent Treatment Centre or GP. Where this is not possible, patients will be sign-posted and provided details of location of care and services provided.

This specification details the scope and operating model for the IUC CAS. It describes the workforce needed and links to the ongoing work outlining the competencies required to work in this service at all skill levels.

1.4. Technology

The IUC Service is underpinned by technology. This service specification therefore sets out the standards against which technology must be procured and emphasises the importance of robust resilient solutions.

- **Telephony**: The function of the national 111 platform and how providers receive 111 calls.

[1] The term 'low acuity' is used here to capture the previous 'Green' calls. Commissioners should ensure those calls formerly coded 'green' but now coded with the new classification as part of the Ambulance Response Programme are managed in the same way.

- **Service Directory**: The importance of maintaining an accurate service directory and how to access and use it.
- **Interoperability**: The challenges associated with referral of encounters into and out of the service, access to records and appointment booking.
- **Future Technology**: The emergence of alternative access channels such as on-line and the replacement / onwards development of existing technologies such as service directories and triage tools.

The underlying principles of IUC technology are that:

- The clinical assessment should take into account any preferences or instructions detailed in a patient's care plans;
- Clinicians should be able to access the patient's record (Summary Care Record (SCR), Enhanced SCR and in the future GP record through National Reporting and Learning System (NRLS) when it is appropriate and beneficial to do so and permission has been gained;
- When required, patients should be referred to the most appropriate location of care in their locality;
- Prescriptions should be issued electronically for collection at a pharmacy of the patient's choice, subject to opening hours and other checks deemed necessary by the Provider (see section 5.13);
- If an ambulance is required it should be dispatched electronically, with verbal transfer capability for business continuity (using audio conferencing with 999); and
- If an appointment is required, it should be booked electronically on behalf of the patient, negating the need for the patient to make a further phone call.

1.5. Clinical Governance

Expected governance standards and clinical quality audits, patient experience and measurement plus outcome data is explained in section 7.3.

This includes:

- National collection of Serious Incident (SI) data;
- National collection of end-to-end review data; and
- Provision of cross provider clinical oversight.

1.6. Delivery Targets

The whole of England's population should be served by IUC Services by April 2019. NHS England will support and manage commissioners to ensure all elements of this service specification are delivered by this date. This will be formally measured by achievement against the 9 key elements and other targets of the IUC service as detailed in this specification.

NHS England will agree with STPs and CCGs delivery trajectories for the achievement of these targets. It has established new governance arrangements through the Urgent and Emergency Care Delivery Programme where achievement will be reported.

1.7. Developing a Lead Commissioner Arrangement

At present NHS 111 call-handling services are generally commissioned separately from GP out of hours (OOH) services. The responsibility for commissioning OOH has been directed by NHS England to CCGs since 2013. Where practices remain opted in[2], CCGs are responsible for assuring the quality of GP OOH services provided. These arrangements have led to a number of providers holding multiple contracts for NHS 111 and GP OOH services for different CCGs.

This service specification outlines that a lead, or co-ordinating, commissioner arrangement is required, in which commissioners serving a wider area are brought together to commission an IUC Service. This has already been shown to be an effective model for engaging with providers (particularly those that deliver services over an area covering a number of CCGs) and to effect strategic change. It is also imperative that commissioning plans for IUC against this service specification fully align with sustainability and transformation planning views of future service delivery for their population (e.g. STP-level as a minimum and potentially across multiple STP footprints).

1.8. Developing a Collaborative Provider Arrangement

The current NHS 111 and GP OOH provider system is characterised by a range of provider organisational types, with a wide range of services provided, across a mix of geographical footprints with variation in investment levels.

Commissioners should continue to promote a healthy and diverse provider market, commissioning for value with a focus on economies of scale, identifying the correct 'footprint' size for delivery capability, resilience and quality. However, to achieve integration and adhere to this service specification, providers will need to collaborate to deliver the new investment required in technology and clinical skills, and to ensure that services are aligned. It is for this reason that commissioners must use the procurement or contracting process to encourage NHS 111, GP OOH and other

[2] Since 2004, GPs have been able to opt out of providing out-of-hours services and most have done so. In these cases (known as *opted-out* services) the NHS commissions out-of-hours services separately from in-hours services. However, an estimated 10 per cent of GPs have retained responsibility for out-of-hours care. NHS England commissions these services (known as *opted-in* services) directly from GP practices.

NHS organisations to collaborate or work within a lead provider arrangement, to deliver the specification for the integrated service.

In doing so, commissioners will need to ensure that the current provider market continues to be developed and is not destabilised. There should be ample opportunity for any willing provider to meet the new service specification in collaboration with other providers but to reiterate, NHS England has no expectation that any organisation should merge locally, commissioning for quality will dictate the provider requirements.

2. Service Specification

2.1. Introduction

The NHS Five Year Forward View clearly set out the need to take action in redesigning the NHS urgent care 'access point', moving towards a "consult and complete" model.

NHS 111 provides a vital service to help people with urgent care needs to get assessment, clinical advice and treatment quickly, taking around 15 million calls a year. The service will be further enhanced by increasing clinical consultation for patients calling 111, so that more patients get the care and advice they need over the phone, and only those who genuinely need to attend A&E or use the ambulance service are advised to do this. All other patients will have their issue resolved over the phone if at all possible, or if not will be directed to appropriate primary care or community services, with an emphasis on strongly supporting patients in self-care.

The core vision for an IUC service builds upon the success of NHS 111 in simplifying access for patients and increasing the confidence that they, local commissioners, health professionals and most importantly the public have in services. The offer is easy access to urgent health care services that is fully integrated with all aspects of the system - through NHS 111. This integration sees urgent care services collaborating to deliver high quality, clinical assessment, advice and treatment, with shared standards and processes and clear accountability and leadership. The 111 number must become the single telephony access point. For the avoidance of doubt the use of other non-geographic numbers for access to out-of-hours services is no longer permitted.

Central to this is the development of a Clinical Assessment Service (CAS) offering patients access to clinicians, both experienced generalists and specialists (such as Dental Nurses, Mental Health Nurses and Palliative Care Nurses). These clinicians will also be available to health professional colleagues who work with patients in the community, such as paramedics and nurses in nursing homes. GP OOH and 111 services will be combined, and multidisciplinary clinicians added to the integrated working model. In addition, the future NHS111 IUC will book people into urgent face-to-face appointments where needed.

Some parts of the NHS are already a long way towards delivering a fully functioning IUC service to their local population. This national service specification has been developed to support commissioners to secure services so that the entire population has access to a functionally Integrated Urgent Care services by the end of March 2019.

This new Service Specification has been developed collectively with commissioners and providers of IUC Services and NHS England will continue to work with commissioners during the implementation and delivery.

3. National/Local Context and Evidence Base

KEY SERVICE REQUIREMENTS

These are key requirements that include but are not limited to;

1. The commissioner shall ensure service provision in line with this service specification.

A full list of requirements can be found in the section below.

The Integrated Urgent Care service is free to call through NHS 111 and is available 24 hours a day, 7 days a week, to respond to the population of England with a personalised contact service when patients:

- Need medical help fast, but it's not a 999 emergency;
- Don't know who to call for medical help;
- Are unsure if they need to go to A&E or another NHS Urgent Care service;
- Need health information or reassurance about what to do next; or
- Require continuity of care when in hours GP services are closed.

When procuring services, the Commissioner shall publish sufficient information to enable bidders to clearly respond to the requirement of delivering an integrated urgent care service in line with national and local specification requirements. This information will include but is not limited to:

- Call volumes
  - Weekday
  - Weekend
  - Bank Holiday
- Intraday call profiling
- Case mix
- Average Handling Times

The IUC Service must be designed around the patient's expectations that:

- Their problem is dealt with on the initial call, including receiving a consultation from a clinician where appropriate;
- The assessment will be quick and not involve unnecessary questions;
- In an emergency an ambulance will be dispatched without delay;
- Their call will be warm transferred to a clinician where clinically appropriate (even if that resource is not co-located);
- When a call back is necessary during periods of peak demand any call back is within safe timescales;
- For the majority of Patients, their call is completed on the telephone (the "consult and complete" model);

- The IUC service has accurate up-to-date information regarding the 'locations of care' and pharmacies in their locality including but not limited to knowing opening times and services offered;
- The service has accurate and up-to-date information regarding local capacity, including new GP extended access offer, and to make appointments;
- Any prescription required will be sent directly to a convenient pharmacy where appropriate; and
- If further care or advice is required they will be referred automatically (electronically) where possible, or signposted to another service including those outside the scope of IUC.

The IUC service must be designed to support patients[3]:

- where English is not their first language;
- with hearing impediment, physical disabilities and communication difficulties; and
- with mental health issues.

A series of pilots have been undertaken to build an evidence base relating to benefits associated with the provision of additional clinical consultation. A full report can be found in Appendix A.

[3] Accessible Information Standard - https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-upd-july-15.pdf

4. Outcomes

KEY SERVICE REQUIREMENTS

These are key requirements that include but are not limited to;

Commissioners shall:

1. Commission a service based on the “consult and complete” model that delivers against the nine key elements of an IUC service.
2. Consider a set of locally defined outcomes depending on local demographics and need.

A full list of requirements can be found in the section below.

4.1. NHS Outcomes Framework Domains & Indicators

The provision of a high-performing, safe and effective IUC “consult and complete” service can be mapped to the domains within the NHS Outcomes Framework.

CCGs are required to commission a service based on the “consult and complete” model that delivers against the nine key elements of an IUC service:

1. A single call to get an appointment during the out-of-hours period.
2. Data and Information can be shared between providers.
3. The capacity for NHS 111 and urgent multidisciplinary clinical services need to be jointly planned.
4. The Summary Care Record (SCR) is available in the Clinical Assessment Service (CAS) and elsewhere.
5. Care plans and special patient notes are visible to the Clinicians in the IUC and in any downstream location of care.
6. Appointments can be made to in-hours GPs and to GP extended access services, offering services in the evening and at weekends.
7. There is joint governance across Urgent and Emergency Care.
8. Suitable calls are transferred to a Clinical Assessment Service containing GPs and other health care and social care professionals.
9. The Workforce Blueprint products and guidance are implemented across all providers.

Progress against the delivery of these key elements will be measured against the CCG Improvement and Assessment Framework (Indicator 127a).

4.2. Locally Defined Outcomes

As well as the common set of outcomes set out in Section 4.1, commissioners shall consider a set of locally defined outcomes depending on local demographics and need.

The following is a set of example outcomes to be considered for this purpose:

- To provide consistent clinical assessment of patient needs at the first point of contact, including direct clinical consultation in at least 50% of clinically appropriate calls;
- Meeting the urgent care needs of patients, including onward referral to primary care, Urgent Treatment Centres and other community settings as required;
- Ensure that specific health needs such as palliative care, mental health and long term conditions are properly met[4].
- Coordination of care with:
    - Community pharmacy services for repeat prescriptions and pharmacists;
    - 'Hear and Treat', 'See and Treat', by ambulance services, for minor illness;
    - Mental Health services providing care for people with mental health conditions;
    - Urgent dental care services;
    - Co-ordination of Specialist Palliative/EOL care including statutory and voluntary sectors;
    - Social care.

[4] http://endoflifecareambitions.org.uk/
http://endoflifecareambitions.org.uk/resources/
https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response
http://www.endoflifecare-intelligence.org.uk/resources/publications/costeffectivecomm

5. Scope

KEY SERVICE REQUIREMENTS

These are key requirements that include but are not limited to;

Commissioners shall ensure:

1. A “consult and complete” model of urgent care access is commissioned, that can streamline and improve patient care across the urgent care system.
2. The procurement of an IUC CAS which aligns with community based services, health and social care, as well as UTCs and A&E.
3. That appointments can be directly booked for face-to-face services.
4. That callers to NHS111 are routed via a national NHS 111 telephony system to the organisation commissioned to receive NHS 111 calls in the geographical area from which the call originated and use Interactive Voice Response (IVR) approaches to stream callers to the most appropriate service.
5. The Provider fulfils any obligations set down in legislation, such as the Civil Contingency Act 2004, the Information Governance Toolkit and other relevant controls for Disaster Recovery and Business Continuity.
6. The service is accessible via NHS 111 telephony, via NHS 111 online or via ambulance referral in due course.
7. The use of an accurate and up to date directory of service as described in this specification.
8. That 100% same day or pre-bookable appointments can be made with general practice by March 2019.
9. That all requests for direct booking to a GP practice will be made by an experienced clinician and shall work with the local extended access provider to model demand for appointment slots during the evening and at weekends.
10. That arrangements are made for the management and referral of callers with dental symptoms; as outlined in this specification.
11. Coordination of organisations to work together in order to provide a consistent and coordinated service to patients. Services must be commissioned so that joint working relationships are recognised with contracts and responsibilities clearly outlined.
12. That local communications and stakeholder engagement strategies are co-created with the Provider to ensure that they are effectively engaged with their public.
13. They support and enable the implementation of the future technology required to support IUC.
14. That the decisions being made about the urgency of presenting patients are underpinned with the best possible information and knowledge and accessed by a clinical decision support system that has been robustly

tested within the NHS in England and has been demonstrated to be safe.

15. There is consideration of how the chosen Clinical Workflow System interoperates with the Online Digital Services.

Providers must ensure:

16. Face-to-face consultations with a clinician are offered, including where necessary, at the patient's place of residence.
17. Appropriate technical solutions are in place and or operational procedures to handle GP Choice patients in accordance with the national requirements.
18. Any clinical decision support system (CDSS) must be used in accordance with and licensing requirements.
19. Non-symptomatic calls should be closed without clinical consultation.
20. Adherence to the principles of the Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis (18 February 2014).
21. That they have a robust telephony system in place to support all of the required activities of the service.
22. Ensure they have contingency plans in place in the event of a telephony failure.
23. There is direct access to clinical advice for HCPs (for example, through a direct telephone number or IVR arrangement).
24. They are involved in planning and preparedness for response to a major incident.
25. That the IUC service is designed in accordance with the "consult and complete" operating model principles outlined in this specification.
26. That the decisions being made about the urgency of presenting patients are underpinned with the best possible information and knowledge and accessed by a clinical decision support system that has been robustly tested within the NHS in England and has been demonstrated to be safe.
27. All elements of the workforce specification and NHS 111 Workforce Blueprint (once published) are delivered.
28. That the chosen clinician workflow system has ability to integrate with the National Repeat Caller Service.
29. That the chosen workflow system has the ability to send an electronic Post Event Message.
30. They consider how the chosen Clinical Workflow System interoperates with the Online Digital Services.
31. That any Location Unknown Calls are handled on a reciprocal basis treating them as if they had originated from the Provider's catchment area and form part of the contracted volume.
32. Installation of an ARP compliant CDSS version.
33. They cooperate with any initiatives that consider how the Clinical

Assessment Service can be used for lower acuity ambulance calls following the full implementation of the ARP.

34. Implementation of electronic referral methods when referring to any other services.
35. Implementation of a solution capable of direct appointment booking with destination services through the chosen clinical workflow system. Booking shall be available for both in-hours services (such as, GP Surgeries) and urgent care services (such as, Urgent Treatment Centres, Out of hours GP and extended access same day services and in time dental services where commissioned).
36. The chosen clinical workflow system has technical integration with the Personal Demographics Service (PDS)
37. That health care professionals have effective access to the Summary Care Record for all patients, subject to appropriate access controls.
38. The chosen clinical workflow system can provide Patient Flag functionality, allowing advisors and health care professionals to be proactively alerted where important information is available to assist with and direct the specific care that is provided to the patient.
39. The ability to automatically identify patients that are registered under the GP Choice scheme when they access the service.
40. The chosen clinical workflow system has the ability to query the Child Protection Information System (CP-IS).
41. Health care professionals are able to access detailed primary care/GP records for all, subject to appropriate access controls.
42. The chosen clinical workflow system has the ability to interoperate with Online Digital Services as they become a more prominent.
43. Access to medicines and devices through the issuing of NHS prescriptions, where clinically appropriate, to meet urgent need as part of a clinical assessment.
44. The use of Post Event Messaging using the Clinical Document Architecture (CDA) in electronic form (ITK), or whatever may supersede it in the future.
45. That procured solutions have multimedia capability.
46. They operate the telephony, online and face-to-face elements of IUC service 24/7 365 days a year (including leap days).
47. A systematic process is in place to regularly seek out, listen to and act on patient feedback on their experience of using the service.
48. The IUC Service is designed around the holistic needs for patients who are carers and carers who are patients – both adult and child carers.
49. Safe management and routing of calls through delivery of the requirements of telephony and IT sections 5.10 and 5.11

A full list of requirements can be found in the section below.

5.1. Aims and Objectives of Service

The vision for an Integrated Urgent Care Clinical Assessment Service (IUC CAS) is to deliver a “consult and complete” model of urgent care access that can streamline and improve patient care across the urgent care system.

The introduction of an IUC CAS will will fundamentally change the way patients access health services. **It will mean patients will receive a complete episode of care concluding with either: advice, a prescription, or an appointment for further assessment or treatment.**

5.2. Service Description/Care Pathway

A series of pilots have been conducted to inform the creation of the service specification and resulting Clinical Assessment Services (CASs).

Where NHS 111 and GP OOH services are currently integrated, or closely aligned, data shows (see Appendix A) that some patients are receiving quicker response times and there is less impact on higher acuity ‘downstream services’.

5.3. Access and Hours of Operation

5.3.1. Access Channels

The Provider shall make provision to receive contacts from the following channels:

- NHS111 Telephony
- On-line
- Video Relay based British Sign Language Interpreting Services

The Provider shall ensure that procured solutions have multimedia capability, including but not limited to:

- Instant Messaging / Web Chat
- E-mail
- SMS (text)
- MMS (picture)
- High definition picture files
- Video

5.3.2. Mapping Service Boundaries

The IUC service boundaries are well established. However, if changes are required, such as the amalgamation or splitting of contract areas the Commissioner shall liaise with neighbouring commissioners to agree any routing changes and instruct NHS England accordingly.

5.3.3. Opening Hours

The Provider shall operate:

- the telephony and online elements of IUC Service 24/7 365 days a year(including leap days); and
- the face-to-face service provision elements during periods when GP surgeries and extended access services in the contract area are not open (including protected learning time when contracted to do so).

5.3.4. Population Covered

The Provider shall receive calls and provide consultation for patients who:

- Are registered with a GP within the geographic area specified in the contract;
- Are registered outside the geographic area specified in the contract but who call from a telephone National Numbering Group (NNG) allocated by NHS England to the provider;
- Call NHS 111 but cannot be identified geographically and are therefore sent to the provider via the NHS 111 national telephony platform (according to their allocated share); and
- Are unregistered and are calling from the geographic area covered by the contract.

In the event of National Contingency activation of a failure of the 111 Carrier, the Provider shall receive and provide consultation to calls from anywhere in England.

5.3.5. Clinical Assessment, Diagnosis and Advice

Commissioners are required to procure an IUC CAS service which:

a. Receives telephone calls via the NHS 111 number, as it is universal and free to call.
b. Assesses the initial call for severity via a Clinical Decision Support System (CDSS) triage tool which is then streamed to the most appropriate clinician when required. This may vary according to time of day, clinician availability, and locally agreed guidelines.
c. Has a responsible GP available 24/7 to allow for generalist clinical consultation at all times with other professionals employed according to times of local need.
d. Offers patients clinical consultations where appropriate, with the aim of completing the consultation on the telephone (“consult and complete” model). Where onward referral for face-to-face consultation is necessary the clinician shall have access either directly or via a specialist resource to directly book appointments.
e. In some existing GP OOH services, clinicians are supported in their decision making by either a CDSS or clinicians with locally agreed clinical protocols. NHS England is working with NHS Digital to develop a new CDSS that will

support both Health Advisors and clinicians throughout the clinical triage process. The new system will capture standardised clinical notes and will be fully documented to agreed quality levels.

f. Ensures all clinicians within the IUC CAS, whether physically co-located or working remotely, shall work to standard professional competencies and must be exposed to regular review and clinically led audit.

The professional composition of the IUC CAS will depend on local commissioning decisions but, as a minimum, shall incorporate those clinicians that the evaluations (Phase 1 and 2 Learning and Development, and the NHS 111 clinical impact evaluations) show to be effective. These include clinical pharmacists, nurses, paramedics, palliative care clinicians, mental health clinicians and paediatric nurses where available.

Providers are required to procure a suitable clinical quality assessment toolkit as described in Appendix B.

5.3.6. Face-to-Face Consultation and Treatment

The importance and value of locality based primary care centres, which at present co-ordinate and provide a range of services, must be recognised. These will not necessarily be co-located with NHS 111 call centres which by their nature are remote and often inaccessible to patients.

Integration and sharing of common functions between NHS 111 call centres and primary care centres (such as extended access centres), will be expected from now on and shall form the core requirements of an IUC Clinical Assessment Service.

Commissioners are required to procure an IUC CAS which:

a. Aligns with community based services, health and social care, as well as UTCs and A&E.
b. Provides the access point for these varied face-to-face services via the NHS 111 number and appropriate clinical triage. Co-location of primary care treatment centres with A&E provides a tried and tested means of dealing with patients with primary care needs but who present at A&E. This latter function will ensure the autonomy of the primary care service so they function as primary care services and not as subsections of hospital A&Es.
c. Ensures the new GP extended access appointments are made available for the direct booking function from a clinical assessment in accordance with the targets set out in Section: 7.6 – Performance Management.
d. Ensures the IUC Service shall have access to patient records, special patient notes and local records such as crisis plans.

e. Incorporates, where already provided, a safe supported discharge process, offering effective integrated primary, community, secondary and social care services, which are resourced, available and co-ordinated seven days a week. It is envisaged that this role will be developed in all IUC CAS eventually. The model must also take into account the complexities of the hospital discharge process.
f. A face-to-face consultation when required, which shall be conducted in an environment most appropriate to patient need at a designated face-to-face provider. The lead commissioner shall agree the locations that the provider will need to use for the purposes of face-to-face consultations and use either, Primary Care Centres, Urgent Treatment Centres or streaming facilities in local A&E departments. All face-to-face consultations shall meet the performance standards outlined in the contract.
g. All treatments provided at the designated IUC treatment centres during the out of hours periods shall be administered by a GP or an Advanced Nurse Practitioner or equivalent health or social care professional as appropriate.

5.3.7. Home Visits

Where it is clinically appropriate, the Commissioner must ensure that the Provider shall:

a. Offer face-to-face consultations with a clinician, including where necessary, at the patient's place of residence.
a. Home visits shall be completed by an appropriate member of a multidisciplinary team with direct access to more senior support. This can be achieved either through connectivity with the CAS or direct with the patient's GP.
b. Home visits shall be undertaken according to local protocols and pathways developed by the Provider and agreed with the lead commissioner to avoid unnecessary re-triage. Patients must be left with a written plan of care and the Provider shall ensure the patient's GP is informed of the visit and its outcomes by 08:00 the following morning.
c. Home visiting must be aligned with the hours of operation and provide adequate resource to assess patients at times of day that support the hospital admission profile.
d. The Provider shall ensure that the mode of transport, medicines management arrangements, availability and suitability of vehicles, the bases, the drivers and associated infrastructure and management controls are able to meet requirements. Vehicles must be suitable for reaching remote homes in adverse weather conditions so except in the most urban areas should have 4 wheel drive capability.

e. The home visiting service must also be available to the GP accepting calls from paramedics and care homes via a rapid access (star-line) telephony route.

5.4. Operating Model–111 Call Handling

Callers to NHS 111 are routed via the national NHS 111 telephony system to the organisation commissioned to receive NHS 111 calls in the geographic area from which the call originated.

The Provider may introduce a simple single layer "press1" style Interactive Voice Response (IVR) to stream callers to the most appropriate resource. For example, "*press 1 if you or the person you are calling about is feeling unwell, press 2 for a repeat prescription, press 3 for dental enquiries*". The design of any such IVR menu must adhere to the Telephony Messaging Strategy found in Appendix F.

With the introduction of IUC some restrictions on how a call is handled have been removed. For example, calls can now be answered by additional staff types: either directly by a clinician (not using a CDSS) or by an intermediary member of staff (Administrator/Navigator) whose function is to record demographics and select the appropriate member of staff to conduct the consultation

When a caller speaks to a staff member this will generally be:

- An Administrator/Navigator – only for non-symptomatic callers or the streaming of those with care plans to appropriate clinician (A/N);
- A Health Advisor;
- Senior Health Advisor (as per the Workforce Blueprint);or
- A Clinician (The clinical advisors now in NHS 111 will be encompassed within the clinical model of the IUC CAS to avoid unnecessary duplication).

In future all clinicians will be expected to work with a CDSS or an agreed clinical protocol. - see Section 5.5

The introduction of Clinical Assessment Services (CAS) means that clinicians can either be locally employed by the NHS 111 call receiving organisation or procured as a service from a third party. Any such arrangements shall adhere to the guidance outlined in this document and any other requirements outlined in the CDSS licence. The Commissioner shall ensure that where multiple organisations are involved in providing the service that processes and technology are in place to facilitate operational requirements.

The Provider shall ensure that the IUC service is designed in accordance with the operating model principles outlined in the following sub sections.

5.4.1. NHS 111 Call Handling Process

It is essential when an NHS 111 call is answered that demographic details are accurately recorded. The patient's NHS number shall be verified using the Patient Demographic Service (PDS).

Callers must always be dealt with in a courteous manner. The capture of information either demographic, or for the purpose of assessment, must be carried out in an efficient way in accordance with the relevant CDSS licence and associated training programme. If an Advisor is unsure of how to proceed with a call they must seek advice from either a Senior Advisor or a clinician.

5.4.1.1. Demographics and Anonymous Callers

Demographics shall be recorded in the order and format set out by whatever host IT system is being employed, in line with requirements in the IUC Technical Standards pack. As stated above, the NHS number should be matched using the PDS.

Any caller has the right to remain anonymous. If a caller states that they wish to remain anonymous the Advisor shall still record some demographic details, this is necessary in order to carry out a safe assessment using a CDSS. These details include:

- Age (group)
- Gender
- Ethnicity

The Provider shall have policies and procedures to support vulnerable individuals where anonymity could cause problems.

5.4.1.2. Out of Area Calls

There will be occasions where a call is received from a patient who is calling from outside of the geographic area covered by the Provider contract. The Provider shall accept the call and assess the patient in the usual manner.

Depending on the systems used by the Provider there may not be the same level of access to patient records, care plans or service information as would be the case with a patient within the Provider's area. In any case the Provider must deal with the patient as fully as possible and utilise the national Directory of Services for onward referral information.

In the event that an out of area caller requires an ambulance, a manual referral to the ambulance service is likely to be required unless a mutual any-to-any arrangement exists. It is NHS England's aim that an electronic process is available in

the future. This must take place according to the process detailed in the Provider's operating procedures.

In the unlikely event of receiving a call from another UK country, the Provider shall assess the acuity of the call and if clinically appropriate, transfer the call to the local 111 service in that country using the call transfer process (an established 0300 number that allows advisors to select the required UK country). In the event that an ambulance is required, the Provider shall warm transfer the caller to 999.

5.4.1.3. Confirmation of the Patient's Registered GP and GP Choice

Traditionally, a patient's registered GP was always local to the patient's residence. However, from January 2015 patients have been able to register at the practice of their choosing. All GP practices are now able to register new patients who live outside the practice area. These GP Choice registrations are without any obligation to provide urgent home visits, or services out of hours under the GP Choice scheme. The patient pathway differs between 'in hours' and 'out of hours' and whether the patient is at home. Table 1 outlines expected arrangements.

Table 1

Patient at home (away from registered practice)	In Hours Patient shall access the GP Choice service as detailed on the Directory of Services (DoS) via NHS 111. The temporary resident (TR) and immediate and necessary treatment (INT) policies do not apply
	Out of Hours Patient should access routine out of hours service nearest to the patient or other urgent care provision via NHS 111
Patient near registered practice	In Hours Patient able to access registered surgery
	Out of Hours Patient should access routine out of hours services and other urgent care provision, including extended access GP services where commissioned via NHS 111

It is the responsibility of each CCG to ensure that services are commissioned for patients who require urgent primary medical care during the OOH period, when patients are in the area they live.

According to GP Choice policy, patients registered under the scheme are NOT able to access care via the 'Temporary Resident' (TR) scheme when they are at their residential address, as these are designed to meet the needs of patients temporarily away from home. In addition, these patients will NOT be able to access care via the

‘Immediately Necessary Treatment’ (INT) scheme except when the clinical need is owing to an accident or emergency. This is particularly an issue when there is an in-hours urgent primary care need and the patient is not near to their registered practice. For these in-hours urgent needs, local urgent primary medical care services have been commissioned. These are known as GP Choice services. Upon registering with the scheme patients are advised to contact NHS 111 if they require referral to their GP Choice service or OOH service when they need to access services at home.

The Provider shall put in place appropriate technical solutions and or operational procedures to handle GP Choice patients in accordance with the requirements set out in Table 1 above.

5.4.1.4. Callers Not Located with the Patient.

If a call is received from a person who is not located in the immediate vicinity of the patient, the Advisor must establish the following:

- Is the patient able to contact the service directly (This is by far the most preferable option)?
- Is the caller in the same building as the patient e.g. residential home? Are they able to move so they can see and talk to the patient whilst undertaking the assessment?
- Is the caller phoning from a remote care line contact centre on behalf of the patient?
- Is the patient contactable? If so, does the caller have the telephone number for the patient?
- Is there any reason the patient should not be contacted?

If the patient is contactable but implied permission to contact them directly cannot be ascertained (i.e. in the instance of the remote care line), the contact details of the original caller shall be recorded and clinical advice sought before the patient is contacted directly, so as not to unwillingly breach data protection principles.

If the patient is not contactable the Health Advisor must gain as much information about the patient’s condition as possible in order to decide what action should be taken, for example:

- Emergency ambulance dispatch;
- Dispatch of another resource be sent (GP visit, community nurse etc.); or
- No action required.

If necessary an Advisor must seek advice from a supervisor on what action is appropriate. In all cases details of the call must be recorded.

5.4.1.5. Clinical Assessment

When conducting a clinical assessment of the patient the safety and appropriate care of the patient must be the primary concern. Clinical assessment can be conducted with the support of a suitable CDSS, from advisor to clinician. The CDSS must be used in accordance with any licensing requirements set out by the CDSS supplier.

It is essential that the clinical assessment is properly recorded for audit, medical-legal, indemnity and professional regulation purposes. All calls must be recorded along with the primary reason for the call, and the disposition reached at the end of the assessment. If the call is required to be passed to another person (for example, a clinician) for further assessment this should be clearly indicated, including the name of any service the caller is referred onto. This forms part of the electronic record.

5.4.1.6. Non-Symptomatic Calls

Some callers will not be experiencing symptoms and may be calling to ask advice on a health related matter or will be seeking some form of health information. The advisor must clearly establish that there are no apparent symptoms being experienced. Once this is established the advisor must deal with the call appropriately using tools such as the DoS if the question relates to service information or repeat medication. We would not expect these calls to receive a clinical consultation, as the Advisor should be in a position to “complete” the call.

5.4.1.7. Speaking to a Clinician

If a warm-transfer takes place this must include a hand-over conversation between the advisor and the clinician which must be voice recorded.

5.4.1.8. Call Backs from Clinicians

Call backs must be conducted according to the urgency of the call and within any specified time limits. Clinicians undertaking telephone consultation must work within any governance requirements set out by the provider and in line with any national NHS England governance standards.

5.4.1.9. Assessment Outcomes

Once an assessment is complete the outcome must be clearly recorded. Dependent upon the nature of the outcome further actions may be required (for example, service referral). Any subsequent actions must also be recorded.

If a referral is required this must be done in accordance with the referral criteria/guidelines set out by the service to which the patient is being referred. If the service is listed on the DoS, referral instructions will be indicated in the DoS record. The provider shall adopt outcome codes as specified by the commissioner.

5.4.1.10. Enhanced Dispositions

Some dispositions reached through the use of a CDSS may benefit from further validation by a clinician (for example low acuity ambulance or A&E dispositions). Where further validation is required the Provider shall specify a clear operational process regarding how this should take place.

5.4.1.11. Discharge Processes

Once a call is completed, an outcome reached and any referral made, the patient must be given appropriate safety-netting advice and asked to re-contact the service should symptoms worsen or their condition changes.

The Provider shall send details of all consultations (including appropriate clinical information) to the GP practice where the patient is registered in the form of a Post Event Message (PEM) by 08:00 the following working morning (see section 5.14). In time this will be extended to dental practice. Where more than one organisation is involved in the provision of services, there must be clearly agreed responsibilities in respect of the transition of patient data.

If a patient is transferred to a clinician within the IUC CAS only a final PEM need be sent with outcome information.

5.4.1.12. Specific Caller Groups

The following are specific caller groups for whom particular processes must be followed:

5.4.1.12.1. Unregistered Patients

Callers who are resident in the Provider area and are not registered with a GP must be advised, when appropriate, to register and provided with information to enable registration. For the avoidance of doubt, calls from unregistered patients and patients without a permanent address must be handled.

5.4.1.12.2. Repeat Callers

In 2005 the Department of Health issued directions to ensure that any health professional assessing a patient's needs in the GP OOHs period would have access to the clinical records of any earlier contact that a patient (or their carer) may have recently made with the service.

If a patient (or their carer) calls NHS 111 three times in 4 days, on the third call the patient must be assessed to determine whether or not an ambulance is required. If an ambulance is not required the call must be transferred to a clinician. The GP must complete a thorough re-assessment of the patient's needs and have access to the details of all three calls

The Provider shall have agreements in place to feed and query the national Repeat Caller Service (RCS) that has been commissioned by NHS England for this purpose. Providers shall include summary details of the number of records sent, number of queries performed and the number of successful returns to/from the national RCS in their monthly reporting.

5.4.1.12.3. Frequent Callers

The Repeat Caller requirements detailed in 5.3.1.12.2 do not apply to that small minority of people who regularly make repeated calls (8 times in 1 month) to the same service, where the Provider has made separate arrangements to respond appropriately to those calls. The Repeat Caller protocol does not apply where there is an agreed care plan for the particular patient either (for example, palliative care, long term conditions etc.).

5.4.1.12.4. Mental Health and Vulnerable Callers

The Provider shall adhere to the principles of the Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis (18 February 2014) and work with commissioners and patient groups to ensure the most convenient and appropriate access to the service.

In accordance with the Mental Health Concordant, the Provider shall work with local mental health services to ensure the Service intervenes early and identifies appropriate callers to refer to local mental health crisis centres. The Provider shall ensure Advisors manage patients in line with local mental health crisis plans when they are available.

In most IUC CAS it is expected that a patient with primary mental health needs will be put through to a mental health nurse within the IUC CAS or straight through to the mental health provider commissioned within a community without needing to be sorted through the NHS 111 service, for example, via IVRs or through having tagged the callers number for bespoke treatment. When a call is routed directly to a dedicated resource, if the call is not answered in accordance with the KPI, the call must be routed back into the NHS 111 service. Where possible there must also be the ability to reroute a caller who has erroneously chosen the Mental Health option on an IVR to be rerouted quickly back to the NHS 111 service for assessment

5.4.1.12.5. Health information Callers

In general there are two categories of non-symptomatic health information requests:

- Where the caller may just want to know something about a health related topic or condition.

- Where the caller wishes to know about the provision of certain health services within their locality.

Where there is a non-symptomatic query relating to a health condition this must be referred to an appropriate Health Advisor or clinician. Service information queries can be dealt with using the DoS. In addition, callers could be directed to NHS Choices or other on-line sources of health information.

5.4.1.12.6. Health Care Professional Calls

The Service is expected to deal with calls from health care professionals (HCP) and potentially other professionals. This supports the 'No decision in isolation' ethos. Providers shall make arrangements available for HCPs and care home staff to have direct access to clinical advice (for example, through a direct telephone number or IVR arrangement). NHS England is currently evaluating a number of pilot sites that have supported staff working in Care Homes. This provides rapid access to a GP via NHS 111,, as a way of avoiding unnecessary ambulance conveyance or A&E attendance. This information will be made available once fully evaluated.

5.4.1.12.7. Rapid Access to GP (star-line) – Clinical Support

Urgent fast track access to a GP via NHS 111 offers a number of benefits:

- Evidence suggest that 60-80% of ambulance low acuity and A&E dispositions can be redirected to more clinically appropriate resources in the community;
- Rapid telephone advice (linking to separately commissioned in-hours GP or OOH GP visiting services) for care homes can help keep frail elderly patients in a safe supportive environment reducing the need for conveyance to hospital; and
- Use of the aforementioned GP resource to aid early recognition of sepsis, mitigating against the risk of GP surgeries being too busy to respond quickly to these cases (changes have been made to the NHS 111 triage algorithm to help pick up those patients who might have sepsis and the disposition will be speak to GP within 1 hour.

The desired outcome of these interventions is to offer better quality care closer to home by moving toward a "consult and complete" model.
The Provider shall provision 24/7 primary care response offering fast access to a senior clinician for the specific purpose of:

- Validation of low acuity ambulance calls;
- Validation of ED dispositions;
- Rapid telephone advice to care homes (star-line);
- Direct referral for sepsis cases; and

- Other groups such as Ambulance crews and community services, to support the no decision in isolation principle.

5.4.1.13. Self-care

Self-care advice shall be managed by an appropriate clinician (or Senior Health Advisor in the future, if defined in the Workforce Blueprint). Where a warm transfer for consultation from an Advisor is not possible the caller should be called back within an agreed timescale.

5.4.1.14. Business Continuity

The Commissioner shall ensure that the Provider fulfils any obligations set down in legislation, such as the Civil Contingency Act 2004, the Information Governance Toolkit and other relevant controls for Disaster Recovery and Business Continuity.

The Provider shall ensure that there are arrangements in place to invoke contingency and maintain acceptable service levels in the event of fluctuations in demand, technical failures or staff shortages. It is vital that the service remains safe for patients at all times. It is suggested that a collaborative provider-to-provider relationship, where possible geographically separated, would be a pragmatic approach to this. If providers are looking at implementing this approach then this must be undertaken in conjunction with NHS England and the Commissioner, so any changes that may be required to the telephone call routing can be implemented. Any arrangement of this sort must have clear agreement regarding how much activity could be potentially transferred to the support provider.

Commissioners and providers should be aware of their responsibilities to support national disaster recovery in the event that another service provider is unable to take calls due to some catastrophic event. In these circumstances, the NHS 111 National Contingency will be invoked and the Provider shall accept an appropriate proportion of calls in order to maintain national patient safety. The proportion of calls will be determined by the amount of activity each provider routinely experiences. Neither funding nor performances penalties shall be applied to the receiving call handling service in this situation. The Commissioner shall seek to establish retrospectively whether the catastrophic event was within the failing party's control and constituted a breach, or whether it should be classed as "force majeure".

The Provider shall ensure that Planned Engineering Works (PEW) are scheduled to minimise disruption and wherever possible undertaken in such a way as to avoid the need for invocation of National Contingency (in a staged manner or using local contingency arrangements). However, on a case by case basis NHS England will consider the use of National Contingency to cover PEW where there is a high risk of severe disruption to services.

The National Business Continuity Escalation Policy is available in a separate document[5]. The capacity of the Service should be sufficient to meet call volume and fluctuations in demand, in line with the National Quality Requirements. Providers shall plan their resources in relation to historical demand and ensure that any current trends in demand are also taken into account. Providers shall ensure that their capacity planning is conducted in liaison with other healthcare providers who may be affected by their outputs (for example, urgent face to face service providers, ambulance services, A&E departments).

5.4.1.15. Response to a Major Incident

The Service has a number of possible roles in response to a major incident. The Provider shall be engaged in planning and preparedness for these roles and must take part in the response if required to do so by NHS England, Public Health England (PHE) or a multi-agency gold command structure.

In certain major incident situations, such as a major chemical explosion, individuals may contact NHS 111 with concerns or symptoms. The Provider shall have mechanisms to identify this type of situation and must link with the appropriate commissioner and provider organisations to ensure appropriate business and service continuity arrangements are put into action.

The Provider shall have mechanisms in place to be informed of a major incident by the NHS and other agencies and to give out the appropriate public health advice as directed by Public Health England or the gold command arrangements which may be in place.

If a major outbreak of a serious infectious disease occurs then the Provider will be an essential component of the response and may experience very high levels of demand. It is likely that the Provider will be part of the NHS command arrangements and will be expected to respond as directed by NHS England.

Therefore, the Provider shall have:

- Staff trained to respond to a major incident at strategic level;
- Major incident plans in place;
- A programme of exercising and testing plans; and
- A plan for implementation of changes to systems to immediately meet the needs of the incident.

[5] https://www.england.nhs.uk/wp-content/uploads/2014/02/nhs111-escl-pol.pdf

The Provider shall include, as part of its Major Incident Plan and Business Continuity Plan, mechanisms, procedures and policies on how to identify any external forces that may affect services and how they plan to handle the matter. These external forces may include, but are not limited to, cyber-attacks, ambulance service strikes, acute hospital declarations of “OPEL level 4” status, resilience groups deciding issues that may affect service and other issues.

Any notification of a major incident made to the Provider must be notified to the Commissioner within 24 hours along with the plan to handle the incident.

5.5. Operating Model – Clinical Assessment Service

There will be a requirement for any Integrated Urgent Care Clinical Assessment Service to adopt a working model that:

- has timely call answering via NHS 111 (memorable, free to call number) by a Health Advisor who triages and streamlines the patient to the dedicated clinician in the CAS or other agreed provider;
- has sufficient multidisciplinary clinicians available to speak to the patient, in an appropriate timescale, to consult and complete the patient’s need;
- can directly book a face to face appointment for the patient;
- can prescribe electronically; and
- can electronically send self-help information to the patient in order to complete the call.

The Provider shall ensure that the IUC service is designed in accordance with the “consult and complete” operating model principles outlined in the following sub sections.

5.5.1. Appointment Booking

It is a key target of IUC that all appointments can be booked using Direct Appointment Booking. Direct Appointment Booking refers to the ability of the Provider to book an appointment at a destination service, preferably by way of direct technical interoperability between the Provider’s chosen clinical workflow system and the clinical system used by the destination service.

The Provider shall implement a solution capable of direct appointment booking with destination services through the chosen clinical workflow system. Direct appointment booking shall be available for both in-hours services (such as, GP Surgeries) and urgent care services (such as, Urgent Treatment Centres, Out of hours GP and extended access same day services and in time dental services where commissioned).

The Commissioner shall ensure that multi-provider commissioning arrangements are designed to enable collaboration for the purposes of Direct Appointment Booking.

The chosen clinical workflow system must make use of nationally-defined interoperability for direct appointment booking, where available and appropriate to the workflows.

Whilst these national APIs are still in development commissioners are advised to make use of other locally-available technical solutions to facilitate direct appointment booking. Where local technical solutions are available, the Commissioner and the Provider shall ensure that appropriate plans are in place for migration to a nationally-defined solution when it becomes a viable option.

To support winter planning NHS England and NHS Digital are working with Regional Teams and system suppliers to fast track the availability of interim technical solutions that will enable direct booking between urgent care and general practice

5.5.2. Streaming

Callers will access the service by the following routes:

- NHS 111 Telephony
- On-line
- Ambulance Trust (in the future).

As described in Section 5.3, callers entering through the NHS 111 telephony channel will have undergone an initial assessment before being streamed to the Clinical Assessment Service. This will have included the capture of demographics. A call entering via the on-line channel will have undergone a similar assessment on-line prior to being passed to the Clinical Assessment Service. On receipt of these calls, the Clinical Assessment Service must validate the demographics and if necessary run a PDS match before placing the call in the appropriate clinical queue for assessment.

5.5.3. Low Acuity Ambulance Validation

The Provider shall undertake further clinical review of low acuity ambulance calls that originate in NHS 111 in line with the existing arrangements. Following the publication of the Ambulance Response Programme, commissioners should now consider arrangements for managing some of those low acuity ambulance calls that originate through the 999 service and are coded as C4H (suitable for Hear & Treat), within the CAS. As this is a new category it will be reviewed in Spring 2018 and the expectation is that the number of calls in this group will increase over time. To avoid the need to call patients back this will involve the warm transfer of calls between services.

5.5.3.1. Standard Operating Procedure for Low Acuity Ambulance Validation and A&E Disposition Validation in NHS 111 Services and IUC CAS

The Provider shall, in conjunction with NHS England and the Commissioner, develop operating procedures covering the validation of low acuity ambulance and A&E dispositions.

Operating procedures shall include, but not be limited to:

- A joint agreement between the NHS 111, 999 and CAS services with all relevant parties being named;
- A clear diagram showing the flow of calls expected with detail of individual roles at each step;
- A description of the clinical consultation – who, how, where, when (e.g. floor walker, NHS 111 clinician, GP OOH clinician);
- Clear descriptions of which CDSS disposition codes are expected to be transferred to the clinician (see guidance in Appendix C);
- Prioritisation method - how the call is passed and flagged to receiving clinician;
- Agreement on timelines for call backs;
- Protocol for management of breaches of call back times;
- Documentation on clear lines of accountability at each stage of the process;
- Clear data collection on numbers of calls being handled by a clinician and subsequent outcome;
- Measurement of true outcome (the recording of all clinician advice must occur in a way that identifies the clinician and is accessible / retrievable for subsequent review if required. It was suggested that if the facility to record this advice existed within the host system in a way that shows at what point in the process the advice was given this would be an additional advantage);
- Risk management processes at the sending and receiving end to identify (and if necessary conduct an enhanced handover - e.g. voice not just electronic) for patients felt to be higher risk than usual so that they are flagged within any clinical queue;
- The ability to evaluate outcomes of these systems (see above) and this must be shared to inform future developments;
- Audit practices for staff involved (e.g. CQI or toolkit);
- Participation in local IUC clinical governance and participation in call and end-to-end review if necessary;
- Record keeping (see section 6.3.1.5);
- Data sharing (see section 6.3.1.2); and
- Access control (see section 5.12).

5.6. Clinical Decision Support System (CDSS)/Clinical Triage and Assessment

5.6.1. Operational Principles

The fundamental principle of IUC is to identify what the patient needs as quickly and accurately as possible, then to be able to connect them with the care they need as seamlessly as possible.

Providers and commissioners of IUC CAS services need to ensure that the decisions being made about the urgency of presenting patients are underpinned with the best possible information and knowledge. This information needs to be part of the standard workflow of a patient interaction. Staff need to be directed, guided and/or supported depending on their role, their competency, the complexity of patient case and the level of clinical decision making they are expected to undertake.

Clinical decision support systems offer a critical component of the IUC CAS assessment process. There are three key stages of the patient journey where clinical decision support systems need to be applied:

- Assessing symptoms to initially identify patient need / risk (either over the telephone, by an advisor, or in some cases an interaction that has started with the patient using a digital 111 online service);
- Gathering further information to ensure case streaming to the right clinical care or gathering information to aid the clinical consultation process; and
- Supporting the clinical consultation and delivering the right care (this may be remotely within the clinical assessment service or by connecting to local pathways of care where has been designed locally).

Where a call can only be appropriately assessed or closed with clinical intervention, the patient needs to be transferred to the clinician with a suitable level of competency in an appropriate timescale and as much as possible where clinically appropriate, consulted and completed on the phone. Where a face–to-face appointment is needed, this must be directly booked. It is important to provide the patient with confidence that the care they need will be provided and reduce the likelihood that they will defer to a higher acuity service.

5.6.2. Role Based Workflow

The Provider shall ensure that the initial call in to the Health Advisor fulfils the following functions and records the information accurately:

- Asking an initial open question "*what can we do for you today*?" Or "*how can we help you today*" to inform the subsequent consultation with the clinician (Rationale - International studies have shown that patient behaviour after an

interaction with a remote clinical assessment service is influenced by what the patient wanted or believed they needed in the first place*);*
- Initial acuity assessment and elimination of life threatening conditions standard questions;
- Capture of patient demographics;
- Ambulance dispatch where needed; and
- Call streaming via appropriate decision support triage tool to competent registered clinician.

The Provider shall ensure that the clinician uses clear clinical protocols, guidelines or systems that are supported by training and monitoring to ensure they are understood and applied. It is recognised that from time to time clinical situations will occur in IUC for which there are no clear guidelines or protocols. In such cases, careful application of mature clinical experience must be brought to bear, and training and monitoring must include explicit focus on this area of challenge. This is necessary to support and standardise the clinical consultation (Rationale: Evidence[6] shows that where any clinician uses a CDSS the outcomes are consistently better for patients and that good clinical practice occurs in organisations where there are formal protocols that individuals with agreed competencies are expected to work with).

Combining local protocols with clinical algorithms within CDSS systems is acceptable provided this has the following attributes:

- Local Clinical Governance approval with defined processes for monitoring and assuring ongoing clinical safety;
- Commissioners and providers explicitly address how this may affect any licensing agreements with existing CDSS providers and any resultant medical legal liability resides with the local service;
- Direct connection with the Electronic Prescribing Service (EPS) is established and embedded as part of the clinical workflow within the IUC CAS (Rationale: For patients needing a prescription following a remote/telephone consultation this can be done without requiring a face-to-face appointment, this approach is widely used across general practice);
- Link to the Directory of Services, this needs to enable the clinician to search for available services based on clinical judgement that maybe broader than the CDSS disposition service set; and
- The clinical workflow enables a patient to be referred to or booked directly to a face-to-face service only following clinical assessment.

The Commissioner shall ensure that directly bookable services are made available in the DoS and through local commissioning arrangements.

[6] Jaspers MWM, et al. Effects of clinical decision support systems on practitioner performance and patient outcomes: a synthesis of high-quality systematic review findings. J Am Med Informatics Assoc. 2011. 18(3) 327-34.

5.6.3. Commissioning and Procurement of CDSS

The Provider shall ensure that any procured CDSS meets the following standards:

- It has been robustly tested within the NHS in England;
- It has been demonstrated to be safe, appropriate for each staff / clinical competency level within the IUC CAS;
- It has an assured evidence base that demonstrates clinical safety;
- It is able to electronically dispatch an ambulance as an integral part of the workflow;
- It can be seamlessly connected to the Directory of Service via the defined ITK messaging standards (see Appendix D);
- It has been assessed by MHRA as not being a medical device or be accredited by MHRA as a medical device ;
- It meets the relevant Information Governance standards; and
- It demonstrates compliance with relevant ISO standards.

In line with the deliverables in the Five Year Forward View, CDSS tools that have been identified through previous EU Prior Information Notices (PIN) are being tested across different local providers in partnership with commissioners. Whilst commissioners are at liberty to procure local systems that adhere to the standards set out above and for 111 online products (covered in section 5.26 of this document) this will need to happen before December 2017. It is important to note that with the delivery of the Clinical Triage Platform in 2019 (see Appendix H) , procurements should be time-limited to ensure that commissioners can take advantage of the benefits of the standards, testing and evidence that will define the Clinical Triage Platform and related products when these become available.

5.6.4. Safety Standards

The Provider shall ensure that the triage products and CDSS meet relevant safety standards in accordance to CQC guidelines.

5.6.5. Governance

The Commissioner shall ensure appropriate clinical and information governance models to govern the use of the CDSS are in place with the Providers. This should include consideration of the minimum data set, other mandatory reporting and appropriate assurance to the commissioner.

5.7. Service Directory & Capacity Management

A service directory that can provide accurate, real-time information to users is of paramount importance to the success of IUC. It is a key enabler to achieving ‘channel-shift’ by promoting alternative pathways to acute emergency and primary care services. It should be seen by urgent care commissioners as the cornerstone workflow engine of their IUC provision: driving clinically and financially efficient

outcomes for patients; informing commissioners of optimal service design, and; subject to a robust governance process.

The Provider shall link to and use the NHS Directory of Services (DoS) for access to information regarding all commissioned healthcare services across England.

The NHS DoS identifies:

- Where services are situated;
- When those services are open;
- The staff and skill sets they employ;
- The types of clinical presentations they are commissioned to respond to;
- The referral method they accept;
- The patient cohort they accept; and
- Service capacity.

The DoS system (database and search functionality) is commissioned centrally by NHS England and delivered by NHS Digital. However, the responsibility to maintain the data held within it, in accordance with both nationally specified standards and local requirements, resides with the CCGs working collaboratively with other commissioners such as NHS England, Public Health England and Local Authorities. Full responsibilities are outlined in the DoS Roles and Responsibilities document (see Appendix E).

The DoS is partitioned into local directories, which together form one national database. Thus accurate information about services in any part of England can be accessed from any other area, enabling enquiries to be serviced from anywhere in the country.

The Commissioner shall:

- **Establish a named role or contact** from all NHS services that is responsible for validating their DoS entry with the DoS workforce (in terms of demographics, opening hours, capacity and clinical releases), incorporated within Service contracts.
- **Ensure arrangements are in place for all DoS entries** to be accurate and up-to-date at all times across the 24/7 period 365 days a year.
- **Promote the DoS Provider and Commissioner Helpline number** (0300 0200 363) to all stakeholders requiring the ability to request changes to DoS at any time across the 24/7 period 365 days a year.
- **Ensure that an expert and well-trained DoS workforce is available** to engage with all providers and service commissioners in order to help them describe their services in DoS-specific terms, and to effectively maintain and

update systems providing access to their service information (including but not limited to updating, profiling and ranking changes).

- **Ensure that their DoS workforce has undergone a programme of appropriate training** for the role and that they partake in regular educational/updating sessions at both regional and national levels (including but not limited to Advisor level CDSS training).
- **Ensure the ranking and profiling of service returns on the DoS is in line with national strategies:** on providing care closer to home at lower-acuity and lower-cost specialist settings, reserving emergency locations of care for those patients that truly require them.
- **Ensure that the DoS workforce employed to maintain service information meet the specific requirements of the DoS Resource Guide and / or produced the desired outputs** (Appendix E).
- **Make conjoint arrangements with outside agencies (for example, a Local Authority)** to enable the addition of services from social care, mental health, public health, community providers and third-sector services so as to improve accessibility for patients to these services.
- **Ensure that service information collected from social care, mental health and the third sector is consistent** with the quality of data collected from NHS services in terms of accuracy and timeliness.
- **Ensure that the access to service information for services within and outside the NHS is completed without duplication across directories**.
- **Ensure that adequate resource is allocated to testing of service information returns** to providers following profiling changes and/or CDSS upgrades (including but not limited to well documented clinical sign off by CCG Clinical Leads and responding to service improvements identified during live operations or as a result of improvement initiatives).
- **Work with the local IUC provider and other associated providers to ensure that follow up information is available to the person calling the IUC service** by (for example) text message or e-mail confirmation with details of the service.
- **Ensure that regularly updated Standard Operating Procedures are in place** for managing the day-to-day access to service information, business continuity in the event that service information cannot be accessed, and approaches to handling calls where access to service information does not correctly link to the CDSS. (Where national initiatives provide solutions to continuity of access to service information, work with its providers to support these initiatives).
- **Implement operating procedures to enable the capture of feedback** from IUC Service staff relating to improvement of access to service information.

- **Ensure their DoS entries are configured to respond to specific patient requirements** (e.g. frailty, domiciliary services and GP Choice).
- **Adhere to the requirements of the nationally agreed DoS Profiling Principles and the DoS Quality Review** (see Appendix E), as specified by NHS England .
- **Ensure the Provider's clinical systems are in line with the IUC Technical Standards** in terms of nationally specified standards on data collection and provision, rejection analysis and DoS display screens.
- **Ensure callers requiring public sector services outside the scope of IUC will be signposted to an alternative service or single point of access through the DoS**.

5.8. Workforce

The success of IUC Services is reliant on a range of factors, including the workforce – both the clinical and non-clinical staff – working together with a focus on providing excellence in patient care.

The elements of the workforce specification are based on the outcomes of the Joint National IUC CAS and NHS 111 Workforce Development Programme, a three-year collaborative programme between NHS England and Health Education England with input from a range of key stakeholders, such as provider organisations, commissioners, professional bodies and Royal Colleges.

The IUC CAS / NHS 111 Workforce Blueprint will be published by early 2018, which will set the key guidance and standards for the IUC workforce. NHS England will continue to work with commissioners during the implementation and delivery of the Workforce Blueprint.

5.8.1. Introduction and Underlying Principles

The national IUC CAS / NHS 111 Workforce Development Programme was established to identify the workforce requirements for the future, in response to the Five Year Forward View for the NHS[7] and Transforming Urgent & Emergency Care Services in England[8] to:

- Define the optimal composition, scope of practice, competencies and associated development needs in the NHS 111 environment;
- Develop a career framework for clinical and non-clinical roles;
- Develop standardised competency-based job descriptions for patient-facing roles Skills for Health Levels 2 to 7; and

[7] Five Year Forward View
[8] Transforming Urgent & Emergency Care Services in England

- Identify core and specialist competences for Skills for Health Levels 7 to 9 roles within the CAS.

These will provide uniformity amongst the workforce, whilst allowing local flexibility across the country.

5.8.2. Non-clinical Telephone/Remote Workforce

Commissioners shall ensure that services are commissioned for quality, that there is a clear understanding of what a high quality workforce is and what systems are required to ensure the maintenance and governance of this workforce. This includes continuous quality improvement systems to include appraisal and feedback for staff to complement robust and high quality personal development and recruitment in addition to audit processes associated with the Clinical Decision Support System (CDSS).

5.8.3. Clinical Telephone/Remote Workforce

Within the IUC contact environment, clinicians will perform multiple roles, providing direct patient contact, clinical supervision and support of the non-registered staff working within the environment. The commissioning arrangements must facilitate and support this. There is also an opportunity to consider the rotation of staff through providers across urgent and emergency care to maintain and develop their skills and foster knowledge sharing, acknowledging that working in the remote/telephone environment requires specific competences.

All clinical staff must be trained in line with the CDSS used in the operational service. However, their practice must not be restricted to solely operating within the scope of the CDSS. In addition their practice outside of CDSS must include the necessary specialist competences and capability to work safely and effectively within the remote urgent and emergency care environment.

The IUC CAS/NHS 111 clinical workforce will require specialised skills and competences in remote telephone assessment as defined in the forthcoming Workforce Blueprint.

Provisioning and maintaining the workforce will require a strategic and tactical regional view, involving provider organisations, commissioners, networks, Sustainability Transformation Plans (STPs) and regional Health Education England – including the Local Workforce Action Boards (LWABs). This support will be required to sustain but also innovate and develop practice, particularly around the introduction of the range of roles across the career framework, from Service Advisors to Specialist and Advanced Level Practice Clinician into the CAS. This will require the

introduction of contracts that support both rotational working and the ability to manage employment and activity across employing organisations.

5.8.4. Mental Health and Wellbeing

The wellbeing, mental health and career development of the IUC CAS/NHS 111 workforce is very important. The interventions required to support this range from appropriate levels of remuneration, and support and development for staff both professionally and in respect of their mental health and wellbeing through the use of the Employee Assistance Programmes.

The Provider shall ensure that:

- NICE guidance on promoting healthy workplaces is implemented[9];
- There are systems and processes in place to manage down staff turnover, maximise retention and encourage staff satisfaction;
- Interventions such as Mental Health First Aid, Mindfulness, Schwartz rounds or accredited equivalent are considered for implementation.

Taking part in the annual NHS staff survey is mandatory for all NHS Trusts – foundation trusts, acute and specialist hospital trusts, ambulance service trusts, mental health, community and learning disability trusts – but voluntary for other parts of the NHS such as clinical commissioning groups, social enterprises and commissioning support units.

In order to encourage retention of clinical and non-clinical staff, the Provider shall carry out an annual staff survey to assess the wellbeing of the workforce and identify where they need to invest to develop their organisation. This can be through taking part in the NHS annual staff survey as mandated, or through a bespoke annual staff engagement survey.

Employee pulse surveys are also recommended for continually assessing staff engagement. Staff engagement is linked to patient care and therefore measures of overall patient care and quality should be seen as indirect measures of the impact of the staff engagement strategy.[10]

5.8.5. IUC Clinical Assessment Service (CAS) workforce

The IUC CAS workforce will comprise generalist clinicians such as paramedics, nurses and GPs as well as specialised clinicians from a range of professions and

[9] NICE: *Mental wellbeing at work:* https://www.nice.org.uk/Guidance/PH22

[10] NHS Employers: How to develop a staff engagement strategy http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/staff-engagement/staff-engagement-resource-library/briefings-and-guidance/how-to-develop-a-staff-engagement-strategy

disciplines, including mental health, dental health, midwifery, pharmacy and paediatrics.

The competencies that will be required to deliver the service are being identified in response to the needs of service users and the services available for publication as part of the Workforce Blueprint.

IUC CAS clinicians may be based within the IUC CAS physically or virtually. It is feasible, therefore, that some professional groups will be directly employed by providers, others will be contracted in or work from other provider organisations, utilising a range of mechanisms (such as where appropriate, secondments or sub-contracted arrangements). Both of these mechanisms have limitations and it is important to ensure the appropriate solution is selected.

All clinicians working within the IUC CAS need to be supported and appraised to provide a consistently high quality service to patients and service users.

5.8.5.1. Potential Skill Mix

An IUC CAS will typically comprise of a range of clinicians offering different clinical skills, including: GPs; pharmacists; mental health nurses; dental nurses, allied health professionals and specialist hospital clinicians. Other than for GPs performing the Clinical Navigator role, the skill mix in the IUC CAS will be for local determination.

The Provider shall develop a workforce strategy, to be agreed by the Commissioner, taking into account the following principles:

- Integrated working across the current workforce deployed within NHS 111 and OOH services;
- The ratio and composition of the workforce in the IUC CAS must be flexible by hours and days, in order to meet the patients' needs and demands on the service;
- 24/7 GP presence is a key requirement of an IUC CAS to enable the clinical consultation function;
- Increased closure of calls by clinical consultation, involving a "consult and complete" model to decrease face to face assessments;
- Faster, better access for patients to an appropriate clinician; and
- Medical and non-medical prescribers must have access to the appropriate prescribing capability, e.g. electronic prescription service, to support access to medicines where clinically required (see section 5.13.1: Prescribing).

5.8.5.2. Audit

The Provider shall develop and utilise a standardised audit system for all clinical staff which supports good governance.

All clinicians must receive regular, at a minimum quarterly feedback on their performance, including standardised feedback on triage, clinical decisions, treatment and complaints. This is in addition to review of incidents, near misses and serious incidents.

Audit forms part of good governance and staff support, and the Provider shall implement the recommendations within the Workforce Blueprint product around governance when published.

5.8.6. IUC CAS / NHS 111 Workforce Blueprint

The IUC CAS / NHS 111 Workforce Blueprint will be published in early 2018 as a key resource for commissioning the workforce, planning and governance. To find out more about future tools to support workforce development - see Appendix J

5.8.7. Recruitment, Retention and Vacancies

Recruitment and retention remains a key challenge across the current workforce. A number of the workforce products are aimed at creating a sustainable workforce through implementing a clear career structure with the development of competences and access to appropriate education and training, and to supporting a resilient workforce through mental health and wellbeing initiatives. The Commissioner and the Provider shall develop relationships with local HEE teams and LWABs to ensure that system-wide workforce planning is implemented.

The Provider and the Commissioner shall undertake pre-employment checks in accordance with the guidance set out by NHS Employers, which includes relevant criminal records checks. This can be found at: http://www.nhsemployers.org/case-studies-and-resources/2014/07/eligibility-for-dbs-checks-scenarios. These checks should be supplemented with robust processes that ensure that the right staff, with the appropriate competences, aptitudes and capabilities are selected.

5.8.8. Medicines and Poisons training

NHS 111 is now the primary user of the National Poisons Information Service (NPIS) to support the handling of accidental poisoning and overdose calls in urgent care. Toxbase is the recognised web based resource to support clinicians handling toxic ingestion calls and supporting decisions about self-care.

Feedback from NPIS and the Toxbase service indicates that training of clinicians working in urgent care contact centres is essential to support safe decision making and managing patients who can be advised to stay at home or need to attend Emergency Departments for clinical assessment.

The Provider shall ensure that where Toxbase is accessed, all clinicians undertake the eToxbase learning module supported by additional medicines and eBNF training in the context of therapeutic overdose.

In addition to the specifics around toxic ingestion, the Provider shall ensure that the clinical workforce has access to appropriate reference resources (i.e. medicines complete and training programmes to allow the appropriate management of polypharmacy issues presented by patients/callers with complex needs).

Further Information can be found at https://www.toxbase.org/

5.8.9. Other Specialist Training

The Provider shall ensure that staff undergo specialist training in areas including but not limited to:

- Dementia;
- Mental Health; and
- Suicidal Callers.

5.9. Interoperability

Interoperability between IUC services is a fundamental enabler ensuring that service providers can facilitate a consistent and integrated journey for patients. The highly distributed and varied nature of IUC services and providers emphasises the need for excellent organisational interoperability.

The Provider shall use a clinical workflow system that can support the following interoperability requirements, in line with the IUC Technical Standards pack found in Appendix D.

5.9.1. Referrals and Transfers (covering Sending, Receiving, Content, and Endpoints)

All patient encounters that are electronically transferred between IUC service providers must follow the interoperability standards defined in the Integrated Urgent Care Technical Standards pack.

5.9.2. Transferring/Referring Patients between Services

All patient transfers and referrals between IUC services must make use of the defined interoperability standards for referrals and transfers (often referred to as ITK Messaging).

The Provider shall identify the interoperability roles that need to be fulfilled, and ensure that the chosen clinical workflow system supports the specific interoperability requirements required for those roles. In the majority of cases, service providers

should require their clinical workflow system to support all possible interoperability workflows as this provides the greatest flexibility for introduction of new service models in the future.

The key transfer/referral interoperability roles are:

- Service provider transferring or referring a patient to another IUC service; and
- Service provider receiving a patient from another IUC service.

The architecture must be designed in such a way as to enable end to end reporting (see Section 7.6.2). In addition the IUC interoperability strategy forms part of the developing NHS Target Architecture. This drives the implementation of the STP based IT operating model as set out in the FYFV.

5.9.3. Directory of Services

The Provider shall ensure that the chosen clinical workflow system has technical integration with the National Directory of Services (DoS) allowing the appropriate search and retrieval of service information. Further information on technical integration requirements can be found in the IUC Technical Standards pack.

5.9.4. Appointment Booking

The Provider shall ensure that the chosen clinical workflow system supports the direct booking of appointments into other service provider systems – including dental in the future. For more information see section 5.4.1 – Appointment Booking.

5.9.5. Ambulance Requests

The Provider shall ensure that the chosen clinical workflow system supports direct ambulance requests using the ambulance interoperability standards (also referred to as ITK Messaging) in line with the IUC Technical Standards.

The chosen clinical workflow system must provide a way of automatically identifying the appropriate ambulance service for a patient – this can make use of either local functionality or a nationally provided directory.

The chosen clinical workflow system must ensure that ambulance request functionality can be made available to appropriate users flexibly in order to support both existing and potential service workflows within IUC.

5.9.6. Continuation of Triage

It is important that a patient does not have assessments repeated when moving through IUC.

The Provider shall ensure that it is possible for existing assessments to be continued where possible (e.g. using the NHS Pathways validation functionality) regardless of whether this is being completed in the same system in which the triage was started.

In the event that an assessment is passed to a clinician using a different clinical workflow system, those systems must support the necessary interoperability to transfer the assessment in a structured form to allow validation and continuity. The messaging standards do not officially support the continuation of an NHS Pathways triage across different systems. However, any referrals must include information relating to previous consultations.

5.9.7. Repeat Caller Service (RCS)

The National Repeat Caller Service exists to ensure that any health care professional assessing a patient's needs within IUC will have access to the clinical records of any recent contacts made with IUC by or on behalf of that patient.

The Provider shall ensure that the chosen clinical workflow system has ability to integrate with the National Repeat Caller Service. The Repeat Caller Service must be automatically queried at the beginning of the patient's encounter with Integrated Urgent Care. In the instance that first contact is made directly with a service other than the telephony service (such as, a Clinical Assessment Service), the Repeat Caller Service query shall be performed by whichever clinical workflow system is used at the first contact.

The Provider shall ensure for patients referred to Integrated Urgent Care from an Online Digital Service, a Repeat Caller query is performed after the patient identity has been confirmed. If this has not been completed by the Online Digital Service, it must be performed within the receiving clinical workflow system.

Where a patient is highlighted as a repeat caller by the Repeat Caller Service, the chosen clinical workflow system must enable an alternative workflow in line with the call handling process for repeat callers.

Note: this technical integration is specific to Repeat Callers and the National Repeat Caller Service and does support the identification of frequent callers, or those with designated care plans.

Although the Repeat Caller Service is currently built to meet a specific set of requirements in line with the existing IUC Repeat Caller processes, the Provider shall ensure that the chosen clinical workflow system can be updated to encompass changes to the service in the future.

Further information on the technical integration requirements for the Repeat Caller Service can be found in the IUC Technical Standards.

5.9.8. Post Event Messaging

The Provider shall ensure that the chosen workflow system has the ability to send an electronic Post Event Message to a patient's registered GP surgery by 08:00 the next working day.

For more information see section: "5.16. Post Event Messages (PEM)".

5.9.9. Online/Digital Services

As online services are being planned and deployed Providers and commissioners will need to consider how the chosen Clinical Workflow System interoperates with the Online Digital Services. In order for Online Digital Services to complement and enhance IUC, it is essential that they provide an integrated patient journey and are seamlessly embedded into the operational processes of the local IUC.

Online Digital Services will perform an element of triage, once a disposition is complete the emphasis needs to be on connecting a patient to IUC services rather than just signposting to services.

The Provider shall ensure that patient entered information captured by the Online Digital Service can flow to support the clinical assessment to avoid duplication of effort and repetition for the patient and clinical staff.

The Commissioner shall ensure that all new contracts for IUC services include provision to support integration and interoperation with Online Digital Services.

The Commissioner shall ensure that all online services are integrated with local IUC services.

For further information on technical interoperability with Online Digital Services, commissioners and providers should refer to the IUC Technical Standards[11].

5.10. Telephony & IT Systems

5.10.1. The Function of the National 111 Telephony Platform

5.10.2. Hosting and charge reversal

The 111 number is hosted on the chosen telephone carrier's network (the 111 Carrier) through a contract procured centrally by NHS England. It is free to call 111

[11] These are being updated for online to be published in August 2017.

from landlines and mobiles, with call charges being automatically reversed in the form of an “inbound-call-charge”, which is levied on the contract holder. For the avoidance of doubt, the cost of hosting the 111 number and reversing the call charge in England is borne by NHS England and not recharged to the Provider.

5.10.3. Other users of 111

The 111 number is available across the whole of the UK national numbering scheme (any country using UK area codes). Devolved Administrations such as Scotland and Wales procure services directly from the 111 Carrier in their locality through side agreements to the main NHS England contract.

In the event of a flu pandemic, the 111 number will also be used by Public Health England (PHE) to access the National Pandemic Flu Service (NPFS). When NPFS is activated, this is achieved by a “*press 2 for antivirals*” style menu option at the front of 111 which will route calls to dedicated NPFS contact centres.

5.10.4. Location based routing

The underlying principle behind 111 call routing is that the call should where ever possible be delivered to the provider covering the area from which the call originated.

Where available, the location of a caller is identified using information sent to the 111 Carrier by the caller’s network operator. In the case of landlines the National Numbering Group (NNG), formerly known as STD or area code, is used. For mobiles the mast from which the call originated or the emergency zone (a group of masts in a specific area) is used.

If it is not possible to determine the location using information from the caller’s network, for example in the case of internet phones, a natural voice recognition system is used. The system asks the caller to state their nearest large town or city (borough, tube or rail station in London) in order to determine the origin of the call. After two attempts, if the caller fails to respond or the response is not recognised, the call is classed as Location Unknown.

In a small number of cases where an NNG, mobile mast or emergency zone straddles a border between providers, a simple “*press 1 if you are in North Essex or 2 if you are in South Essex*” style call steering mechanism is used.

The Commissioner shall work with the NHS England IUC Team to map postal towns and cities, NNG, mobile masts and emergency zones to the Provider’s catchment area. Where necessary the Commissioner shall liaise with bordering commissioners.

5.10.5. Location Unknown Calls

Any calls where location could not be determined are distributed amongst all providers based on each provider's normal share of the national call volume.

The Provider shall handle any Location Unknown Calls on a reciprocal basis treating them as if they had originated from the Provider's catchment area and form part of the contracted volume. For the avoidance of doubt, no recharges will be levied on the caller's local commissioner.

5.10.6. Call Steering - Interactive Voice Response (IVR)

The 111 Carrier's platform is capable of providing Interactive Voice Response (IVR) functionality (e.g. "*press 1 if you or the person you are calling about is feeling unwell, press 2 for repeat prescriptions*…"). This functionality can be requested by the Commissioner when services are delivered by multiple providers or when the Provider is unable to implement such functionality within the required timescales.

5.10.7. Resilience

The 111 Carrier's platform is located across multiple data centres for resilience. In the extremely unlikely event of the primary platform failing, the 111 Carrier's underlying network can continue to route 111 calls using what is known as 'default routing'. This involves distributing 111 calls across providers using the same principles as Location Unknown Routing.

When 'default routing' is active, the Provider shall treat these substitutional calls as if they had originated from the Provider's catchment area and form part of the contracted volume. For the avoidance of doubt, no recharges will be levied on the caller's local commissioner.

5.10.8. National Contingency

If a provider suffers a major technical failure or site evacuation, NHS England can re-route calls to the remaining providers based on their normal share of the 111 call volume (adjusted to compensate for the absence of the failing provider).

The Provider shall handle any National Contingency calls on a reciprocal basis treating them as if they had originated from The Provider's catchment area and form part of the contracted volume. For the avoidance of doubt, no recharges will be levied on the caller's local commissioner or failing provider.

In exceptional circumstances, if a provider is deemed to have become clinically unsafe, a percentage of calls can be re-routed away from that provider using National Contingency.

The Commissioner shall monitor the use of National Contingency. If the Provider's use of National Contingency is deemed to constitute a breach of Key Performance Indicators (KPI) or contract, appropriate action shall be taken. This will include but not be limited to invocation of service credits and the contractual remedies process.

5.10.9. Maintenance of The 111 Carrier's Platform

Where possible, maintenance work on the 111 Carrier's platform will be carried out during quiet periods (predominantly Tuesday to Thursday 10:00 to 16:00).

5.10.10. Local Planned Engineering Works (PEW)

Where possible all local Planned Engineering Works on the Provider's systems should be undertaken in such a way as to avoid downtime.

On a case by case basis NHS England shall consider requests to use National Contingency to cover local Planned Engineering Works.

5.10.11. Receiving calls from 111

To deliver the 111 call to providers, the 111 Carrier's platform simply dials a delivery number. If that delivery number is busy or no front end announcement is detected, secondary or even tertiary numbers can be dialled.

If required, calls can be load balanced across two sets of delivery numbers. This is beneficial when delivering to larger providers operating split architecture. For the avoidance of doubt, this functionality can only be used at data centre level and cannot be used to mimic a virtual system across multiple contact centres.

The Provider shall issue delivery numbers to which 111 calls can be delivered. At a minimum delivery numbers are required for:

- Delivery of calls under normal circumstances
    - Primary
    - Secondary
    - Tertiary (optional)
- Delivery of National Contingency Calls
- Delivery of Unknown Location Calls
- Delivery of 'default routed" calls
- Any IVR options

In the event that a call cannot be delivered to the Provider, due to a fault or line congestion, a message stating that "*it has not been possible to connect your call"* is played to the caller *(*known as the Technical Difficulties message*)*. The Provider shall take appropriate action to ensure that the Technical Difficulties message is not played. This should include but not be limited to requesting that the 111 Carrier

change delivery numbers to bypass faulty components and ensuring sufficient line capacity.
The porting of individual telephone numbers between carriers involves call redirection which in turn can result in carrier interconnect congestion. The Provider shall ensure that the chosen carrier has sufficient carrier interconnect capacity and where possible avoid previously ported numbers.

5.11. Local provider telephony and IT

5.11.1. Lines

The 111 Carrier's platform does not queue calls, as to do so would create significant reporting challenges. It is therefore essential that there are sufficient lines to support local queueing.

The Provider shall provision a minimum of 3 lines for every equipped agent position. These lines can be conventional ISDN or modern SIP, but where SIP is provisioned, at least one ISDN bearer is recommended as the primary circuit for resilience. Any traffic on SIP bearers should be uncompressed for optimum voice quality.

5.11.2. Automatic Call Distribution/PBX

The Provider shall procure a high availability Automatic Call Distribution system (ACD) to queue calls that cannot be delivered directly to agents.

Voice traffic shall be prioritised in accordance with manufacturer's guidelines and transverse the network in uncompressed format for optimum voice quality.

It is likely that in order to work as part of a clinical hub it will be necessary for some clinicians to work remotely, in particular those with specialist skills. This may involve individuals working from home or from their substantive place of work.

To facilitate remote working the Provider shall procure a solution to securely extend the contact centre telephony and desktop in such a way as to emulate the contact centre experience. This solution must utilise n3/HSCN circuits where available with any traffic over the public internet being encrypted using appropriate levels of encryption. To achieve this requirement an accredited VPN token authenticated solution, such as the one provided by n3/HSCN must be procured.

Although there are remote telephony solutions that allow both the voice and call control to traverse the public internet, they are reliant on extremely good internet connections. Home working solutions that allow the voice path to be established over the analogue public telephone network are preferable. These solutions keep the

telephone line open for the duration of the shift to ensure good audio quality and are less likely to suffer disconnections.[12] They also allow the call to be recorded at source on the Clinical Hub voice recording platform which is another essential requirement for all hub calls. The provider shall ensure that the procured solution supports home working.[13]

5.11.3. Desktop IT Systems

The Provider shall ensure that agent's desktop should be delivered using established virtual desktop technology in such a way as to ensure that there is no "data at rest" on the remote device. A softphone package should also be installed for telephone call control and access to real-time queue information.

5.11.4. Call Steering - Interactive Voice Response (IVR) & Announcements

The Provider shall procure a solution capable of "*press 1 for …*" type functionality to steer callers to the correct resource. Sufficient ports shall be provisioned to ensure that the initial call from the 111 Carrier's platform is answered within 5 seconds and that there is no noticeable inter announcement delay.

The Provider shall adhere to the IUC Telephony Messaging Standards (See Appendix F).

5.11.5. Voice Recording

The Provider shall ensure that all calls are voice recorded on extension side and that all conversations, including internal consultation and warm transfer requests, are recorded to a legally admissible standard. The Commissioner shall make specific reference to the retention period for voice recordings in the Records Retention Policy.

The Provider shall store voice recordings in accordance with the Records Retention Period. For the avoidance of doubt, this may involve the need to tag calls with the patient's date of birth to enable records to be purged when the retention period has elapsed.

5.11.6. Records Management

The Provider shall maintain all records in accordance with an NHS Information Governance compliant Records Management Policy (see section 6.3). The provider shall have in place appropriate systems for the appropriate management of records

[12] There are tariffs available to minimise the cost of this call which is established from the hub to the remote telephone for the duration of the shift.

[13] Although the aforementioned solution uses the existing telephone line, for health and safety reasons headsets are essential. In the case of business systems such as those used in GP practices, headsets are readily available. However, it may be necessary to procure new telephones for home based staff in order to ensure they can be used with suitable headsets.

at the end of any contract, including transfer, ongoing access agreements to meet medico-legal obligations and appropriate certified destruction.

5.11.7. Reporting Systems

The Provider shall procure reporting systems to satisfy the Commissioner's Minimum Data Set (MDS) requirements. A real-time reporting solution will also be required to service the Provider's intra-day performance management requirements.

5.11.8. Resilience and Capacity Planning

At a minimum the Provider's platforms shall employ a geographically separated resilient architecture avoiding single points of failure. All key components shall be powered by generator backed supplies with uninterruptable battery backup. Data and telephone lines shall be diversely routed and where possible sourced from multiple carriers or network providers. Any relevant preferential listings should be sought and all components shall be maintained in accordance with manufacturer's guidelines. For the avoidance of doubt, all maintenance contracts should include priority 24-hour, 365-day, on-site cover.

The Provider shall undertake regular capacity planning exercises to ensure that networks, platforms and lines are scaled to handle peak demand without degradation. It should not be assumed that roster fulfilment will be achieved; therefore modelling must take into account the impact of excessive queueing on lines, IVR ports and other technical components.

It is often the case that certain positions within the contact centre are only used at peak times. The Provider shall therefore undertake pre-busy period inspections to ensure that all workstations and phones are fully functional.

5.11.9. Security

The Provider shall ensure that appropriate security measures, in line with the Data Protect Act principles, are put in place to protect systems from malicious attack and or loss of data. This shall include but not be limited:

- Adherence to the National Data Guardian 10 Cyber Security standards[14]
- Penetration testing of any public internet facing components;
- Deployment of Intruder Protection Systems;
- Behavioural monitoring;
- Anti-Virus (AV) with real time updates; and
- Application of all security related patches where there is deemed to be a significant vulnerability.

[14] https://www.gov.uk/government/publications/cyber-risk-management-a-board-level-responsibility/10-steps-summary

5.11.10. British Sign Language (BSL)

NHS England has procured a British Sign Language (BSL) interpreting service through the 111 Carrier. BSL callers establish a video link with the interpreter via an app or link on NHS Choices. A voice call is then made by the interpreter into the correct provider after identifying the callers location based on the postcode. In the event that a call-back is required, a dedicated BSL call-back number has been issued (call back only works with the app and requires the app to be running to receive the call).

The Provider shall issue a separate delivery number for BSL interpreted calls. Due to the fact that an interpreted call takes longer than a normal voice call, and interpreters require regular breaks, priority should be given to answering these calls. It is also preferable to warm transfer as opposed to scheduling a call-back.

5.12. Referral to Other services

5.12.1. Ambulance Services

5.12.1.1. Roll out of Ambulance Response Programme (ARP)

The ARP aims to change the way ambulance services operate in England to release efficiencies and provide a more clinically focused response to all 999 calls. The ARP aims to improve ambulance service efficiency and stability through a new system of call handling and prioritisation. This aims to reduce long waits and improve the speed of response in rural areas.

As part of the ARP implementation and rollout, the Provider shall install an ARP-compliant CDSS version to ensure compliance with the ARP.

5.12.1.2. Implementing Hear and Treat/See and Treat

Following the full implementation of the ARP, the Provider shall cooperate with any initiatives that consider how the Clinical Assessment Service can be used for lower acuity ambulance calls, removing the need to have two separate clinical desks/services.

The Provider shall cooperate with any other initiatives or commissioning plans to align services such as Urgent Treatment Centres, NHS 111, Ambulance Services, OOHs and improved GP Access with face to face urgent care.
The Provider shall maximise the use of the Clinical Assessment Service to support opportunities to increase rates of Ambulance Service ‘Hear & Treat’ and ‘See & Treat’.

5.12.1.3. Using the Ambulance Workforce

The Provider shall consider the implications of the new Band 6 Paramedic Job Description to ensure enhanced clinical autonomy and delivery of 'Hear & Treat' and 'See & Treat'.

5.12.2. Primary Care Response

With the delivery of an IUC CAS the distinction between General Practice delivery in and out-of-hours is evolving.

The vast majority of urgent care will continue to be supplied by General Practice during their present opening hours, as individual practices and as groups of practices working together. General practice will also offer same day and pre-bookable evening and weekend appointments, with 100% offering this by by March 2019 and will be contingent upon GMS/PMS contractual arrangements. This additional capacity will be appropriate for urgent care needs in accordance with national requirements for extended access and will be bookable from NHS 111. However if a patient struggles to get access to General Practice at any time or is away from home the Provider shall make a GP telephony consultation available in the IUC CAS according to need.

The "generic" GP in the IUC CAS must be able to "consult and complete" for the majority of relevant cases or refer on for a face to face consultation where needed. It is vital that when a local GP practice is open AND it is considered essential that the patient see their own GP that the IUC CAS has access to the practice appointments for direct booking.

At present only 20% of the total call volume for NHS 111 occurs "in hours" and the requirement for a patient to be seen at their own GP practice is infrequent. The Commissioner shall work with local GP practices to model the demand for in-hours appointment slots. Bookings will be made from NHS 111 only if the patient has already been assessed and referred to primary care by a GP working within the NHS 111 service (IUC Clinical Assessment Service) or by other staff where locally agreed. The Commissioner shall work with the local extended access provider to model demand for appointment slots during the evening and at weekends.

It is important to note that where extra provision is made according to local need these are not lost in the commissioning of the new IUC CAS but encompassed within it. For example:

- In-patient care for community hospitals including 'clerking-in' new patients, ward rounds at weekends etc.;
- Cross cover for Urgent Treatment Centres and Primary Care Hubs;
- Palliative Care;

- Police Surgeon Cover;
- Social care cover;
- Emergency carers;
- Support for hospital discharge pathways/weekends for example;
- Care home clerking; and
- Where provided and subject to the required controls, Police Surgeon Cover.

5.12.2.1. Co-location with other services

Co-location with, and strong links to, other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector will also be beneficial in providing an effective and integrated service.

5.12.2.2. Standards for Urgent Treatment Centres

The Provider shall ensure that Urgent Treatment Centres conform to the Urgent Treatment Centre Standards set out in NHS England published guidance[15] and any local variances as stipulated by the Commissioner.

The Provider shall co-ordinate with services (including mental health and social care) to keep patients in the community and avoiding the easier but often more costly option of a hospital admission.

Examples of services include but are not limited to:

- Clinical advice and treatment;
- Home visits by clinicians;
- Community nurse visits;
- Palliative care team access;
- Mental health assessment, help and advice;
- Emergency dental services;
- Social services emergency duty teams;
- Pharmacy services; and
- Elderly care.

5.12.3. Dental Services

Management and Referral of callers with dental symptoms.

5.12.3.1. General Conditions

The Provider shall make provision for the following general conditions:

[15] https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres–principles-standards.pdf

- Call streaming through Interactive Voice Recognition or an equivalent system should be utilised for the management of callers with oral symptoms.
- Callers with dental symptoms must be managed using a clinical decision support tool operated by either health advisors or service advisors. Where dental professionals are handling these calls they must operate within their scope of practice and can use a decision support tool to guide them. .
- We expect dental calls to follow the same pathway as other calls to NHS 111 and to be re-routed to a relevant clinician if required and be available for the same operating period.
- The Provider shall refer to services returned in the Directory of Services, considering them (and as long as suitable then offering them to the patient) in the order returned where an end point has been provided to refer to that service through ITK or NHSmail.
- The Provider shall ensure that clinical staff receive suitable training on the management of callers with dental symptoms (including trauma) in order to appropriately refer or manage cases that cannot be referred to another service.
- The Provider shall ensure that all clinical staff working in the service have received training on Toxbase or its equivalent to ensure that analgesia overdose can be identified and managed amongst dental callers.

5.12.3.2. Commissioner Specific Requirements

The provider shall implement a solution capable of streaming calls to a local dental help and advice services where this has been commissioned by NHS England

Where NHS England has made available urgent access dental appointments the Provider shall implement a solution capable of booking patients into these appointments.

5.12.4. Other Services

When referring to any other services, the Provider shall implement electronic referral methods with appropriate prioritisation information as part of the agreed referral protocol to ensure callers do not have to repeat themselves other than to validate who they are / any symptom changes. Where a patient is identified as needing to attend another service, the Provider shall, where technically possible and requested by the Commissioner, electronically book an appointment.

Where a patient has received a consultation from a clinician in the IUC CAS and a face to face appointment is deemed necessary it must be directly booked according to need where:

- a ‘generic’ GP or nurse resource can be used in an urgent community provider, it must also be booked; or
- it is more clinically sensible for the patient to be seen by their own registered practice a direct booking should be made.

Where direct booking is made by a Health Advisor the Commissioner shall first establish a local clinical governance agreement between all the providers delivering the IUC CAS function detailing which dispositions may result in an appointment. Appendix K attached shows those Pathways SD/SG codes which would be unlikely to benefit from increased clinical telephone triage. When agreeing the list of codes not requiring further clinical telephone triage, the Commissioner shall ensure that any opportunity for a “consult and complete” outcome is not missed. If a Health Advisor is in any doubt referral to a clinician is required.

For the avoidance of doubt, direct booking into General practice, including extended access services or hubs, must only be after a clinical consultation not after Health Advisor input.

The Provider shall implement a solution capable of recording where booking has not been possible as a result of slot unavailability.

In areas where agreement for direct referral to services (for example, acute, community, mental health, sexual health, social care etc.) have been established it must be possible for the advisor to direct callers to services via the DoS. The advisor must consider the services returned (and if suitable then offer them to the patient) in the order displayed. The Providers chosen clinical workflow system shall query the DoS and where possible the NHS 111 assessment information must be sent to the selected service electronically. In all cases the patient must be clear about which service they are being referred to, what the next steps in their care pathway are and in what timescale their next contact will be. Where patients are expected to attend/contact the service they are being referred to, the Provider shall issue contact details to the patient.

5.12.5. Booking Workflow

The Provider shall ensure that the chosen clinical workflow system provides direct appointment booking as an integrated part of the user workflow, this means that users should be able to complete the booking functions within the same clinical workflow system in use by the Provider wherever possible.

System suppliers shall ensure that workflow design follows a user-led approach to ensure that functionality is provided at the appropriate points within the system. A

seamless and supportive user experience is essential to realising the benefits from direct appointment booking interoperability.

The Commissioner shall ensure that a consistent direct appointment booking experience is provided for the patient across all commissioned services and providers.

5.12.6. Technical Interoperability

The chosen clinical workflow system must provide technical interoperability to allow booking of appointments into other services as an integrated part of the system workflow. The Provider shall ensure that full technical specifications are made available from the chosen System Supplier for any technical interfaces that are implemented for appointment booking.

The Provider shall ensure that the chosen clinical workflow system is committed to implementation of national appointment booking interoperability standards at the earliest opportunity.

Further information on the technical interoperability requirements for Direct Appointment Booking will be published in the IUC Technical Standards.

5.12.7. Cancellations and Amendments

The Provider shall implement a solution that allows the cancellation and amendment of booked appointments which were originally booked via an integrated Urgent Care service. Where a technical solution is not available an operational process should be in place.

5.12.8. Notifications and Reminders

The Provider shall implement a solution capable of sending an optional appointment confirmation and/or reminder messages to patients using SMS or email.

As a minimum, appointment confirmations should provide the time/date of the booked appointment, and details of the service into which the appointment has been booked. Appointment confirmations should avoid containing personally identifiable data (PID) unless specifically necessary and should only be sent to a verifiable contact number.

5.12.9. Reporting and Data

It is crucial that Providers and Commissioners can effectively report on the utilisation and activity of appointment booking within Integrated Urgent Care services in order to support both initial implementations and continuous improvement of the service and workflows.

The Provider shall ensure that it is possible to report freely on appointment booking activity from within the chosen clinical workflow system.

The Commissioner shall ensure that Providers are able to provide activity reporting for appointment booking within Integrated Urgent Care services when requested, and that this reporting information can be usefully aggregated across multiple providers and services where applicable.

5.13. Access to Records

5.13.1. Personal Demographic Service (PDS)

The Personal Demographics Service (PDS) allows the Provider to confirm a patient's demographics including their name, date of birth, sex, the GP surgery at which they are currently registered, and their current home address. This is an essential enabler for interoperability between services, and enables the Provider to send Post Event Messages to the patient's registered GP surgery.

The Provider shall ensure the chosen clinical workflow system has technical integration with PDS, and supports the use of Advanced PDS Tracing. An Advanced PDS trace shall be performed by the Provider for all patients during their encounter with IUC. Performing an advanced PDS trace shall be an integrated part of the workflow within the clinical workflow system and available to all users, subject to appropriate access controls. For the avoidance of doubt, it is not permissible for traces to be performed manually by use of a separate system.

For patient referrals/transfers from another service, the receiving service should first establish if the patient's details have already been traced using PDS by the sending service – in some cases this can be explicitly identified in the referral/transfer message. Where a patient's details have not been traced, the receiving service must perform a PDS trace for that patient. Following successful identification of the patient using PDS, a Repeat Caller query shall be performed where applicable – see section 5.8.7 Repeat Caller Service for more details.

Where a PDS lookup has been performed online, the information must be captured by the provider's workflow system as part of the referral. Where PDS lookup has not been performed by the online service then the PDS lookup must be performed at the point of referral.

5.13.2. Summary Care Record (SCR)

The Provider shall ensure that health care professionals have effective access to the Summary Care Record for all patients, subject to appropriate access controls. To ensure effective access the Provider shall ensure all pre-requisites for access are met.

Access to the Summary Care Record must be embedded within the chosen clinical workflow system as an integrated part of the workflow.

5.13.3. Permission to View (PTV)

In situations where the patient may call one organisation then be passed to others, as part of receiving care, any information provided to patients must explain this. This includes capturing permission to view (PTV) of any records. The information provided on the original call must provide a clear and succinct explanation that sets the clear expectations for the patient on how their information will be accessed and used. When closing a call, a summary of what will happen next should include any information that will be provided.

5.13.4. Patient Flags/Special Patient Notes (SPN)

The Provider shall ensure the chosen clinical workflow system can provide Patient Flag functionality, allowing advisors and health care professionals to be proactively alerted where important information is available to assist with and direct the specific care that is provided to the patient.

The Provider shall ensure that the clinical workflow system supports the necessary interoperability requirements to ensure that important information held in other systems is available and presented in a timely manner to the users.

The Commissioner shall support and enable information sharing between providers, in particular where multiple providers are commissioned. This must include but not be limited to relevant Special Patient Notes.

This can be achieved by appointing a lead Provider acting as the data controller with others Providers acting as data processors, or by appointing joint data controllers across the Providers. The Commissioner shall ensure that this provision is covered within all contracts.

5.13.4.1. GP Choice

The Provider shall establish the ability to automatically identify patients that are registered under the GP Choice scheme when they access the service.

At the time of publication, a national solution for identification of patients registered under the GP Choice scheme is in development but not available for implementation by System Suppliers. There is an aim to have this in place by the end of the calendar year. The Provider shall ensure that System Suppliers are committed to implementing the national solution within a reasonable timescale once available.

More information about technical interoperability to support GP Choice will be made available via the IUC Technical Standards.

5.13.4.2. Child Protection Information System (CP- IS)

(https://digital.nhs.uk/child-protection-information-sharing) is a national solution (part of the NHS Spine) that connects local authority children's social care systems with those systems used within NHS unscheduled care settings.

The Provider shall ensure that the chosen clinical workflow system has the ability to query the CP-IS and alert users to the presence of a record where appropriate. Queries to the CP-IS are also reported to the responsible social care organisations to make them aware that a child has presented to IUC. The Provider shall work with the CP-IS programme team to establish appropriate use of CP-IS within the context of the service

Further information on CP-IS integration requirements can be found within the IUC Technical Standards.

5.13.5. Access to Patient Records

5.13.5.1. Primary Care/GP Records

The Provider shall ensure that health care professionals are able to access digital, detailed, primary care/GP records for all, subject to appropriate access controls. This could be expanded to include other locally held information, such as mental health and discharge information.

5.13.5.2. Regional Shared Records

Where there are close borders and complex telephony routing challenges, patients may be managed by other providers to their home providers; and it is important to ensure that patients receive the same standard of care identified within the plans agreed with the patient.

5.13.5.3. National Shared Records

The Provider shall ensure that the chosen clinical workflow system has the ability to interoperate with Online Digital Services as they become a more prominent piece of the IUC system. In order for Online Digital Services to complement and enhance IUC, it is essential that they provide an integrated patient journey into the rest of IUC.

Many Online Digital Services will perform an element of triage and/or clinical assessment before signposting or referring a patient to IUC services. The Provider shall ensure that best use is made of the information already collected by the Online Digital Service as to avoid duplication of effort and repetition for the patient.

Lead Commissioners shall ensure that all new contracts for IUC services include provision to support integration and interoperation with Online Digital Services.

Further information on technical interoperability with Online Digital Services can be found in the IUC Technical Standards.

5.14. Medicines Management

5.14.1. Prescribing

The Provider shall deliver access to medicines and devices through the issuing of NHS prescriptions, where clinically appropriate, to meet urgent need as part of a clinical assessment.

The Provider shall adhere to the following criteria:

- Provision of a competent[16] medical (for example, GP) and/or non-medical prescriber (for example, Pharmacist, Nurse) within the IUC CAS 24 hours a day;
- Access to the Summary Care Record (SCR) and/or local electronic health care record for the patient that provides access to any clinically relevant information to support good prescribing practice e.g. palliative care record[17];
- Provision of an electronic prescribing system within the IUC CAS to support the issuing of NHS prescriptions;
- Establishment of standard operating procedure to support the process of managing the issuing of prescriptions, directing the prescriptions to the pharmacy of the patient's choice and ensuring secure and timely delivery of the prescription request to the dispensing pharmacy (this may include but not be limited to the ability to print and fax prescriptions following a telephone consultation, the posting of the original prescription form to the dispensing pharmacy and the prescribing of controlled drugs within a remote consultation).

The Provider shall work with prescribing system suppliers to prepare for the linking of NHS 111 and GP OOHs to pharmacies via the Electronic Prescription Service (EPS)[18].

Consideration should be given to the range of medicines that would be prescribed by clinicians within the IUC CAS to ensure medicines optimisation for patients through the application of relevant NICE Guidelines[19] including consideration of antimicrobial resistance and use of antibiotics.

[16] https://www.rpharms.com/resources/frameworks/prescribers-competency-framework
[17] http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp
[18] https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/
[19] https://www.nice.org.uk/guidance/ng5

The Commissioners shall identify a prescribing budget for all prescribing undertaken within the service and ensure there are resources in place to monitor and audit prescribing activity.

5.14.2. Repeat Prescriptions

The Provider shall prioritise urgent requests for repeat prescriptions according to clinical need. Consideration may be given to how repeat prescription requests could be handled via the use of “Interactive Voice Recognition” at the front end of NHS 111 to stream the calls for a quick assessment by non-clinical staff to identify when the prescription would be required.

The Commissioner must consider the referral of patients to a community pharmacy to make a direct supply of urgent repeat medicines where there is access to a commissioned service, for example, NHS Urgent Medicines Supply Advanced Service (NUMSAS)[20]. A prescription is not required and an electronic referral to a community pharmacy will close the call and enable a more direct access to medicines for the caller.

5.14.3. Electronic Prescription Tracker

The Electronic Prescription Service (EPS) provides access to a “tracker” that can be viewed via a weblink to find out the status of an NHS prescription issued by a GP practice[21].

The Provider shall make this tracker available to prescribers and pharmacists working within the IUC Service to support decisions about urgent repeat prescription requests. NHS Digital is working towards implementing the use of the tracker across all NHS 111 providers by March 2018.

5.15. Post Event Messages (PEM)

5.15.1. Overview

A patient's registered GP should always be notified about the clinical outcome of a patient’s encounter with an IUC CAS via a Post Event Message (PEM). This should ideally be sent at the end of a patient’s whole IUC encounter to avoid multiple messages being sent to the GP and to ensure that the GP is informed of the final outcome for that patient.

Where the telephone service transfers the patient to an IUC CAS, a PEM does not need to be sent from the initial telephone assessment providing that a PEM will be guaranteed once the whole patients IUC encounter is complete.

[20] https://www.england.nhs.uk/commissioning/primary-care-comm/pharmacy/urgent-care/
[21] https://digital.nhs.uk/electronic-prescription-service/rx-tracker

When an assessment is performed and the resulting outcome is on the Never Send List (a list of Never Send situations can be found in Appendix 1 of the IUC Technical Standards) then a PEM should not be sent regardless of where the call is taken.

5.15.2. Format

The Provider shall send PEM using the Clinical Document Architecture (CDA) in electronic form (ITK), or whatever may supersede it in the future. A more detailed specification can be found in the IUC Technical Standards. For the avoidance of doubt, fax transmission is only permissible as a last resort backup and must adhere to NHS Information Governance 'safe haven' fax guidelines.

5.15.3. Content

The Provider shall ensure that PEM is clear, concise, and where possible articulates the primary reason for the encounter. The Provider shall ensure that the GP can interpret and possibly take action based the information provided.

The PEM shall at a minimum contain:

- The presenting condition
- The disposition of the encounter (timescale/clinical urgency/clinical need)
- Service Details (where patient is referred or transferred)
- A summary of the consultation(s)
- A summary of the triage process (where applicable)
- A summary of any advice provided to the patient

A detailed description of the content and structure of the PEM can be found in the IUC Technical Standards.

5.15.4. When to send

The Provider shall ensure that PEM is sent at the end of a patient's whole IUC encounter to avoid multiple messages being sent to the GP and to ensure that the GP is informed of the final outcome for that patient.

For the avoidance of doubt, where the telephone service transfers the patient to a Clinical Assessment Service, a PEM does not need to be sent from the initial telephone assessment providing that a PEM will be sent at the end of the whole IUC encounter.

The Provider shall ensure that appropriate permission has been sought from the patient before sending a PEM to any recipient.

5.15.5. Recipients

For all IUC encounters (with the exception of those excluded by other criteria), the Provider shall send a PEM to the patient's registered GP surgery.

In addition to this, the Provider may be required to send a PEM to other recipients where they are directly involved in the patient's care and have a legitimate need to be informed about the encounter.

If required to do so the Provider shall send PEM to other providers within the local IUC model or to any centrally managed repository as specified by the Commissioner.

5.16. Transport – Only where patient transport is already commissioned for local GP OOH services

The Provider shall supply or procure a transport service to convey patients unable to travel to the primary care centre(s) with sufficient capacity to transport patients within the timescale appropriate to the patient's condition.

Patient transport is required to enable patients without access to their own transport and unable to make reasonable alternative arrangements to attend the nearest primary care centre for a consultation and to avoid professionals having to make inappropriate home visits.

The Provider shall:

- Transport patients from their home to the nearest place of care;
- Transport patients from the primary care centre back home where no other practical means exists;
- Transport patients from the primary care centre to A&E/Medical Assessment Unit or other NHS destination, where it is clinically safe to do so and does not require an emergency ambulance;
- Pay due regard to clinical governance and insurance implications for transporting unwell patients;
- Ensure that the patient transport service is strictly on the basis of assessed need (service can only be used if the patient is unable to reasonably arrange their own transport to the nearest primary care centre); and
- Ensure that other options are explored such as a friend/neighbour's car, patient calls own taxi etc. to transport the patient to the primary care centre.

The Provider shall only offer the transport to patients who are fit to travel. For the avoidance of doubt, transport is not a substitute for a home visit to seriously ill patients.

Where possible, a family member or companion should accompany the person being transported to the primary care centre.

All children transported to the face-to-face services must be accompanied by a parent/guardian.

The Provider shall ensure that all vehicles and drivers, either directly provided or sub contracted (for example, the use of taxis used to transport patients) meet the following criteria:

- Are subject to appropriate confidentiality/Data Protection agreements,
- Are wheelchair accessible where required;
- Are maintained and serviced in line with manufacturers' requirements; and
- That service and other documentation are available for inspection by the Commissioner.

The Provider shall be responsible for all associated costs (for example, insurance, road tax, maintenance, fuel). Drivers will be responsible for locating patients' homes, so must be familiar with the primary areas covered and have access to satellite navigation.

5.17. Acceptance and Exclusion Criteria and Thresholds

The Commissioner shall define locally applicable acceptance and exclusion criteria and thresholds.

5.18. Interdependencies with Other Services/Providers

The Commissioner shall define locally applicable interdependencies.

5.19. Intelligent Commissioning

The Commissioner shall coordinate organisations to work together in order to provide a consistent and coordinated service to patients. Services must be commissioned so that joint working relationships are recognised with contracts and responsibilities clearly outlined. This is particularly relevant in relation to the local ambulance service.

The Commissioner shall consider the commissioning footprint when tendering to ensure the scale of the service is large enough to achieve sufficient service efficiency. Alignment with STP and other strategic health administrative areas must also be considered.

The Commissioner shall use information from services to ensure the service is commissioned as a whole employing alliance agreements where this is appropriate.

5.20. Improved Patient Experience

The Provider shall implement a systematic process to regularly seek out, listen to and act on patient feedback on their experience of using the service, ensuring delivery of a patient centred service.

This must include but not be limited to:

- Clear and well-publicised routes for both patients and local health professionals to feedback their experience of the service (such as patient forums and user groups);
- Honouring the NHS Constitution;
- Providing prompt and appropriate responses to that feedback;
- Regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional insight into the quality of the service; and
- Implementing systems to collate, aggregate and triangulate feedback from a range of sources such as complaints, surveys, social media and online resources including NHS Choices; www.nhs.uk or patientopinion.org.uk.

The Provider shall ensure that the whole patient feedback process is fully transparent whilst recognising confidentiality. It is important that the Commissioner and Provider adopt an approach that allows users to see the views and experiences of other service users and the responses made by the service.

The Provider must put appropriate measures in place to ensure that their service can gather information about patients' journey through their services. With the appropriate engagement of patients, patient participation groups, and the use of patient surveys - valuable information can be provided to help improve, develop and tailor the service. The Provider shall set up systems to appropriately collate patient experience and feedback for patients and the Commissioner. This will need to take appropriate account of the required patient communicate, consent and de-identification of details.

5.21. Communications, Engagement and Marketing

Communications and engagement are essential to the success of the IUC service. Ongoing dialogue is needed to ensure that patients, carers, clinicians and other interested parties are kept informed of developments as the service is implemented, and are able to raise any concerns they may have about the service.

The Commissioner is responsible for co-creating local communications and stakeholder engagement strategies with the Provider to ensure that they are effectively engaged with their key local stakeholders.

The Provider shall communicate effectively with the Commissioner, local services (including, but not limited to, GP providers, acute trusts, mental health providers and community health providers), the local population and any organisations representing their interests.

To support this, The Provider shall:

- Work with Commissioners and local patient groups to jointly establish a strategy to manage any communications relating to IUC Service;
- Co-operate with Health Scrutiny and Overview Committees, Health & Well Being Boards and other stakeholders, as directed by Commissioners; and
- Ensure that Commissioners are made aware of anything that has the potential to impact on service delivery or generate adverse publicity.

For the NHS to improve A&E performance it is important that when someone has an unexpected, unplanned urgent medical need, that is not life threatening, they call 111 instead of attending their local A&E department. That way they can have their clinical condition managed, or be directed to the best placed local service for their needs.

Public facing marketing of the NHS 111 number is essential to changing the way that people access urgent and emergency care services. This becomes more important as new urgent care services are introduced because it is simpler to change people's behaviour to calling 111 instead of attending A&E than to explain all alternative the services that are available to them.

As a national service all public facing communications and marketing for NHS 111 must be consistent across the country. This is the responsibility of both national and local teams to deliver in partnership. This section sets out the national and local responsibilities for marketing the NHS 111 number.

To deliver nationally consistent public facing communications and marketing it is essential that the NHS 111 brand is properly applied. The Commissioner shall ensure that the NHS 111 brand guidelines are followed. The NHS 111 brand must not be altered. If any issues are encountered with applying the brand it is the Commissioner shall inform the national NHS England IUC team.

NHS England shall manage the NHS 111 brand and guidelines, including updating as necessary. This includes but is not limited to monitoring the application of the NHS 111 brand.

To ensure that marketing activity is nationally consistent all NHS 111 marketing materials will be developed with the national IUC team. National marketing of the

NHS 111 number can only be delivered at a national level. The responsibility for delivering national NHS 111 campaigns resides with NHS England; this includes the following aspects of marketing:

- Development of the national marketing strategy for the NHS 111 number and Online;
- Development of marketing campaign creative (campaign assets) to be used both nationally and locally. These will be made available to local teams by the national IUC team, such as digital assets, infographic, posters, flyers etc.;
- Management and implementation of national marketing activity for the NHS 111 number.

The Commissioner shall:

- Ensure that all local communications and marketing activity follows the NHS 111 and Online brand guidelines and where appropriate makes use of nationally developed marketing creative;
- If the nationally marketing creative is not suitable for local marketing requirements, liaise with the national IUC team to develop new creative that is consistent with national NHS 111 campaign materials;
- Liaise with other local NHS commissioners and providers to ensure that any communications and marketing activity does not negatively impact on service delivery; and
- Deliver local marketing activity that is consistent with the national IUC (including NHS 111) marketing strategy.

5.22. Staff and Patient Feedback Surveys

Patient and staff feedback is a fundamental part of understanding the performance of the IUC service and whether it is meeting patients' needs. Feedback allows the experiences of patients and staff to inform service design and changes. Consistent approaches to surveys between areas are a key requirement of providing information that is comparable between areas. The Commissioner shall ensure that services are contracted to meet the requirements outlined in Section 5.7.6. This will ensure that data are comparable, providing insight within and across areas for both commissioners and NHS England.

5.23. IUC for Carers

In May 2014, NHS England published *Commitment to Carers* seeking to give the 5.5million carers in England the recognition and support they need to provide invaluable care for loved ones. In December 2014 NHS England and the Royal College of General Practitioners published Commissioning for carers: Principles and resources to support effective commissioning for adult and young carers a resource to support CCGs identify and help carers to stay well and deliver the best outcomes

for carers. In May 2016 NHS England published an integrated approach to identifying and assessing carer health and wellbeing paper to address changes to the way carer health and wellbeing is identified, assessed and supported. The Commissioner shall ensure that this guidance is understood and implemented within the IUC Services.

The Provider shall ensure that the IUC Service is designed around the holistic needs for patients who are carers and carers who are patients – both adult and child carers.

The Provider shall ensure that staff training and systems enable the needs of carers to be considered within the unscheduled urgent & emergency care episodes of care; as cemented within the Equality Act (2010), associated Equality Duty and the NHS Constitution, this means that services must be flexed and reasonable adjustments (include where appropriate, more favourable arrangements) made when dealing with carers.

The Provider and the Commissioner shall work with patient representatives and service users to embed the services needed to meet the needs of carers, which includes ensuring information systems and patient records are able to record relevant information about carers and their dependents.

Based on feedback from services users, two vignettes guiding the types of service considerations that must be made have been included in Appendix G.

5.24. Service Development and Changes

The Commissioner and the Provider shall work as an integral part of local systems and with stakeholders to create improvements in service, embed evidenced based national and local learning into local service provision and plan for changes in strategy, technology and demand, to achieve the aims set out in this specification. In order to achieve this, the Commissioner and the Provider shall demonstrate how fundamental principles set out below are reflected in their organisational structure and culture:

- Partnership and Integrated Approaches
- Innovative and developmental
- Listening
- Flexible
- Responsive
- Resilient
- Excellent Clinical Governance & Assurance processes
- Robust Policies and Procedures
- Open and Transparent

- Focus on Patient Pathways and outcome
- Delivering appropriate value for money

5.25. Future Technology

Three programmes (see Appendix H) have been established to deliver the future technology required to support IUC. The Commissioner must support and enable the implementation of these initiatives. Where these are emerging products and solutions initial phases will be able building sufficient flexibility into any contracts and commissioning arrangements. Where there are more defined deliverables such as 111 Online it is expected that local decisions will involve STPs as well as considering connections to primary care digital patient access.

5.25.1. Clinical Triage Platform

The Clinical Triage Platform (CTP) is a programme of transformation to improve the precision, access, and utility of patient triage in the urgent care system.

The objective of the Clinical Triage Platform is to provide NHS 111 services as well as the wider UEC system with the ability to benefit from more advanced triage systems. These systems will be tailored to the needs and risk profiles of the individual patient; enable more responsive improvements and critically will be underpinned by connections to patient and system wide outcomes. Further details are contained in Appendix H.

5.25.2. Access to Service Information

The Directory of Service (DoS) remains central to ensure providers are able to get the patient to the right service. There are improvements needed to support the transformation of urgent and emergency care. These include the functionality to book appointments, transfer care and understand capacity and real time availability. Further details are contained in Appendix H.

5.25.3. NHS 111 On-line

In 2017 patients expect to be able to access healthcare via digital channels. As defined in the Five Year Forward View Next Steps published in April 2017, all NHS 111 services are required to have an online service in place by December 2017. More detailed guidance on expectations and implementation decisions for NHS 111 is set out in Appendix H and regional workshops will be held during the summer to finalise planning and share final evaluations from the pilot projects.

5.26. New Services/Helplines

NHS 111 should be the telephone contact for all urgent care services. However, there may be occasions where there is a need for a bespoke helpline using a separate non-geographic Freephone number (for example, a service only required

by a very small number of people for a limited period). The provider shall provision any such numbers at local level on request.

6. Applicable Service Standards

KEY SERVICE REQUIREMENTS

These are key requirements that include but are not limited to;

The Provider shall ensure:

1. The IUC Service is delivered in accordance with best practice in health care and shall adhere to the current standards and updated standards as outlined in this specification.
2. They fully comply with the Care Quality Commission's registration requirements.
3. They lead Serious Incidents investigations where appropriate and must adhere to local policies.
4. Any actual or potential breaches of confidentiality including loss of data and cyber security incidents are reported in accordance with the HS Digital and NHS England guidance.
5. A written complaints procedure in line with the NHS Complaints (England) Regulations 2009.

A full list of requirements can be found in the section below.

6.1. Applicable National Standards

The Provider shall deliver the IUC Service in accordance with best practice in health care and shall adhere to the current standards and updated standards and guidance as these are developed and recommendations including those contained in, issued, or referenced as follows:

- Access Information Standards.
- Common law duty of confidentiality (CLDC).
- Code of Confidentiality, Records management;
- Standards issued by the Care Quality Commission, including Essential Standards of Quality and Safety.
- Data Protection Act 1998.
- NHS Constitution.
- The Vetting and Barring Scheme.
- Registration of staff who carry out regulated activity with the Independent Safeguarding Authority (ISA).
- All National Institute for Health and Clinical Excellence (NICE) guidance that is relevant to conditions presenting in an Urgent Care Centre.
- National IUC CAS Key Performance Indicators.
- NHS Complaints regulations 2009.
- National Incident management guidance.

- Child and adult safeguarding regulation and guidance.
- Central Alerting System (CAS) Safety Alerts.
- National outcomes framework.
- Freedom of Information Act 2000.
- Environmental Information Regulations 2004.
- National Dementia training requirements.

6.2. Applicable Standards set out in Guidance and/or Issued by a Competent Body (for example: Royal Colleges)

The Provider shall adhere to:

- ISO 9001 – Quality Management standards
- ISO 27001 – information Security Standards
- ISO 22301 – Business Continuity Standards

The Provider shall ensure that all Information Standards Notifications issued by NHS Digital are implemented in a timely fashion where applicable to the service.

The Provider shall adhere to other standards issued by a competent body such as the Royal Colleges and Health Education England/committee General Practice Education Directors requirements for GP registrars.

6.3. Statutory Duties

6.3.1. Information Governance

6.3.1.1. Information Governance Compliance

The Provider shall complete an annual assessment of its compliance against the NHS IG Assurances as an NHS Business Partner view (where not already registered for the NHS IG Toolkit).

The Provider shall achieve the current Information Governance standard, as directed by NHS Digital and NHS England, currently ICT level 2 adherences (with supporting evidence) for each of the standards identified in the assessment. Any standard that does not achieve this level must have an improvement plan to be completed within reasonable timeframes and approved by the Commissioner.

The Provider shall supply a copy of its internal audit report of each year's assessment and ensure that any recommendations for improvement have been implemented in appropriate timeframes.

6.3.1.2. Data Protection and Confidentiality

The Provider shall adhere to current Data Protection legislation, with due regard to the common law duty of confidentiality, and obligations towards privacy under the

Human Rights Act. Providers will need to ensure they are aware of the latest statutory guidance and policy positions on the use of patient data and patient choice. This includes, but is not limited to; the latest NHS Caldicott guidance for information governance and NHS Codes of Practice in regards to Confidentiality, Integrity and Availability (including Information and Cyber security) for all the information processed as part of its service.

The Provider shall have relevant policies and procedures in place to manage Subject Access Requests (SAR) from users or their representatives. The Provider shall report against adherence to the SAR target to the timeframes set out in current legislation and policy. As of writing this is 80% of requests managed within 21 calendar days of receipt and 100% within 40 calendar days of receipt but may change with the introduction of new Data Protection legislation in 2018 and any associated policy changes.

The Provider shall notify the Commissioner of any potential/actual legal claims / court orders for the release of records within 2 working days of notification.

The Provider shall establish a nominated Confidentiality or Information Sharing Lead Officer, policies relating to information governance, security and confidentiality of personal confidential information and robust Data Sharing Agreement procedures.

The Provider shall ensure that all staff (including locum, contractor and temporary) have received regular training and retain records on all aspect of data security and Information Governance.

6.3.1.3. Protection and Retention of Information

The Provider shall demonstrate adherence to the protection and retention of all information collected and used for the purpose of this contract in line with the Public Records Act[22] and NHS Codes of Practice – Record Management (Part1 and 2[23]), whether electronic or manually held.

Any information required to be held longer than minimum periods outlined in the NHS Code of Practice – Records Management, must be approved by the Commissioner prior to retaining the relevant data. All requests must include details of the extension required and justification for request.

The Provider shall provide a copy of its relevant management policies and procedures upon the Commissioner's request.

[22] http://www.legislation.gov.uk/ukpga/Eliz2/6-7/5
[23] https://www.england.nhs.uk/wp-content/uploads/2014/02/rec-man-pol.pdf

The Provider shall ensure that disposal of records and information is in line with minimum retention periods, and make use of appropriate and adequate secure destruction methods. The Provider shall also ensure that any sub-contracted / out sourced services are compliant with these standards.

The Provider shall supply a full list of information (including digital assets) that have been destroyed each year and certificates of destruction to support

The Provider shall not process any Personal Confidential Information outside of the European Economic Area without prior approval from the Commissioner (which will not be unduly withheld).

Where information is scanned and held in digital format, the Provider shall ensure that this is done in line with ISO 15489 – Information and Document standard[24] (or the Code of Practice for Legal Admissibility and evidential weight for information stored electronically. For the avoidance of doubt this will include voice recording data.

6.3.1.4. Privacy Impact Assessment

The Commissioner and Provider shall complete a Privacy Impact Assessment (PIA) at commencement of service, and shall provide regular annual reviews throughout the duration of the contract. Privacy Impact Assessments must be carried out for all services and projects identifying potential risks and threats to Personal Confidential Data. Subsequent reviews must confirm previous mitigation is effective and identify that current / new risks are being managed accordingly. The PIAs must be appropriate for the scale of the services and demonstrate adequate robustness in line with ICO and NHS guidelines.

6.3.1.5. Record Keeping

The Provider shall adhere to all legislation and best practice concerning record keeping covering both administrative and clinical records. All calls/contacts with users must to be recorded accordingly and retained in line with Department of Heath guidance on records retention schedules (NHS Code of Practice – Records Management).

The Provider shall ensure that all records created, held and transferred within its services, and other NHS organisations include a verified NHS number as the unique identifier of any record and are legally admissible.

[24] http://www.iso.org/

6.3.1.6. Freedom of Information

The Provider shall ensure there are relevant policy and procedures in place to support the Commissioner's roles and functions identified in the Freedom of Information (FOI) Act.

The Provider shall:

- notify the Commissioner of all FOI requests received in regards to the Service within 5 working days of receipt; and
- consult with Commissioner on all FOI requests received in relation to this service, including, but not limited to, commercial and operational issues.

6.3.1.7. Environmental Information Regulations 2004 (EIR)

The Provider shall have robust policies and procedures to manage requests made under the EIR and respond in accordance with the regulations.

6.3.2. Safeguarding Children and Vulnerable Adults

The Provider shall ensure:

- Up to date appropriate policies and procedures on safeguarding children and vulnerable adults are in place. These will adhere to all relevant legislation, Care Act 2014, codes of practice, statutory guidance and good practice guidance published by the Department of Health and the local safeguarding boards as appropriate. They must also adhere to the requirements in section 11, Children Act 2014 and London Child Protection Procedures 2015.
- Safeguarding policies are effectively communicated to its employees (including volunteers).
- All staff are up to date with appropriate level of safeguarding training (for both children and adults) relevant to their role in the organisation safeguarding children and vulnerable adults at risk —as recommended in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Royal College of Paediatrics and Child Health, 2014).
- Compliance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards Accountability and assurance framework for adults at risk, also training and competency framework for Prevent. In line with Bournemouth competencies framework as referenced in Care Act 2014 and associated code of practice.
- Under the Safeguarding Vulnerable Groups act 2006 the Protection of Children Act (POCA) and Protection of Vulnerable Adults (POVA) lists have been replaced by the Vetting and Barring Scheme administered through the new Independent Safeguarding Authority (ISA). The Provider shall fulfil its legal obligations concerning the gaining of Disclosure and Barring Service checks and checking employees through the ISA and relevant national or local safeguarding authority where applicable and will provide evidence of adherence of this to the Commissioners.

The Provider shall ensure that there are appropriate procedures in place to support:

- The immediate reporting of safeguarding concerns through clear procedures;
- The encouragement of 'whistle blowing' where appropriate, including allegations against staff, through clear procedures for staff;
- Effective working practices and policies to prevent abuse and protect individuals;
- Policies shall highlight the inappropriate nature of private arrangements of any sort between the carer and the patient, including the potential for gross misconduct; and
- Other actions necessary to support relevant policies, including the mandatory participation in safeguarding adults reviews, strategy meetings, serious case reviews and other investigations pertaining to safeguarding of adults at risk or vulnerable children.

The Provider shall not take responsibility for providing care to any other vulnerable adults, or children, in addition to the named service user, such as 'baby-sitting' even for short periods of time.

The Provider shall have in force a written policy of confidentiality that will address the needs of this patient group. This must ensure that personal information disclosed to the Provider or named worker in the course of its work is treated by all employees as confidential. Such information will only be disclosed in adherence with the Data Protection Act (1998) and common law duty of confidentiality. Where appropriate confidential information will only be disclosed with the consent of the patient concerned, though there are circumstances where consent should not be sought or is only sought under the common law duty of confidentiality. Examples include circumstances where disclosure is required by law or to safeguard children and vulnerable adults at risk of harm. The Provider shall also ensure that all employees are aware, and understand the importance of confidentiality.

6.3.2.1. Children

The Provider shall publish a named local lead for Child Protection and Vulnerable Adults, who will undertake a local governance role, attend NHS safeguarding children advisory groups and liaise with local agencies to keep children and vulnerable adults safe.

The Provider shall establish a system for accessing information of children subject to a child protection plan with the local authorities in their area and ensure governance arrangements are in place and that this record system is kept up to date.

6.3.2.2. Vulnerable Adults

The Provider shall adhere to the Department of Health “No Secrets” guidance (March 2000) on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse and also the Care Act 2014.

The Provider shall adhere to all guidance and legislation and have procedures in place to safeguard and promote the welfare of vulnerable adults.
The Provider shall evidence that it has:

- A named lead for adults at risk who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named lead for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named Prevent lead who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- Up to date policies for Adults at Risk, MCA, DoLS and Prevent, which will be shared with the Commissioner on request;
- Systems in place to ensure that all staff have the appropriate level of safeguarding training, including MCA, DoLS and Prevent and evidence figures for training to meet required standards;
- Systems in place to record data relating to referrals, concerns raised and involvement in strategy meetings and Safeguarding Adult Reviews; and
- Met the requirement under Making Safeguarding Personal.

6.3.3. Care Quality Commission

The Provider shall fully comply with the Care Quality Commission’s registration requirements (i.e. any person [individual, partnership or organisation] who provides regulated activity in England must be registered with the Care Quality Commission otherwise they commit an offence) . In addition they must notify commissioners of any statutory and legal requirements, enforcements or improvement notices served upon them.

The Provider shall meet all appropriate recommendations made by the CQC into the IUC Service including the Consultation on the Approach to Regulating NHS 111 Services and Appendices issued February 2015.

The Provider shall meet all appropriate recommendations that were made by the CQC interim report into GP OOHs services published in the autumn of 2009, the Department of Health report into GP OOHs services published in January 2010 and the latest CQC approach to inspect commencing from October 2014.
In the future the Provider(s) will be expected to meet all appropriate recommendations in the CQC guidance for IUC Clinical Assessment Services.

6.3.4. Serious Incidents

The Provider shall lead Serious Incident investigations where appropriate and must adhere to local policies.

Provider reports of Serious Incidents including Never Events must be reported in accordance with National Guidance:

- The Provider ensures Serious Incidents are reported on Strategic Executive Information System (StEIS) within 2 working days. It is an obligation on the provider – so the clock starts when the provider knows.
- The Provider agrees grading with Commissioner as per guidance within 3 working days. This should be linked to NHS standard operating procedure for SI reporting.
- The Provider and the Commissioner agree who the lead provider is to undertake the investigation, complete the report and shares initial findings with the patient / family in accordance with the duty of candour.
- The Provider submits report to the Commissioner for quality assurance review within 45/60 days dependant on grade (100% must be completed in time frame).
- The Commissioner will agree that the report is robust and suitable for closure or the Commissioner may require the Provider to make changes to the investigation report or action plan before closure.
- Provider shares the altered report with patient / family within 10 days.
- The Provider shall submit reports to demonstrate 95% completion of actions within timeframes agreed on the action plan. Commissioner to monitor through quality and safety team.

6.3.4.1. Breaches of Confidentiality/Data Security/Cyber Security

The Provider shall ensure that any actual or potential breaches of confidentiality including loss of data and cyber security incidents are reported in accordance with the NHS Digital and NHS England Guidance. This includes reporting of incidents via the NHS IG Toolkit or its successor (designated reporting tool).

6.3.5. Health and Safety

The Provider shall:

- Adhere to and ensure that its employees adhere to the requirements of the Health and Safety at Work Act 1974 and other relevant legislation, including regulations and codes of practice;
- Maintain a specific health and safety at work policy relating to the employment of its own staff whilst carrying out their duties in relation to the Contract on the Commissioners' or any beneficiary's premises; and

- Ensure all notifiable accidents will immediately be brought to the attention of the Commissioners.

6.3.6. Infection Control

The Provider shall ensure that the service is delivered in a suitable environment that meets the NHS and Department of Health (DOH) standard for this type of service.

The Provider shall:

- Provide infection control training for all staff during induction and ensure staff attend annual refresher courses;
- Ensure all staff have copies of an up-to-date infection control manual and Infection Control policies;
- Undertake an infection control audit every year from the commencement date of the contract and produce an action plan for areas where the need for improvement has been identified (the scope of this audit must be submitted to the Commissioner for agreement);
- Allow representatives of the Commissioner to visit the site(s) from where the Provider is delivering the service at any time;
- Notify the Commissioner within 24 hours of confirmation of any outbreaks of infection or if any serious incidents arise;
- Ensure that cleaning arrangements are carried out in accordance with the current NPSA Healthcare Cleaning Manual; and
- Ensure that healthcare waste is disposed of safely and in line with current legislation and DH guidance.

6.3.7. Complaints

The Provider shall have a written complaints procedure in line with the NHS Complaints (England) Regulations 2009. This will include informing and involving the Commissioner's Clinical Lead at the earliest possible stage and obtaining sign off of responses before they are sent to complainants.

It is recognised that some complaints or dissatisfaction may be raised informally. The Provider shall establish a system for dealing with informal complaints (wherever lodged) and patient expressions of dissatisfaction with the service and will engage with other providers and patient groups to improve processes and pathways.

The Provider shall ensure that all complaints are monitored, audited and appropriate action taken within required timescales in line with national guidance.
The Provider shall publish their complaints procedures in a range of formats such as easy read, different languages and online, to ensure that patients are aware of the complaints procedure.

The Provider shall take reasonable steps to ensure that the complaints procedure is accessible to all patients, including those with specific issues such as hearing impairment, non-English first languages, visual impairment, learning disabilities and other access issues and will ensure that they adhere to the requirements of the Equality Act 2010 at all times.

The Provider shall issue a monthly summary report to the Commissioner of all complaints and recommendations received; a status of the progress to address each, any outcome of any investigations and recommended actions to be taken.

The Provider shall ensure that:

- Complaints regulations are adhered to;
- The Complaints Policy is explicit as to Duty of Candour in respect of complaints handling;
- 100% complaints are acknowledged within 2 working days;
- 85% Complaints responded to in 25 working days. The response must include an action plan (monthly complaints audit results to detail compliance);
- Monthly reports should include but not be limited to:
    - Number of complaints
    - Complaints rates and timeliness of responses
    - Trend analysis of complaints broken down by operational department and division and theme. The report shall contain actions implemented as a result and lessons shared
    - Number of complaints reopened
    - Number of complaints sent to the Health Service Ombudsman and outcome
    - Complainant survey results, detailing 100% complainants surveyed, response rate and survey results

6.3.8. Record Keeping

The Provider shall ensure that record keeping complies with agreed records retention and keeping policies.

7. Applicable Quality Requirements and CQUIN Goals

KEY SERVICE REQUIREMENTS

These are key requirements that include but are not limited to;

The Commissioner must ensure:

1. They run a CQUIN scheme that ensures referrals to 999 and A&E are only made when required.
2. The Commissioner shall ensure that the procured service is resilient and well-performing. This includes the ability to plan for and respond to peaks in demand.
3. The Commissioner shall ensure that providers are contractually obliged to share any corporate data required to performance manage and inform the ongoing development of the IUC Service.

The Provider must ensure:

1. A robust internal clinical governance structure with an identified senior clinical lead.
2. A monthly integrated quality report is provided to the Commissioner as the basis of the of the Clinical Quality Review Group (CQRG) meeting.
3. Full requirements are met for equality legislation both in relation to the universal service offered to patients but also in how it delivers equality within its organisation and constituent staff.
4. Reporting against all aspects of the minimum data set (MDS) within the specified timescales and using the specified mechanisms outlines in this specification.
5. The relevant data feeds are established to support syndromic surveillance in IUC and that the relevant data sharing agreements are put in place.

A full list of requirements can be found in the section below.

7.1. Applicable Quality Requirements/Standards

The strategic direction as set out in the Five Year Forward View, and the Urgent and Emergency Care Review, is that UEC services are configured with the aim of managing patients with urgent care needs closer to home rather than in a hospital (A&E or inpatient) setting.

This CQUIN scheme will help realise that strategic aim for patients who access clinical advice through NHS 111, specifically that referrals to 999 and A&E are only made when required. Two of the three components directly link payment to reductions in such inappropriate referrals. The third encourages improved data capture of dispositions for service improvement, quality of the Directory of Services (DOS) as well as to inform a basis for payment of the CQUIN.

This CQUIN is designed to incentivise providers to ensure only those patients which need to go to either the ambulance service or A&E are referred, where an alternate service is available it should be used. The Commissioner shall ensure that when applied retrospectively through contract variation the CQUIN incentive does not result in double charging.

7.2. Applicable CQUIN Goals

The CQUIN indicator 13 - *"A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department",* will be achieved through the introduction of IUC CAS which will provide the following enablers:

- Access to urgent care via NHS 111, either a free-to-call telephone number or online;
- triage by a Health Advisor;
- streaming to the correct clinician in an appropriate timescale for the presenting condition;
- consultation with a clinician using a Clinical Decision Support System (CDSS) to complete the episode on the telephone where possible; and
- direct booking post clinical assessment into a face-to-face service where necessary.

7.3. Clinical Governance Quality Requirements

The Provider shall establish a robust internal clinical governance structure with an identified senior clinical lead. The clinical lead is responsible for assuring the clinical quality of the service and that this is supported by a suite of robust policies and procedures. The Provider shall submit the policies and procedures (and any subsequent amendments) to the CCGs Clinical Group during mobilisation and afterwards via the Clinical Quality Review Group (CQRG) for review and approval. A range of metrics will be agreed to monitor service quality and these must be reported to commissioners formally at CQRG and upon request by the Commissioner.

The Provider shall ensure:

- A named Clinical Lead is appointed to the service to provide clinical leadership and that a substantial part of their role is spent at the service providing clinical leadership to staff;
- The Clinical Lead is an experienced senior medical doctor who has the authority and responsibility to make decisions relating to the clinical direction of the service;
- The Clinical Lead has sufficient time and capacity to effectively undertake his or her duties (part of the role of the Clinical Lead will be to link with local

primary care, community based services and local urgent care providers to promote and maintain a whole system integrated response); and

- The Clinical Lead, as part of his or her role, engages with and participates in work to develop ongoing understanding of the health needs of the local population and of local health care services.

The Provider's Clinical Lead shall participate in the development of shared governance structures with other urgent care providers in the area and to move towards the implementation of system-wide metrics to fully understand the performance of each component of the urgent care system. This is required to assure quality and ensure there is high quality and seamless integrated care for patients. To achieve this outcome the Provider's Clinical Lead shall work collaboratively with the CCG, primary care networks and other services.

The Provider shall ensure that:

- There is a named governance Lead with a clinical governance supporting structure; and
- There is a clinical governance audit programme and processes to monitor clinical standards (this must be linked to the Royal College GP audit toolkit or equivalent so there is systemic approach to measuring outcomes).

The Provider shall produce a monthly integrated quality report to the Commissioner. This will form the basis of the Clinical Quality Review Group (CQRG) meeting. It is recognised that there may be a number of providers involved in the IUC CAS delivery. The Commissioner shall develop and maintain an appropriate reporting structure and ensure that there is close working between all providers.

The Provider shall submit a monthly report to the Commissioner, using data captured from electronic systems wherever possible, no later than the third Friday of the following month to which it applies.

The monthly report must include but not be limited to:

- Details of all KPIs within contract;
- Safeguarding issues;
- Incidents;
- Significant incidents - both reported and concluded within period;
- Complaints - divided by theme;
- HCP forms - divided by theme;
- Health advisor, clinical adviser and clinical call and case audits;
- Shift-fill by clinician (including details of agency staff used);
- Ambulance and A&E validation - including details of percentage of those validated and outcomes of validation;

- Clinician involvement in case (as per 5.22 criteria);
- Outcome/disposition - for all cases in IUC CAS (telephone and face to face contacts) and detailed by skill type;
- Friends and family test results;
- Patient survey;
- End to end call reviews; and
- Additional audits as agreed by CQRG (for example, infection control, antibiotic prescribing, ambulance non conveyance reviews or drugs of potential misuse prescribing)

The report must be prefaced with a high level summary detailing:

- Significant incidents
- Complaints
- HCP forms
- Ambulance and A&E validation
- Clinician involvement in case

Additional elements will depend on local variations and developments in the service provided and must be agreed with the Commissioner (examples are available on request).

It is expected that for some areas with multiple providers forming the IUC CAS there will be additional local clinical governance arrangements with host CCGs for some elements. The Commissioner shall ensure that any such arrangements feed into the CQRG to complement the overall IUC CAS Clinical Governance process.

7.3.1. Governance Arrangements

The Commissioner shall publish an organogram describing clinical governance arrangements.

7.3.2. End to End Reviews and Process to Share Learning

7.3.2.1. Complaints

See section 6.3.7.

7.3.2.2. Serious Incidents

See also section 6.3.4.

On meeting the requirement of out statuary duty to produce the 72 hour report it must be provided to the CCG quality and clinical leads. This will be further reported to the Regional PMO IUC CAS Clinical Lead who will review this and subsequent RCA in order to provide oversight and challenge back to relevant CCG and provider.

Colleagues will note the variation needed for the specific arrangements of each Commissioner.

The SI reporting to the Regional PMO IUC CAS Clinical Lead will be triangulated against the KPI reporting but this clinical reporting collects the details and RCA from each provider.

The Regional PMO IUC CAS Clinical Leads and the National Medical Advisor for IUC CAS will keep continual oversight on all SIs through this system.

The Provider shall participate in quarterly themed SI "deep dives" to monitor the quality of reporting and RCAs that are sent into the learning log. Following these meetings a brief IUC CAS quality briefing will be shared across all providers in order to share learning and improvement opportunities (see Appendix G).

7.4. Privacy Impact Assessment (PIA)

The Commissioner and Provider shall undertake PIA in accordance with NHS Information Governance guide-lines, the Provider shall undertake a Privacy Impact Assessment (PIA) for all services. The PIA must include but not be limited to the assessment and treatment of all known risks and be commensurate with the types of services delivered. Whether this is a joint PIA, or separate PIAs for the commissioner to identify risks and providers to demonstrate appropriate management and mitigation.

7.5. Equality Impact Assessment

The Provider shall meet the full requirements of equality legislation both in relation to the universal service offered to patients but also in how it delivers equality within its organisation and constituent staff. The Provider shall complete an Equality Impact Assessment for the service for the Commissioner’s approval.

7.6. Performance Management

Data and metrics about the IUC Service are critical in allowing monitoring, service design and to ensure service resilience. This section outlines the requirements for data provision.

Monitoring will be undertaken through the provision of a range of performance metrics that are reported at regular, specified points. These metrics will provide management information to NHS England and the Commissioner and will allow the Provider to be held to account. Elements of this information will be published by NHS England to provide transparency and visibility.

The Commissioner shall ensure that the procured service is resilient and well-performing. This includes the ability to plan for and respond to peaks in demand, the timing which is usually predictable. The Provider shall plan for, and respond to these changes in demand sharing any information required by the Commissioner to assure the quality and appropriateness of these plans. This information, along with performance data during the period may be required by NHS England to assure it of the ability of the service to meet the desired levels of performance. On request, the Provider shall release any additional data required by NHS England to undertake this process.

To develop the IUC service to further benefit patients, a robust evidence base is required to inform the service design process. This will require the collection of data items above and beyond those required for the monitoring of performance metrics. The Provider shall share any such data on request establishing connectivity with any centrally provisioned data repositories.

The Provider shall report against all aspects of the MDS within the specified timescales.

The Provider shall integrate with local and or national dashboards rendering real time and historical performance data.

The dashboard will collate (including but not limited to):

- Automatic Call Distributor (ACD) performance data including calls offered, calls answered, abandonment and speed to answer;
- Resource availability and utilisation;
- Clinical queues; and
- Pseudonymised Post Event Messaging (PEM) for syndromic surveillance.

7.6.1. Principles

The Commissioner shall ensure that providers are contractually obliged to share any corporate data required to performance manage and inform the ongoing development of the IUC Service. This will be corporate data about the delivery of the service. Where personal data is required to flow between provider and commissioner, the appropriate patient communication, lawful basis and controls will need to be in place.

The Provider shall ensure that all systems are capable of providing data in accordance with the Commissioner's definitions. These definitions can be found in

the NHS England Data Dictionary (Data Dictionary)[25] and other supporting documentation and standards, such as the IUC/NHS 111 Minimum Data Set (MDS)[26]. Where conflicts occur, the IUC MDS definitions take precedence.

The breadth of the IUC service means that data will be required to follow the patient journey through IUC and into the wider health care system. It is important that data is captured and available at each touch point within the IUC service for each patient. This requires that data should be available at the patient level across all IUC services, allowing Commissioners the ability to understand the patient journey through the health care system, starting with IUC. This will afford better understanding of the differential needs of the diverse patient groups. The NHS number should be used and patient confidentiality maintained at all times.

Commissioner will need to be assured that providers have an appropriate plan in place to ensure that these flows of data are lawful and appropriate.

This includes:

- A comprehensive (and ongoing) review of privacy issues and mitigations (Privacy Impact Assessment);
- An patient communication and engagement plan, that appropriately informs patients and which, when required, provides and explains choices as well as more detailed information where required ;
- An understanding of the proposed flows of data, data sets and data items;
- Clarity on the lawful basis for flowing data between the IUC service with
- appropriate contracts, agreements and controls in place;
- How data will be treated to de-identify, aggregate and anonymous where possible (for example, providing commissioners with accurate dashboards on performance);
- How the service will interact with functionality such as the RCS and integrate with other local services (such as GPs);
- Supporting patients to provide feedback on their experience, the patient pathway and contributing to the development of the service; and
- The provision of assurance that controls are proportionate and in place.

7.6.2. Reporting and Coverage

Regular reporting of data will be required that covers the entirety of the IUC service for a Commissioner's area. Reporting will involve the provision of data to NHS England and Commissioners. Patient-level aggregate data must be available to NHS

[25] http://www.datadictionary.nhs.uk/
[26] https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/

England. The Commissioner shall ensure that information is provided to meet the requirements outlined in this Service Specification.

The IUC service is enabled by information sharing and flow. These principles must be continued into the supply of data. A lead supplier of data and information must be specified by the Commissioner who will collate and coordinate requests for data and information that covers the commissioned IUC Service. Any sub-contracted providers shall share and provide information about their service to the Provider. This will ensure that, in multi-provider areas, there are clear responsibilities on the collation and supply of data to NHS England, and across services and their commissioners.

Performance reporting will be required at regular intervals, as specified in the IUC MDS. Data to provide assurance of plans at peak periods, such as all bank holidays but in particular the longer bank holidays at Christmas and Easter, will be required to ensure a resilient service. The Commissioners shall assure of the quality and appropriateness of these plans. This information, along with performance data during the period may be required by NHS England to assure it of the ability of the service to meet the desired levels of performance. The details of these requirements will be outlined prior to any request for information. The Providers shall support any such information provision in a timely manner.

NHS England will publish a sub set of the information provided, including the MDS, in an aggregate form on the NHS website to provide transparency and visibility. For the avoidance of doubt, this data will be in a form that is non-patient identifiable. The Provider shall ensure that data provided is of adequate quality.

7.6.3. IUC Minimum Data Set

The Commissioner shall ensure the data required to populate the IUC MDS is collected and reported. The IUC MDS is an adaptation of the NHS 111 Minimum Data Set (MDS) and has been specified in close collaboration with providers and commissioners. The IUC MDS forms the minimum level of data provision to NHS England for performance monitoring.

The details of the IUC MDS are published in supplemental document(s). These document(s) may be subject to review and change as the service evolves to meet the needs of patients. The Commissioner shall ensure data complies with the specification outlined in the latest versions of these documents.

Development work will continue to create and set system-wide metrics responsible for tracking patient outcomes as well as service performance. The Provider shall comply with these metrics once agreed.

7.6.4. Data Submissions

The Commissioner shall ensure that data submissions are made using the mechanisms specified and the deadlines outlined in the Service Specification, supplementary document(s) or direct requests. This may be in the form of patient-level data that flows to NHS England, or via aggregate forms. The Commissioner shall ensure a lead Provider is appointed for the IUC Service and that they supply data at the frequency and quality required to comply with local and National requests. The Commissioner shall link the timely provision of data to commensurate service credits within the contract.

7.6.5. Disposition and Outcome Monitoring

A key element of understanding the performance of the service and its wider benefit on the health service is the disposition and outcome monitoring. Understanding will be provided through regular performance monitoring and periodic evaluations undertaken by NHS England. This work will be underpinned by information on the call outcome, or disposition and the patient outcome and impact on the wider health service. This information must be captured in line with guidance provided by NHS England, whether that is within the IUC MDS, or evaluation specific guidance.

7.6.6. Staff and Patient Feedback and Surveys

Patient feedback is a fundamental part of understanding the performance of the IUC Service. It allows the Patient's experience of the Service to inform Service design and modification. The Commissioner shall ensure a regular Patient Survey is undertaken for each area to capture Patients' Feedback. The details of the Survey are contained within the IUC MDS. This outlines the frequency of collection, prescribes question wording and methodology. The Commissioner shall ensure that Services are contracted to meet the requirements outlined in the IUC MDS for Patient Surveys. By following this prescribed information, the Commissioner and NHS England will have comparable data on which to compare performance between areas.

7.6.7. Staff and Financial Metrics

In order to allow the Commissioner and NHS England to understand the value for money, efficiency and effectiveness of the IUC service, the Provider shall share financial inputs and staff models. Staff and financial information are also required by NHS England for service design purposes. The Commissioner shall ensure that the information available aligns with the requirements outlined in the IUC MDS and is supplied at the frequency to meet these needs. Any staff or financial information that is commercially sensitive, and that is supplied to NHS England, will not be publically disclosed, unless required otherwise by the information commissioner.

7.7. Syndromic Surveillance

Syndromic surveillance is the process of collecting, analysing and interpreting health-related data to provide an early warning of human or veterinary public health threats, which require public health action.

The Public Health England (PHE) real-time surveillance team (ReSST) coordinates several syndromic systems collecting and analysing health data from several sources.

The Provider shall ensure that the relevant data feeds are established to support syndromic surveillance in IUC and that the relevant data sharing agreements are put in place.

7.7.1. Remote Health Advice Syndromic Surveillance System

Monitoring patterns in phone calls to the NHS 111 service each day across England, to track the spread of infectious diseases like flu and norovirus. This is achieved by linking data held in the Repeat Caller Service (RCS) database.

7.7.2. Integrated Urgent Care Surveillance System

Monitoring the number of visits to GPs during regular surgery hours for known clinical indicators. This data is collected directly from GP systems.

Monitoring the number of unscheduled visits and calls to GPs during evenings, overnight, at weekends and on public bank holidays. This data is collected directly from IUC systems.

7.7.3. Emergency Department Syndromic Surveillance System

The Emergency Department Syndromic Surveillance System (EDSSS) monitors the daily visits in a network of emergency across England.

7.8. Technical Standards

The provider shall deliver services in accordance with the Integrated Urgent Care Technical Standards (see Appendix D).

8. Local Provider Premises

KEY SERVICE REQUIREMENTS

These are key requirements that include but are not limited to;

Commissioners must ensure:

1. Call handling arrangements offer adequate economy of scale.
2. The consideration of any channel shift resulting from the introduction of online services.

A full list of requirements can be found in the section below.

It is recognised that call handling contact centres benefit from economy of scale and require a critical mass below which significant inefficiencies can be encountered (based on the industry standard Erlang C modelling tool). The Commissioner shall ensure that commissioning arrangements offer adequate economy of scale. This should include but not be limited to the ability to roster specialist staff groups throughout the 24 hour period.

When considering economies of scale and commissioning footprints, the Commissioner should take into account any channel shift resulting from the introduction of on-line services.

The Provider shall ensure that contact centres are located to maximise recruitment potential. This may include virtualisation with hard to recruit specialist staff working remotely.

Appendix A – Evidence Base

IUC Evaluation Interim Findings (August 2017)

1. There is evidence that NHS 111 currently directs more people to A&E than need to go because the NHS Pathways algorithm by itself lacks flexibility. The hypothesis is that if more NHS 111 callers received clinical advice, fewer people would be directed to A&E.

2. This view was supported in a North of England Commissioning Support (NECS) study which showed that for a sub-set of callers recommended to attend A&E by the Pathways algorithm, 83% were recommended not to attend after clinical input was provided.

3. Pilots were set up to test this finding across other NHS 111 sites in the North East (NE), Staffordshire, and Outer North West London (ONWL), to understand the impact on Type 1 A & E attendances of providing clinical consultation to NHS 111 calls through a Clinical Assessment Service (CAS) .

<u>Key Findings</u>

4. A clinical advice service can reduce the number of callers being advised to attend A&E. Of NHS 111 callers in the NE who would have been advised to attend A&E and who were subsequently referred to a CAS, 82% were not then advised to attend A&E.

5. However, the overall effect on the proportion of callers advised to attend A&E is more modest. This is because only around a fifth of callers who would have been advised to attend A&E were deemed appropriate clinically to refer to a CAS. In the NE, the overall proportion of NHS 111 callers advised to attend A&E reduced from 8.0% to 6.4% as a result of this intervention, i.e. a reduction of around 20%.

6. Figure 1 shows that people who attend A&E after calling NHS 111 are comprised of both those who are advised to attend and those who were referred to other services but still choose to attend A&E.

7. The proportion of NE NHS 111 callers actually attending A&E reduced from 21.8% to 21.2%. This is a 3% reduction in A&E attendances by NHS 111 callers. In the NE, 20% of A&E attendances were preceded by a call to NHS 111, therefore the effect on all A&E attendances would be a reduction of 0.6%.

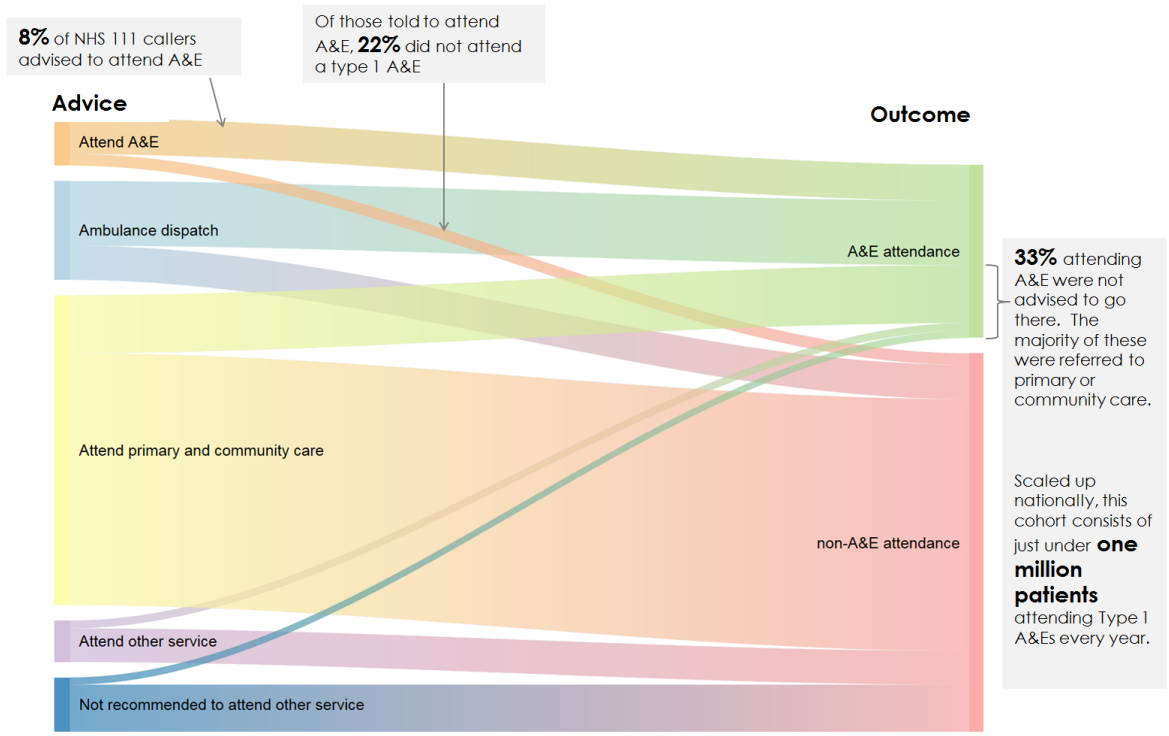

Fig 1

8. These results are consistent with results from Staffordshire. In Staffordshire the proportion of callers advised to attend A&E fell from 7.8% to 6.8% as a result of the CAS. However, there was no statistically significant impact on type 1 A&E attendances from NHS 111.

9. In ONWL, the model piloted was different. It targeted patients with a pathways disposition of attend ED or contact GP and then compared those who received clinical input to those who did not. There was no statistically significant reduction on type 1 A&E attendances as a result of clinical input.

10. Further evaluation work will focus on understanding why people not advised to go to A&E adhere (or don't adhere) to advice; and the extent to which these related A&E attendances are inappropriate. Key lines of enquiry include:
    - Would increased clinical input to this group improve adherence to advice?
    - Would immediately bookable GP appointments for these patients improve adherence?
    - Would immediately bookable appointments in a UTC help?
    - NHS 111 able to issue repeat and new prescriptions?
    - Are there other behavioural factors we can target (e.g. how the advice is phrased)?

11. Full phase 1 evaluation findings are available upon request.

Appendix B - Clinical Governance Tool Kit

https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/clinical-governance-in-iuc-guidance-for-commissioners/file_popview

Appendix C – Low Acuity Ambulance and ED Disposition Validation

Candidate dispositions including but are not limited to:

111 Clinical Assessment:
Warm transfer: DX32; DX106; DX321 - 328
Normal transfer: DX36; DX35; DX38; DX58; DX59

A&E Calls:
DX89; DX92; DX03; DX118; DX02; DX0

The timelines required for call back are as follows:
The following pathway disposition codes and call back times are being used in an operational IUC CAS and have been approved by the National Clinical Governance meeting on 22nd February 2017.

This is guidance that may be adopted locally but only after local clinical agreement is reached.

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
DX05	To contact the GP practice or other local service within 2 hours.	Appointment booking required	Urgent	20 min	Less Urgent	60 min	111 to book appointments directly
DX06	To contact the GP practice or other	Appointment booking	Less Urgent	2 hrs	Less Urgent	4 hrs	111 to book appointments directly

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
	local service within 6 hours.	required					
DX07	To contact the GP practice or other local service within 12 hours.	Appointment booking required	Less Urgent	2 hrs	Less Urgent	4 Hrs	111 to book appointments directly
DX08	To contact the GP practice or other local service within 24 hours	Appointment booking required	Less Urgent	2 hrs	Less Urgent	4 Hrs	111 to book appointments directly
DX11	Speak to GP practice within 1 hour.	Clinician call back required	Less Urgent	60 min	Less Urgent	60 min	To go directly to CAS if this is technically possible
DX32	Speak to a clinician within our service immediately	Clinician call back required	Immediate	Warm transfer	Urgent	15min	To go directly to CAS if this is technically possible
DX34	Speak to a clinician within our service within 30 mins	Clinician call back required	Urgent	30 min	Urgent	30 min	To go directly to CAS if this is technically possible
DX35	Speak to a clinician within 2 hours	Clinician call back required	Less Urgent	2 hours	Less Urgent	2 hrs	To go directly to CAS if this is technically possible
DX38	Speak to a clinician for home management	Clinician call back required	Less Urgent	4 hours	Less Urgent	4 hrs	To go directly to CAS if this is technically possible
DX39	Symptom management advice (colds & flu)	Clinician call back required	Less Urgent	4 hours	Less Urgent	4 hrs	To go directly to CAS if this is technically possible

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
DX46,96	Refer to Health Information	Clinician call back required	Less Urgent	12 – 24 hours	Less Urgent	4 hrs	To go directly to CAS if this is technically possible
DX58,59	No 111 CA available. Refer for urgent Primary Care assessment	Clinician call back required	Less Urgent	20 min (G3) 60 min (G4)	Urgent	20 min 60 min	To go directly to CAS if this is technically possible
DX82	Medication enquiries	Clinician call back required	Immediate	Warm transfer	Less Urgent	1 hr	To go directly to CAS if this is technically possible
DX321	Refused ambulance disposition	Clinician call back required	Immediate	Warm transfer	Urgent	15min	To go directly to CAS if this is technically possible
DX322	Refused ED disposition	Clinician call back required	Immediate	Warm transfer	Urgent	30min	To go directly to CAS if this is technically possible
DX323	Refused Primary Care disposition	Clinician call back required	Immediate	Warm transfer	Less Urgent	2 hrs	To go directly to CAS if this is technically possible
DX324	Refused disposition	Clinician call back required	Immediate	Warm transfer	Urgent	30min	To go directly to CAS if this is technically possible
DX325	Toxic ingestion/inhalation	Clinician call back required	Immediate	Warm transfer	Urgent	15min	To go directly to CAS if this is technically possible
DX326	Frequent caller	Clinician call back required	Immediate	Warm transfer	Less Urgent	2 hr	To go directly to CAS if this is technically possible

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
DX327	Chemical eye splash	Clinician call back required	Immediate	Warm transfer	Urgent	15 min	To go directly to CAS if this is technically possible
DX110	Community nurse within 4 hours.	Clinician call back required	Less Urgent	60 min	Less Urgent	2 hrs	Contact centre to deal with this request
DX111	Community nurse within 24 hours.	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	Contact centre to deal with this request
DX1111	Speak to primary care service within 1 hour possible viral haemorrhagic fever.	Clinician call back required	Urgent	?	Less Urgent	60 min	
DX112	Community nurse next working day.	Clinician call back required	Less Urgent	4 hrs	Less Urgent	4 hrs	Contact centre to deal with this request
DX113	Health visitor next working day.	Clinician call back required	Less Urgent	4 hrs	Less Urgent	4 hrs	Should not be coming to Urgent care.
DX114	Community midwife next working day	Clinician call back required	Less Urgent	4 hrs	Less Urgent	4 hrs	Should not be coming to Urgent care
DX115	Contact own GP practice next working day for appointment.	Clinician call back required	Less Urgent	4 hrs	Less Urgent	4 hrs	Should not be coming to Urgent care
DX116	Speak to GP practice within 2	Clinician call back	Urgent	60 min	Less Urgent	60 min	To go directly to CAS if this is technically possible

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
	hours	required					
DX117	To contact GP practice or other local service within 1 hour	Clinician call back required	Urgent	20 min	Less Urgent	60 min	To go directly to CAS if this is technically possible
DX12	Speak to GP practice within 2 hours	Clinician call back required	Less Urgent	60 min	Less Urgent	2 hrs	To go directly to CAS if this is technically possible
DX13	Speak to GP practice within 6 hours	Clinician call back required	Less Urgent	60 min	Less Urgent	4 hrs	To go directly to CAS if this is technically possible
DX14	Speak to GP practice within 12 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	To go directly to CAS if this is technically possible
DX15	Speak to GP practice within 24 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	6 hrs	To go directly to CAS if this is technically possible
DX76	call-back by healthcare professional within 20 minutes	Clinician call back required	Less Urgent	20 min	Urgent	20 min	To go directly to CAS if this is technically possible
DX77	call-back by healthcare professional within 60 minutes	Clinician call back required	Less Urgent	20 min	Less Urgent	60 min	To go directly to CAS if this is technically possible
DX79	Failed contraception	Clinician call back	Less Urgent	2 hrs			DX code no longer in use

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
		required					
DX80	Repeat prescription required within 6 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	Can these be managed differently without the need for urgent care input?
DX85	Repeat prescription required within 2 hours	Clinician call back required	Urgent	2 hrs	Less Urgent	4 hrs	Can these be managed differently without the need for urgent care input?
DX86	Repeat prescription required within 12 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	Can these be managed differently without the need for urgent care input?
DX87	Repeat prescription required within 24 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	Can these be managed differently without the need for urgent care input?
DX93	Speak to GP practice within 1 hour (3 calls within 4 days)	Clinician call back required	Urgent	20 min	Less Urgent	60 min	To go Directly to CAS if this is technically possible

Indicates NHS 111 CA dispositions

Appendix D – IT Standards

https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/integrated-urgent-care-technical-and-interoperability-standards/file_popview

Appendix E – DoS Standards hypertext link

DoS Profiling Principles: https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/directory-of-services-dos-profiling-principles/file_popview

DoS Resource Guide: https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/directory-of-services-dos-resource-guide/file_popview

Appendix F – Telephony Messaging Strategy

https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/iuc-telephony-messaging-standards/file_popview

Appendix G – IUC for Carers

Based on feedback from services users, the following vignettes guide the types of service considerations that must be made:

1. In the early evening at the weekend, a Carer in her 60's calls NHS111 for herself, she has a long history of asthma and has developed a chest infection – she knows from many years of experience that she must seek early oral steroid and antibiotics to avoid hospital admission. This is very important for her as she is the only carer for her husband with advanced Alzheimer's disease. He is suffering with Sundowning and is unable to leave the house and there are no carers due until the Tuesday, after the bank holiday weekend. She appropriately receives a primary care disposition to see a GP at an urgent treatment centre, however is unable to attend due to her needs as a Carer for her husband without securing emergency carers. After trying to get emergency carers for nearly two hours, this proves impossible and she calls NHS 111 to ask to have a home visit but this takes many hours to arrange. Eventually she is seen at home at 02:30am by a GP, which disturbed her husband who could not sleep again all night. She was unable to get the prescription until the following day.

In this case the service should have taken into account the fact that the caller was a Carer and sought to understand how best to meet her needs and that of her husband – in this case a telephone conversation with a clinician may have ameliorated the need to see the patient, or alternatively a home visit should have been made available earlier, supported by appropriate prescribing and dispensing capabilities.

2. A 14 year old calls NHS111 about his mother who has a learning disability at midday on Saturday – she has been suffering with depression over the previous 4 weeks and the caller has taken time off of school to look after her as they live alone. The triage identifies no immediate clinical need and suggests that he contacts the GP on Monday morning; the Health Advisor speaks to a clinician and they talk to the caller to identify any safeguarding requirements – however there are no immediate priorities identified and it is considered that whilst a safeguarding referral was appropriate in the circumstances as this has happened quite a lot of times and the school were aware, that no immediate action should be

taken. However, what was not disclosed during the telephone call was that the caller had been self-harming for a significant period of time, as a result of social isolation from school and worries about exams. In fact he had been self-harming that morning and was very capable at hiding his distress. Unfortunately, the service was not aware of this as they did not have access to the records around the Carer associated with the patient's records.

In this case the service the safeguarding issues were considered well, but the holistic needs of the Carer were not well address – instead a system should have been available to ensure a fast track referral to a visiting primary care team was undertaken over the weekend, who have links with the social care teams, to undertake a holistic assessment of the needs of the Carer and patient. This should have been supported by a patient record and a Carer's record to enable the most appropriate and well-informed decision to be made.

Appendix H – Future Technology

Clinical Triage Platform (CTP)
The Clinical Triage Platform (CTP) is a programme of transformation to improve the precision, access, and utility of patient triage in the urgent care system.

The Clinical Triage Platform will be tailored to the needs of the individual; with continual improvements in accuracy and timeliness being underpinned by both individual patient data and evidence of outcomes. Through accurate and personalised triage the CTP will contribute to intelligent demand management, promoting and supporting a sustainable, clinically effective, and financially affordable NHS. The CTP will include improvement of the current NHS Pathways service but is also exploring commercial and partnership options to optimise value for money and provide the best fit with the requirements of the future design of the service.

There are a number of objectives that the CTP programme anticipates delivering:

- The CTP will enable **alternative access routes** to triage that are appropriate to the channel they are accessed by (for example, online), these alternative routes will need to be able to integrate with all other channels providing a seamless journey for patients, and provide consistent and replicable outcomes across the system.
- The CTP will enable triaging in a consistent and replicable manner while being deployed in a variety of situations, with users of differing needs and skill levels. The programme acknowledges that providers may procure a variety of systems locally and are asked to ensure that there are provisions within any service contract to provide detailed outcome data (including NHS Number) to a central repository under Legal Direction, to ensure consistency and replicability of triage across systems can be assured.
- The provision of this data will be **linked with clinical outcomes** from national and local data sets to enable evidence-based decision making for triage and patient care, referring users to the **most appropriate care** for them based on their needs assessment and all available evidence.
- The CTP will be a responsive system that can utilise data and technology for **continuous triage improvement**, delivering updates into the live environment in the shortest time possible whilst maintaining clinical safety. Providers are asked to factor regular releases and associated training into their operational plans.

- The future CTP will also utilise patient specific data to provide a more **personalised triage**. Providers are asked to ensure their technology roadmaps include the ability to connect with and integrate GP and other patient data via APIs (Application Programming Interfaces) into the CDSS, to enable a personalised, improved and streamlined triage.
- To enable a **seamless user journey** and facilitate transfer of a patients care, the CTP will interoperate by providing integration of data flowing in, through, and out of the whole system.
- Providers are advised to ensure technology procurements and roadmaps factor this interoperability in.

Access to Service Information (A2Si)

The Access to Service Information (A2Si) programme has been created to ensure the existing DoS is both sustained in its current form and is developed to support a wider set of use cases across and in support of Urgent and Emergency Care.

It will be possible for IUC Providers and their system suppliers to access and query the DoS irrespective of the triage/CDSS in use. The existing DoS service is primarily designed around the use of NHS Pathways; however it is acknowledged that clinical professionals operating in IUC also require access to the DoS (including searching for service by service type and/or symptom group) as a necessary part of their day to day operations. Accordingly, standalone applications and integrated access to the DoS via APIs will be developed in order to support the wide range of IUC models and systems planned or in use.

Providers are advised to ensure technology procurements and roadmaps factor this future development.

In order for the above initiative to be successful it is essential that upon completion the clinical triage of a patient there are common standards relating to the resulting clinical disposition. The A2Si programme will be working to develop these standards and encourage all providers to contribute to the development of and ensure the adoption of these standards.

There are a number of emerging themes and anticipated technology deliverables that will become applicable to IUC providers in future:

- The programme acknowledges the existence and ongoing development of other directories of service. Providers are encouraged to ensure that existing

and future directories are developed consistently with the national DoS in order to ensure integration across technical and regional boundaries to improve service information accuracy.

- The programme will also look to develop a common approach to collection, storage and presentation of urgent and emergency care capacity and demand data such as waiting times, service availability and bed management to support IUC providers in the way they recommend or refer patients to an onward service. Providers are encouraged to ensure their existing systems are able to both store, send, receive and display such capacity and demand data to their users and to downstream systems and services. Similarly, the programme is exploring how users can seamlessly use this information and their local systems in order to fully transfer the care of patients from their care to an appropriate onward service. This potentially includes the ability to refer a patient and directly book an appointment.
- Finally, the programme will ensure any urgent and emergency care activity data is maximised in terms of its ability to provide intelligence on how patients and professionals require access to and interact with urgent and emergency care services. By applying open data principles and data science methodology NHS Digital will research how this can potentially inform future urgent and emergency care commissioning and service design. Providers must ensure all activity data they collect is available for publication and research subject to appropriate stakeholder agreement and privacy impact assessments etc.

111 On-line

Patients increasingly expect to be able to access healthcare via digital channels. But as well as better meeting patient needs, digital access to care provides the potential for channel shift to mitigate costs of rising call volumes. They can be quicker than telephone triage; and demonstrate strengths in dealing with pre-primary, low acuity conditions. They can also help support unmet patient needs for specific conditions and needs such as sexual health concerns, dental complaints, or repeat prescriptions. As defined in the Five Year Forward View Next Steps published in April 2017, all NHS 111 services are required to have an online service in place by December 2017.

To ensure that these new digital services are implemented appropriately and based on tested technologies, and that there is evidence of the impact of opening a new digital channel a series of tests have been undertaken in each of the four regions.

A pragmatic evaluation of the 111 online pilots was undertaken in 2017. Its findings were:

- While the numbers through the service are small, the online channel does not appear to stimulate additional demand.
- Uptake is moderately low; between 4 and 15% of callers opt for an online journey, but with development and additional marketing is likely to increase.
- Utilisation generally tends to be for relatively lower complexity conditions but with greater awareness this could also change.
- There has been positive clinical validation of the streaming of patients from the digital services, i.e. the cases sent to a clinician was appropriate.
- There has not been a single product that has stood out as the best. There are local preferences that have influenced the successful implementation.

Commissioners will have the option to choose the service they believe will best meet their needs and are encouraged to contact the test sites to discuss experiences before making a procurement decision. There will be a series of standards and products made available during the summer to provide more detailed guidance to commissioners.

An internal NHS product was commissioned, developed and tested as part of this discovery work. The NHS 111 online product is based on NHS Pathways algorithms. This product will be made available to commissioners.

This service will be hosted on the NHS.UK web domain and will be fully interoperable with the Directory of Services and local services via ITK messaging. This will form an addendum to the NHS Pathways licence.

Where commissioners opt for one of the private sector tested services the responsibility for clinical governance and assurance will sit outside of the NHS Pathways agreements and rest with local services. Commissioners must consider the following in the decision making process for their NHS 111 online product:

- **Commissioning and procurement**. Where possible procurement of digital systems locally should adhere to best practice approaches set out in the government's Technology Code of Practice. In particular given the pace of change in this market NHS England recommends that any contract length with providers of digital triage technology should not exceed 2 years. Given the fast moving nature of these products commissioners are advised to

ensure that supplier switch and transition arrangements are included in any contracts and that the chosen supplier can comply with strategy of becoming part of a central platform for all clinical triage tools. A more detailed set of key procurement standards for NHS 111 online will be produced by August 2017

- **Safety standards**. NHS England will expect triage products on the market to meet relevant safety standards; and be developed in accordance with MHRA or CQC guidelines
- **Directory of Service**. Where relevant commissioners should be mindful of the work that may be required to the DoS to render it suitable for exposure to the public
- **Workforce issues**. Commissioners should consider downstream effects on workforces of increased access to clinicians via digital routes at particular times of the year
- **Testing**. Commissioners must extensively test and assure themselves of the quality and safety of products available in an area. . Plans must be in place for what to do if the digital service goes offline.
- **Governance**. CCGs must establish appropriate clinical and information governance models to govern the use of online channels. This should include consideration of the minimum data set and other mandatory reporting.
- **Service design**. CCGs should consider overall service design in their delivery of online services. For instance, by looking at digital access to primary care and how this might link to digital services in urgent care. Suppliers will be required to adhere to a national brand for the NHS 111 online service
- **Implementation**. Commissioners should plan resources necessary to implement 111 online services by December 2017; and consider any downstream impacts on call volumes.

Commissioners are not advised to procure untested products at this time however where new technologies become available there will be a further series of testing and evaluation.

To support a mixed economy of suppliers in this market, a central project team will be available to provide advice and standards on governance (both clinical and information), support interoperability activity, and providing advice to commissioners on products on the market covering the following areas:

- Setting central standards for triage technologies
- Providing advice on implementing interoperability solutions
- Providing access to key infrastructure such as the DoS via APIs

Appendix I – Roles and Responsibilities

Clinical Commissioning Groups (CCGs) are responsible for:

- Commissioning IUC as an integral part of the urgent care system according to national requirements and standards.
- Providing NHS England with evidence that they have undertaken a robust procurement with an appropriate assurance process.
- Assuring NHS England that they have a contingency strategy in place should the chosen provider fail to deliver the IUC service as contracted.
- Monitoring the impact of IUC on local services so that over/under utilised services are identified and improvements to the urgent care system are made.
- Ensuring the effective mobilisation and operational delivery of an IUC service that serves the CCG population, either directly or via joint commissioning arrangements.
- Performance managing the contract against agreed metrics and KPIs.
- Reporting on the quality, benefits and performance of IUC services.
- Ensuring that Access to Service Information (formerly DoS) is fully up to date with the availability of local services and the agreed referral protocols with service providers.
- Ensuring that the summary care record, local care records, care plans, special patient notes and end of life care records are up to date and available to IUC services.
- Ensuring clinical governance of IUC as an integral part of the urgent care system. This will ensure the quality, safety and effectiveness of the service, leading to people experiencing continuity of service.
- Publicising IUC locally.
- Local stakeholder communications and media handling.
- Ensuring that business continuity and disaster recovery procedures are in place in the event of disruptions to the provision of the IUC service locally.
- Meeting the public sector Equality Duty
- Reporting on the quality, benefits and performance of IUC services and coordinate the collection of data from different organisations where this may be required.

Networks are responsible for:

- Creating and agreeing an overarching, medium to long term plan to deliver IUC aligned to the objectives of the Urgent and Emergency Care Review.
- Designating urgent treatment centre facilities within the network, setting and monitoring standards, and defining consistent pathways of care and equitable access to diagnostics and services for both physical and mental health.
- Making arrangements to ensure effective patient flow through the whole urgent care system (including access to specialist facilities and repatriation to local hospitals).
- Maintaining oversight and enabling benchmarking of outcomes across the whole urgent care system, including primary, community, social, mental health and hospital services, the interfaces between these services and at network boundaries.
- Achieving resilience and efficiency in the urgent care system through coordination, consistency and economies of scale (e.g. agreeing common pathways and services across boundaries).
- Coordinating workforce and training needs: establishing adequate workforce provision and sharing of resources across the network.
- Ensuring the building of trust and collaboration throughout the network, spreading good and best practice and demonstrating positive impact and value, with a focus on relationships rather than structures.

STPs are responsible for:

- In line with the 'must dos' for urgent & emergency care of the NHS Operational Planning Guidance 2017 – 2019, STPs will need to ensure a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.

NHS England is responsible for:

- Monitoring the performance of IUC and compliance with national requirements, quality and performance standards.
- Monitoring the impact of IUC with the urgent care system.
- Assuring that CCGs are managing their responsibility for quality and safety.

- Commissioning and management of IUC national telephony infrastructure and IT systems including repeat caller service, NHS Pathways and Access to Service Information (formerly DoS).
- Liaison with Ofcom over the use of the 111 number.
- Accreditation of IUC Clinical Decision Support System(s)
- National communications and media handling.
- Ownership of and development of the IUC (111) brand, core values and guidelines for usage.
- Ownership of the IUC Commissioning Standards and governance of any changes.
- Identifying and sharing lessons learned and good practice across local areas.
- Meeting its legal duties on equality and on health inequalities
- Assuring national business continuity and CCG's contingency arrangements for managing unforeseen surges in demand.
- Approving key decisions, plans, deliverables and any changes to the IUC service design.
- Overseeing interdependencies with related initiatives and programmes outside the scope of IUC.
- Assuring that the interests of key stakeholder groups are represented.
- Providing a formal escalation point for the NHS and other stakeholders for issues and concerns relating to IUC.
- Periodically providing assurance to the NHS England Board.
- Supporting CCGs' re-procurements of IUC contracts and the transition of services from their current state to any new provider.

Appendix J – Workforce Blueprint

The Provider shall implement these products as a key element of the IUC service. Where a product does not exist, there is a requirement for Commissioners and Providers to ensure that best practice is implemented.

The Blueprint will include the following products:

1. Career Framework; competency based job descriptions Skills for Health Levels 2-7
2. Core and specialist competencies Skills for Health Levels 7-9
3. Apprenticeship scheme
4. Workforce Governance Guide
5. Workforce Mental Health and Wellbeing
6. Accreditation of education and training
7. Leadership development
8. Workforce modelling
9. Career of choice
10. Workforce Survey Recommendations Report

During the development of the Blueprint products commissioners and providers must remain clearly sighted on the quality, composition and competence of the existing workforce. Specifically, that all staff working within IUC call-centre services, including the CAS, must have an appropriate level of understanding and competence in telephone/remote practice/consultation, the use of the CDSS systems, and knowledge of the wider urgent & emergency care system, to ensure a consistently safe and high quality service for patients.

Appendix K – SG/SD Codes

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1000	abdominal or flank injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1001	abdominal or flank injury, blunt, pregnant	4052	ED Full assessment and management capability	FALSE	FALSE
1002	Abdominal or Flank Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1003	Abdominal or Flank Injury, Penetrating, Pregnant	4052	ED full ED assessment and management capability	FALSE	FALSE
1004	abdominal pain	4052	ED Full assessment and management capability	TRUE	TRUE
1006	abdominal, flank, groin or back pain or swelling	4052	ED Full assessment and management capability	TRUE	TRUE
1009	Alcohol Intoxication	4052	ED full ED assessment and management capability	TRUE	FALSE
1010	allergic reaction	4052	ED Full assessment and management capability	TRUE	TRUE
1011	ankle or foot injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1011	Ankle or Foot Injury, Blunt	4304	ED unable to weightbear	FALSE	FALSE
1012	Ankle or Foot Injury, Penetrating	4009	ED amputation, digit	FALSE	FALSE
1012	Ankle or Foot Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1013	ankle or foot pain or swelling	4052	ED Full assessment and management capability	TRUE	TRUE
1014	arm injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1015	Arm Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1016	arm, pain or swelling	4052	ED Full assessment and management capability	TRUE	TRUE
1018	behaviour change	4052	ED Full assessment and management capability	TRUE	TRUE
1018	behaviour change	4245	ED suicidal, no means nor plan	TRUE	TRUE
1020	bites or stings, insect or spider	4052	ED Full assessment and management capability	TRUE	TRUE
1020	Bites or Stings, Insect or Spider	4132	ED tick, removal required	TRUE	FALSE
1021	Bites, Animal	4009	ED amputation, digit	FALSE	FALSE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1021	bites, animal	4052	ED Full assessment and management capability	TRUE	FALSE
1022	bites, human	4052	ED full assessment and management capability	TRUE	FALSE
1023	bites, snake	4052	ED Full assessment and management capability	FALSE	FALSE
1024	Blisters	4052	ED Full assessment and management capability	TRUE	TRUE
1034	breathing problems, breathlessness or wheeze	4052	ED Full assessment and management capability	TRUE	TRUE
1034	breathing problems, breathlessness or wheeze	4403	ED viral haemorrhagic fever	FALSE	FALSE
1035	breathing problems, breathlessness or wheeze, pregnant	4052	ED Full assessment and management capability	FALSE	FALSE
1035	Breathing Problems, Breathlessness or Wheeze, Pregnant	4052	ED full ED assessment and management capability	FALSE	FALSE
1036	bringing up blood	4052	ED Full assessment and management capability	TRUE	TRUE
1036	Bringing Up Blood	4403	ED viral haemorrhagic fever	FALSE	FALSE
1037	Burn, Chemical	4024	ED management, significant burn	FALSE	FALSE
1037	burn, chemical -	4052	ED full assessment and management capability	TRUE	FALSE
1038	Burn, Thermal	4024	ED management, significant burn	FALSE	FALSE
1038	burn, thermal -	4052	ED full assessment and management capability	TRUE	FALSE
1039	chest and upper back pain	4052	ED Full assessment and management capability	TRUE	TRUE
1040	chest or upper back injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1041	Chest or Upper Back Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1042	child safeguard/protection or vulnerable adult concern	4052	ED Full assessment and management capability	FALSE	FALSE
1043	cold or flu	4052	ED Full assessment and management capability	TRUE	TRUE
1043	cold or flu	4403	ED viral haemorrhagic fever	FALSE	FALSE
1044	cold or flu, pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1044	cold or flu, pregnant	4403	ED viral haemorrhagic fever	FALSE	FALSE
1045	Constipation	4052	ED Full assessment and management capability	TRUE	TRUE
1046	constipation, pregnant	4052	ED Full assessment and management capability	TRUE	TRUE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1047	Cough	4052	ED Full assessment and management capability	TRUE	TRUE
1047	Cough	4403	ED viral haemorrhagic fever	FALSE	FALSE
1048	cough, pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1048	Cough, Pregnant	4403	ED viral haemorrhagic fever	FALSE	FALSE
1049	coughing up blood	4052	ED Full assessment and management capability	TRUE	TRUE
1049	coughing up blood	4389	ED post tonsillectomy bleeding	FALSE	FALSE
1050	deliberate selfharm	4052	ED Full assessment and management capability	TRUE	TRUE
1050	deliberate selfharm	4245	ED suicidal, no means nor plan	TRUE	TRUE
1051	Dental Bleeding	4052	ED full ED assessment and management capability	TRUE	FALSE
1051	Dental Bleeding	4391	ED bleeding post dental procedure	FALSE	FALSE
1052	Dental Injury	4052	ED full ED assessment and management capability	FALSE	FALSE
1054	Diarrhoea	4052	ED Full assessment and management capability	TRUE	TRUE
1054	Diarrhoea	4403	ED viral haemorrhagic fever	FALSE	FALSE
1055	diarrhoea and vomiting	4052	ED Full assessment and management capability	TRUE	TRUE
1055	diarrhoea and vomiting	4403	ED viral haemorrhagic fever	FALSE	FALSE
1056	diarrhoea or vomiting, pregnant, over 20 weeks	4052	ED Full assessment and management capability	TRUE	TRUE
1056	diarrhoea or vomiting, pregnant, over 20 weeks	4403	ED viral haemorrhagic fever	FALSE	FALSE
1059	dizziness or vertigo	4052	ED Full assessment and management capability	TRUE	TRUE
1060	dizziness or vertigo pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1061	drowsiness -	4052	ED full assessment and management capability	TRUE	FALSE
1061	drowsiness -	4245	ED suicidal, no means nor plan	TRUE	FALSE
1062	drowsiness, pregnant -	4052	ED full assessment and management capability	TRUE	FALSE
1062	drowsiness, pregnant -	4245	ED suicidal, no means nor plan	TRUE	FALSE
1063	Ear Discharge or Ear Wax	4052	ED full ED assessment and management capability	TRUE	FALSE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1063	ear discharge or ear wax	4022	ED foreign body, removal required	FALSE	FALSE
1064	Earache	4022	ED foreign body, removal required	FALSE	FALSE
1064	Earache	4052	ED Full assessment and management capability	TRUE	TRUE
1064	Earache	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1065	easy or unexplained bruising	4052	ED Full assessment and management capability	TRUE	TRUE
1066	Electrical Injury	4052	ED full ED assessment and management capability	FALSE	FALSE
1066	electrical injury	4094	ED electric shock, domestic or lesser supply	FALSE	FALSE
1067	External Fixation Problems	4052	ED full ED assessment and management capability	FALSE	FALSE
1068	eye injury, blunt -	4052	ED full assessment and management capability	TRUE	FALSE
1068	Eye Injury, Blunt	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1069	Eye Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1069	eye injury, penetrating -	4052	ED full ED assessment and management capability	FALSE	FALSE
1071	eye splash injury or minor foreign body	4052	ED Full assessment and management capability	TRUE	FALSE
1071	Eye Splash Injury or Minor Foreign Body	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1071	Eye Splash Injury or Minor Foreign Body	4306	ED highly dangerous chemical	FALSE	FALSE
1071	eye splash injury or minor foreign body	4312	ED extended ophthalmic assessment and prescribing capability (MECS)	FALSE	FALSE
1072	eye, painful	4052	ED Full assessment and management capability	TRUE	TRUE
1072	eye, painful	4134	ED full ophthalmic assessment and management capability	FALSE	FALSE
1072	Eye, Painful	4312	ED extended ophthalmic assessment and prescribing capability (MECS)	FALSE	FALSE
1073	Eye, Red or Irritable	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1073	Eye, Red or Irritable	4312	ED extended ophthalmic assessment and prescribing capability (MECS)	FALSE	FALSE
1074	Eye, Sticky or Watery	4052	ED full ED assessment and management capability	TRUE	FALSE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1074	Eye, Sticky or Watery	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1074	Eye, Sticky or Watery	4312	ED extended ophthalmic assessment and prescribing capability (MECS)	FALSE	FALSE
1076	Eye, Visual Loss or Disturbance	4052	ED full ED assessment and management capability	TRUE	FALSE
1076	Eye, Visual Loss or Disturbance	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1076	Eye, Visual Loss or Disturbance	4312	ED extended ophthalmic assessment and prescribing capability (MECS)	FALSE	FALSE
1078	Eyelid Problems	4052	ED full ED assessment and management capability	TRUE	FALSE
1078	Eyelid Problems	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1078	Eyelid Problems	4312	ED extended ophthalmic assessment and prescribing capability (MECS)	FALSE	FALSE
1080	face, neck pain or swelling	4022	ED foreign body, removal required	FALSE	FALSE
1080	face, neck pain or swelling	4052	ED Full assessment and management capability	TRUE	TRUE
1080	Face, Neck Pain or Swelling	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1081	falls or faints without injury	4052	ED Full assessment and management capability	TRUE	TRUE
1081	falls or faints without injury	4245	ED suicidal, no means nor plan	TRUE	TRUE
1082	Falls or Faints Without Injury, pregnant	4052	ED full ED assessment and management capability	TRUE	FALSE
1082	falls or faints without injury, pregnant -	4245	ED suicidal, no means nor plan	TRUE	FALSE
1083	falls without injury	4052	ED Full assessment and management capability	TRUE	TRUE
1084	Fever	4052	ED Full assessment and management capability	TRUE	TRUE
1084	Fever	4403	ED viral haemorrhagic fever	FALSE	FALSE
1085	Finger or Thumb Injury, Blunt	4014	ED constricting object, removal required	FALSE	FALSE
1085	finger or thumb injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1086	Finger or Thumb Injury, Penetrating	4009	ED amputation, digit	FALSE	FALSE
1086	Finger or Thumb Injury, Penetrating	4014	ED constricting object, removal required	FALSE	FALSE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1086	Finger or Thumb Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1086	Finger or Thumb Injury, Penetrating	4410	ED hydraulic injection injury	FALSE	FALSE
1088	fits within the last 12 hours	4052	ED Full assessment and management capability	TRUE	TRUE
1089	flank or side pain	4052	ED Full assessment and management capability	TRUE	TRUE
1091	Foreign Body, Ear	4052	ED full ED assessment and management capability	FALSE	FALSE
1091	Foreign Body, Ear	4022	ED foreign body, removal required	FALSE	FALSE
1092	Foreign Body, Ingested or Inhaled	4022	ED foreign body, removal required	FALSE	FALSE
1092	Foreign Body, Ingested or Inhaled	4052	ED full ED assessment and management capability	FALSE	FALSE
1093	Foreign Body, Nose	4052	ED full ED assessment and management capability	FALSE	FALSE
1093	Foreign Body, Nose	4022	ED foreign body, removal required	FALSE	FALSE
1094	Foreign Body, Penis	4022	ED foreign body, removal required	FALSE	FALSE
1094	Foreign Body, Penis	4052	ED full ED assessment and management capability	FALSE	FALSE
1095	Foreign Body, Rectum	4022	ED foreign body, removal required	FALSE	FALSE
1095	Foreign Body, Rectum	4052	ED full ED assessment and management capability	FALSE	FALSE
1096	Foreign Body, Vaginal	4022	ED foreign body, removal required	FALSE	FALSE
1096	Foreign Body, Vaginal	4052	ED full ED assessment and management capability	FALSE	FALSE
1097	genital injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1097	genital injury, blunt	4057	ED foreign body, vagina	FALSE	FALSE
1098	genital injury, blunt, pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1099	Genital Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1100	Genital Injury, Penetrating, Pregnant, Over 20 weeks	4052	ED full ED assessment and management capability	FALSE	FALSE
1101	genital problems	4052	ED Full assessment and management capability	TRUE	TRUE
1101	genital problems	4072	ED testicular torsion	FALSE	FALSE
1103	groin pain or groin swelling	4052	ED Full assessment and management capability	TRUE	TRUE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1104	groin pain or groin swelling, pregnant, under 20 weeks	4052	ED Full assessment and management capability	TRUE	TRUE
1107	hand or wrist injury, blunt	4010	ALL assault, sexual	FALSE	FALSE
1107	hand or wrist injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1108	Hand or Wrist Injury, Penetrating	4009	ED amputation, digit	FALSE	FALSE
1108	Hand or Wrist Injury, Penetrating	4014	ED constricting object, removal required	FALSE	FALSE
1108	Hand or Wrist Injury, Penetrating	4015	ED bleeding disorder	FALSE	FALSE
1108	Hand or Wrist Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1108	Hand or Wrist Injury, Penetrating	4410	ED hydraulic injection injury	FALSE	FALSE
1110	head, facial or neck injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1111	Head, Facial or Neck Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1112	Headache	4052	ED Full assessment and management capability	TRUE	TRUE
1112	Headache	4245	ED suicidal, no means nor plan	TRUE	TRUE
1112	Headache	4403	ED viral haemorrhagic fever	FALSE	FALSE
1113	headache, pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1113	headache, pregnant	4245	ED suicidal, no means nor plan	TRUE	TRUE
1113	headache, pregnant	4403	ED viral haemorrhagic fever	FALSE	FALSE
1114	heat exposure	4052	ED Full assessment and management capability	TRUE	TRUE
1115	hip, thigh or buttock pain or swelling	4052	ED Full assessment and management capability	TRUE	TRUE
1115	hip, thigh or buttock pain or swelling -	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1115	hip, thigh or buttock pain or swelling	4245	ED suicidal, no means nor plan	TRUE	TRUE
1117	knee or lower leg pain or swelling	4052	ED Full assessment and management capability	TRUE	TRUE
1119	leg injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1120	Leg Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1121	Locked Jaw	4052	ED full ED assessment and management capability	FALSE	FALSE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1122	lower back injury, blunt	4010	ALL assault, sexual	FALSE	FALSE
1122	lower back injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1123	lower back injury, blunt, pregnant	4010	ALL assault, sexual	FALSE	FALSE
1123	lower back injury, blunt, pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1124	Lower Back Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1125	Lower Back Injury, Penetrating, Pregnant	4052	ED full ED assessment and management capability	FALSE	FALSE
1126	lower back pain	4052	ED Full assessment and management capability	TRUE	TRUE
1128	lower limb pain or swelling	4052	ED Full assessment and management capability	TRUE	TRUE
1130	nasal congestion	4022	ED foreign body, removal required	FALSE	FALSE
1130	nasal congestion	4052	ED Full assessment and management capability	TRUE	TRUE
1130	nasal congestion	4403	ED viral haemorrhagic fever	FALSE	FALSE
1131	nosebleeds without injury	4022	ED foreign body, removal required	FALSE	FALSE
1131	nosebleeds without injury	4052	ED Full assessment and management capability	TRUE	TRUE
1132	Nosebleeds, Traumatic	4052	ED full ED assessment and management capability	FALSE	FALSE
1132	Nosebleeds, Traumatic	4022	ED foreign body, removal required	FALSE	FALSE
1133	numbness or pins and needles	4052	ED Full assessment and management capability	TRUE	TRUE
1134	Other Dental Problems - Fillings, Crowns Bridges, Appliances etc	4052	ED full ED assessment and management capability	FALSE	FALSE
1137	Palpitations	4052	ED Full assessment and management capability	TRUE	TRUE
1138	palpitations, pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1139	Plaster Cast Problems	4052	ED full ED assessment and management capability	FALSE	FALSE
1139	Plaster Cast Problems	4140	ED tight/painful plaster	FALSE	FALSE
1139	Plaster Cast Problems	4141	ED loose/damaged plaster	FALSE	FALSE
1139	Plaster Cast Problems	4146	ED ischaemia, digit/s	FALSE	FALSE
1139	Plaster Cast Problems	4305	ED local infection	TRUE	FALSE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1140	predetermined management plan	4052	ED Full assessment and management capability	TRUE	TRUE
1140	predetermined management plan	4245	ED suicidal, no means nor plan	TRUE	TRUE
1141	Probable Stroke	4052	ED full ED assessment and management capability	FALSE	FALSE
1143	rectal bleeding	4052	ED Full assessment and management capability	TRUE	TRUE
1144	rectal pain, swelling, lump or itch	4052	ED Full assessment and management capability	TRUE	TRUE
1145	scratches and grazes	4052	ED Full assessment and management capability	TRUE	FALSE
1145	Scratches and Grazes	4138	ED wound, contaminated	FALSE	FALSE
1146	Sexual Problems or Concerns	4022	ED foreign body, removal required	FALSE	FALSE
1146	sexual problems or concerns	4052	ED Full assessment and management capability	TRUE	TRUE
1146	sexual problems or concerns	4056	ED toxic shock syndrome	FALSE	FALSE
1146	Sexual Problems or Concerns	4058	ED foreign body, rectum	FALSE	FALSE
1146	Sexual Problems or Concerns	4081	ED foreign body, skin, small	FALSE	FALSE
1147	shoulder pain	4052	ED Full assessment and management capability	TRUE	TRUE
1147	shoulder pain	4134	ED full ophthalmic assessment and management capability	FALSE	FALSE
1148	Sinusitis	4022	ED foreign body, removal required	FALSE	FALSE
1148	Sinusitis	4052	ED Full assessment and management capability	TRUE	TRUE
1148	Sinusitis	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1150	skin, glued	4052	ED Full assessment and management capability	TRUE	TRUE
1150	Skin, Glued	4134	ED full ophthalmic ED assessment and management capability	FALSE	FALSE
1151	skin, minor foreign body	4052	ED Full assessment and management capability	FALSE	FALSE
1151	Skin, Minor Foreign Body	4081	ED foreign body, skin, small	FALSE	FALSE
1152	skin, rash	4052	ED Full assessment and management capability	TRUE	TRUE
1153	skin, yellow	4052	ED Full assessment and management capability	TRUE	TRUE
1154	sleep difficulties	4052	ED Full assessment and management capability	TRUE	TRUE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1154	sleep difficulties	4245	ED suicidal, no means nor plan	TRUE	TRUE
1155	Social or Domestic Emergency	4052	ED full ED assessment and management capability	TRUE	FALSE
1155	social or domestic emergency	4245	ED suicidal, no means nor plan	TRUE	TRUE
1156	sore throat	4052	ED Full assessment and management capability	TRUE	TRUE
1156	sore throat	4389	ED post tonsillectomy bleeding	FALSE	FALSE
1156	sore throat	4403	ED viral haemorrhagic fever	FALSE	FALSE
1157	stoma problems	4052	ED Full assessment and management capability	TRUE	TRUE
1158	Sunburn	4050	ED dehydration	FALSE	FALSE
1158	Sunburn	4052	ED Full assessment and management capability	TRUE	TRUE
1158	Sunburn	4062	ED welding flash/UV exposure	FALSE	FALSE
1158	Sunburn	4312	ED extended ophthalmic assessment and prescribing capability (MECS)	FALSE	FALSE
1162	tiredness (fatigue)	4052	ED Full assessment and management capability	TRUE	TRUE
1162	tiredness (fatigue)	4245	ED suicidal, no means nor plan	TRUE	TRUE
1163	tiredness (fatigue), pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1163	tiredness (fatigue), pregnant	4245	ED suicidal, no means nor plan	TRUE	TRUE
1164	Toe Injury, Blunt	4014	ED constricting object, removal required	FALSE	FALSE
1164	toe injury, blunt	4052	ED Full assessment and management capability	TRUE	TRUE
1164	Toe Injury, Blunt	4127	ED subungual haematoma	FALSE	FALSE
1165	Toe Injury, Penetrating	4009	ED amputation, digit	FALSE	FALSE
1165	Toe Injury, Penetrating	4014	ED constricting object, removal required	FALSE	FALSE
1165	Toe Injury, Penetrating	4052	ED full ED assessment and management capability	FALSE	FALSE
1166	Toe Pain or Swelling	4052	ED full ED assessment and management capability	TRUE	FALSE
1166	Toe Pain or Swelling	4014	ED constricting object, removal required	FALSE	FALSE
1168	Toothache After Dental Injury	4052	ED full ED assessment and management capability	FALSE	FALSE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1169	Toothache Without Dental Injury	4052	ED full ED assessment and management capability	TRUE	FALSE
1170	toxic ingestion/inhalation/overdose	4052	ED Full assessment and management capability	TRUE	FALSE
1171	tube and drain problems	4052	ED Full assessment and management capability	FALSE	FALSE
1172	unwell, under 1 year old	4052	ED Full assessment and management capability	TRUE	FALSE
1172	unwell, under 1 year old	4403	ED viral haemorrhagic fever	FALSE	FALSE
1173	Urinary catheter Problems	4052	ED full ED assessment and management capability	TRUE	FALSE
1174	vaginal bleeding	4052	ED Full assessment and management capability	TRUE	TRUE
1174	vaginal bleeding	4057	ED foreign body, vagina	FALSE	FALSE
1175	vaginal bleeding, pregnant	4052	ED Full assessment and management capability	TRUE	TRUE
1175	Vaginal Bleeding, Pregnant	4057	ED foreign body, vagina	FALSE	FALSE
1176	vaginal discharge	4052	ED Full assessment and management capability	TRUE	TRUE
1176	Vaginal Discharge	4057	ED foreign body, vagina	FALSE	FALSE
1177	Vaginal Itch or Soreness	4052	ED full ED assessment and management capability	TRUE	FALSE
1177	vaginal itch or soreness	4056	ED toxic shock syndrome	FALSE	FALSE
1177	Vaginal Itch or Soreness	4057	ED foreign body, vagina	FALSE	FALSE
1178	vaginal swelling	4052	ED Full assessment and management capability	TRUE	TRUE
1179	Vomiting	4052	ED Full assessment and management capability	TRUE	TRUE
1179	Vomiting	4403	ED viral haemorrhagic fever	FALSE	FALSE
1180	Vomiting Blood	4052	ED full ED assessment and management capability	TRUE	FALSE
1180	Vomiting Blood	4389	ED post tonsillectomy bleeding	FALSE	FALSE
1180	Vomiting Blood	4403	ED viral haemorrhagic fever	FALSE	FALSE
1181	wound problems	4052	ED Full assessment and management capability	TRUE	TRUE
1182	wrist, hand or finger pain or swelling	4014	ED constricting object, removal required	FALSE	FALSE
1182	wrist, hand or finger pain or swelling	4052	ED Full assessment and management capability	TRUE	TRUE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1183	nail injury -	4052	ED full assessment and management capability	TRUE	FALSE
1183	nail injury -	4126	ED nail avulsion	TRUE	FALSE
1183	Nail Injury	4127	ED subungual haematoma	FALSE	FALSE
1184	abdominal pain, rectal bleeding, pregnant over 20 weeks	4052	ED Full assessment and management capability	TRUE	TRUE
1185	Drug, solvent, alcohol misuse	4052	ED full ED assessment and management capability	TRUE	FALSE
1185	drug, solvent, alcohol misuse -	4245	ED suicidal, no means nor plan	TRUE	FALSE
1186	worsening known mental health problem	4052	ED Full assessment and management capability	TRUE	TRUE
1186	worsening known mental health problem	4205	ED schizophrenia	TRUE	TRUE
1186	worsening known mental health problem	4208	ED mania/hypomania	TRUE	TRUE
1186	worsening known mental health problem	4245	ED suicidal, no means nor plan	TRUE	TRUE
1187	diabetes, blood sugar problem	4052	ED Full assessment and management capability	TRUE	TRUE
1188	Deceased	4248	ALL unexpected death	FALSE	FALSE
1196	Declared Seizure Warning	4052	ED full ED assessment and management capability	TRUE	FALSE
1198	stings, water creature	4052	ED Full assessment and management capability	FALSE	FALSE
1198	stings, water creature	4314	ED Weever Fish, Sea Urchin	FALSE	FALSE
1200	frequent caller -	4052	ED full assessment and management capability	TRUE	FALSE
1203	mental health problem	4052	ED Full assessment and management capability	TRUE	TRUE
1203	mental health problem	4245	ED suicidal, no means nor plan	TRUE	TRUE
1205	hearing problems or blocked ear	4022	ED foreign body, removal required	FALSE	FALSE
1205	hearing problems or blocked ear	4052	ED Full assessment and management capability	FALSE	FALSE
1206	NHS Pathways In House Clinician	4052	ED full ED assessment and management capability	FALSE	FALSE
1207	Reception Point	4052	ED full ED assessment and management capability	FALSE	FALSE
1207	Reception Point	4058	ED foreign body, rectum	FALSE	FALSE
1207	Reception Point	4403	ED viral haemorrhagic fever	FALSE	FALSE

SG	Symptom Groups	SD	Symptom Discriminators	CLINICALLY APPROVED CODESET	GM AGREED CODESET
1210	Tremor	4052	ED Full assessment and management capability	TRUE	TRUE
1210	Tremor	4245	ED suicidal, no means nor plan	TRUE	TRUE
1211	eye splash injury, chemical	4052	ED full assessment and management capability	FALSE	FALSE

Glossary

Initialisation /Term	Definition/Use
111	Free to call telephone number for non-emergency care (Easy to remember three digit telephone number, used for single point of entry access IUC services)
0300	An 11 digit non-geographic Freephone number for government, healthcare, charities and non-profit use.
999	Free to call telephone number for emergency service (i.e. Ambulance Service)
24/7	24 hours a day, 7 days a week.
'No decision in isolation'	Clinical process by which colleagues are always available to support decision making.
24/7/365	Every hour of the day, day of the week and day of the year (including leap years)
A&E	Accident and Emergency (also known as ED)
A2Si	Access to Service Information
ACD	Automatic Call Distribution (the telephone system that distributes calls to agents and produced management information).
Administrator/Navigator	A person within the contact-centre environment that may manages queues, takes demographics but does not carry out any clinical assessment.
Algorithm	A process or set of rules to be followed in problem solving.
Any-to-any	A process by which a system has the ability to communication with any other similar system, in the IUC context it is the ability for providers to electronically despatch ambulances from any ambulance trust.
App	Application (Software used on either a PC or mobile phone)
ARP	Ambulance Response Programme
AST	Ambulance Service Trust
Average Handling Time	The average time taken to complete a telephone assessment.
BSL	British Sign Language – communication used by the deaf community.
Call Volumes	The number of calls received by a specific contact-centre over a define period of time
CAS	Clinical Assessment Service
Case Mix	The different types of presented symptoms received within the contact-centre
CCGs	Clinical Commissioning Groups
CDSS	Clinical Decision Support System (Computer based tool for gathering patient demographics and providing clinical assessment workflow)
CG	Clinical Governance
Channel Shift	Providing alternative access channels to meet the changing needs of the population (for example, the shift from voice to online).
Clinician	A medically qualified person.

Initialisation /Term	Definition/Use
Consult and Complete	A consultation where no further intervention is required.
Contact-centre	Location where patient contact is made, primarily via telephone but may include other media
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CTP	Clinical Triage Platform
CWS	Clinical Workflow System
DAB	Direct Appointment Booking
DAs	Devolved Administrations
Data Dictionary	A set of information describing the contents and format of a database.
Disposition	End point in a consultation
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DoS	Directory of Service - containing information pertaining to locations of care.
Dos Profiling Principles	Document detailing the process for ensuring that the DoS outcome provides the most appropriate range of dispositions.
DPA	Data Protection Act
ED	Emergency Department (also known as A&E)
EDSSS	Emergency Department Syndromic Surveillance System
EIA	Equality Impact Assessment
EIR	Environmental Information Regulations
EoL	End of Life
EPS	Electronic Prescribing Service
Erlang C	A formula used to predict the number resources needed to service a given demand (i.e. number of agents)
Face to Face	Consultation in person
FOI	Freedom of Information
force majeure	Occurrences beyond the reasonable control of a party, generally in reference to contractual obligations.
Freephone number	Telephone number free for use by the caller
GP	General Practitioner
GP Choice	An NHS initiative which allows a patient to choose the GP and GP practice of their choice.
HCP	Health Care Professional
Health Advisor	A non-clinician trained in the use of a CDSS.
Hear and Treat	Ambulance Response Principle (ARP) where the telephony consultation offers completion on the phone where possible.
HEE	Health Education England

Initialisation /Term	Definition/Use
HSCN	Health & Social Care Network – a data network for health and care organisations which will replace N3
HSOCs	Health Scrutiny and Overview Committees
hypertext	Hypertext Transfer Protocol (HTTP) an embedded link within a document that allows direct access to a different web-based resource.
ICO	Information Commissioners Office
IG	Information Governance
INT	Immediate and Necessary Treatment
Intraday call profiling	Variation of calls received at different times of the day used to calculate staffing requirements.
ISA	Independent Safeguarding Authority
ISDN	Integrated Services Digital Network – conventional digital telephone lines.
ISO	International Organisation for Standardisation
IT	Information Technology
ITK	Interoperability tool kit
IUC	Integrated Urgent Care
IVR	Interactive Voice Response - A process which allows callers to choose options during the telephone call by using the telephone keypad or by speech recognition (Natural Voice IVR).
KPI	Key Performance Indicator (Metric used to measure the performance of a system or service)
Locations of Care	Also known as 'Service of Care', the point of patient referral.
Low Acuity Ambulance	Lower acuity Ambulance disposition formally known as Green Ambulance.
LWABs	Local Workforce Action Boards
MCA	Mental Capacity Act
MDS	Minimum Data Set (as specified by NHS England)
MHRA	Medicines and Healthcare products Regulatory Agency
Mindfulness	A completive/meditative process for reducing stress by bringing one's attention to the internal experiences occurring in the present moment.
Minor Injuries unit	A walk in centre for non-emergency treatment.
MMS	Multimedia Messaging Service, a standard protocol to send multimedia content to and from mobile phones.
n3	The national high-speed IP-based virtual private network used by NHS (superseded by HSCN).
NHS	National Health Service
NHS 111 Workforce Blueprint	Workforce Strategy document due for publication in 2018
NHS Digital	Formally the Health and Social Care Information Centre (HSCIC)
NHS Five Year Forward View	NHS future planning strategy document issued in October 2014
NHSmail	Email system used within NHS, the only system designate safe

Initialisation /Term	Definition/Use
	for the transmission of PID.
NICE	National Institute for Health and Care Excellence
NNG	National Numbering Group (Area code), Formerly known as STD codes.
Non-symptomatic call	A caller requiring information on a pre-diagnosed condition or information on local services.
NPFS	National Pandemic Flu Service
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NUMSAS	NHS Urgent Medicines Supply Advanced Service
Online	Web based service (delivered either via a web browser or as a mobile app)
OOH	Out of Hours (Historically covering services the period outside of normal GP consulting hours)
Pathways	NHS owned algorithmic clinical assessment tool
PBX	Private Branch Exchange
PC	Personal Computer
PDS	Personal Demographic Service (System for referencing patients NHS number based of demographics)
PEM	Post Event Messages (Message sent to GP to provide information on patient interaction with IUC)
PEW	Planned Engineering Works
PHE	Public Health England
PIA	Privacy Impact Assessment
PID	Personal Identifiable Data
PIN	Prior Information Notice
PMO	Programme Management Office
POCA	Protection of Children Act
POVA	Protection of Vulnerable Adults
Primary Care	Day to day health care given by health care providers, typically as the first contact point for
PSTN	Public Switched Telephone Network
PTV	Permission to View (a flag within the CDSS that says that the patient has given consent for the patients record to be viewed during this encounter)
RCA	Root Cause Analysis
RCS	Repeat Caller Service
Repeat Caller	Identifies repeat caller that calls the 111 service on multiple occasions over a short period of time (in response to the section 28 of the coroners ruling in the Penny Campbell case).
ReST	real-time surveillance team
Royal Colleges	The organisations that provide oversight and governance to the medical professions.
Schwartz rounds	A process developed by Kenneth B Schwartz designed to offer

Initialisation /Term	Definition/Use
	healthcare providers a regularly scheduled time to discuss the social and emotional issues they face in caring for patients and families.
SCR	Summary Care Record (High level patient clinical history)
See and Treat	Ambulance Response Principle (ARP) where treatment is completed on the scene with no need for conveyance.
SI	Serious Incident
SIMS	Serious Incident Management System
SIP	Session Initiated Protocol. A protocol that allows voice to be transmitted as packets of data across a data network. SIP trunks use this technology to deliver telephone lines.
Smart Phone	Mobile phone with enhanced features, such as the ability to run applications (Apps).
SMS	Short Message Service (text messaging)
SP-IS	Child Protection Information System
SPN	Special Patient Notes (Specific Information on a given patient, their history, any special requirements or factors that need to be taken into account during an encounter)
Star line	Telephony menu option for providing rapid access to additional clinical support for Care Homes and paramedics
STD	Subscriber Trunk Dialling (now superseded term for telephone area code, i.e. NNG)
StEIS	Strategic Executive Information System
STP(s)	Sustainability and transformation plans
Toxbase	Toxic substance reference database
TR	Temporary Resident
Triage	Process for Assessing Clinical Acuity
UCT	Urgent Treatment Centre
UECDP	Urgent and Emergency Care Delivery Programme
Use Case	A methodology used in system analysis to identify, clarify, and organise system requirements.
Walk-in centre	Non-emergency treatment centre that does not require appointment booking

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