Integrated Urgent Care Key Performance Indicators and Quality Standards 2018

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- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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Contents

1 Introduction

This document outlines the Integrated Urgent Care (IUC) Key Performance Indicators and other standards which commissioners must apply in relation to the service. The document is for use by local commissioners, providers and NHS England. It must be read in conjunction with the Integrated Urgent Care Aggregate Data Collection Specification (2018) and the Integrated Urgent Care Service Specification (2017).

The introduction of IUC can be traced back to the recommendations made in the Urgent and Emergency Care Review (2013) and its proposal for a radical shift in care to a 24/7 functionally integrated access, assessment, advice and treatment service. It is also a key policy aim in the Five Year Forward View:

"…urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services"[1]

The way in which patients access urgent and emergency care services is changing. Whilst traditionally patients accessed care face-to-face and via booked appointments (e.g. at their GP surgery), increasingly patients are accessing urgent and emergency care services through other means. NHS 111 is now seen as the front door to urgent care services, with more patients able to speak directly to a clinician, being given self-care advice, issued prescriptions if required and being booked directly into to a wider range of points of care. This approach is referred to as the 'Consult and Complete' model and expanding its impact is a core part of our urgent and emergency care strategy. We also anticipate that patients will increasingly expect to engage with services through online and digital technology, which for NHS 111 means the provision of apps and NHS 111 Online.

This document seeks to clarify which organisations need to report against the KPIs listed and provides guidance to both commissioners and providers on compliance. In addition to these KPIs NHS England will be monitoring other sources of information related to urgent and emergency care including data linking NHS 111 calls and activity data to ensure IUC providers are maximising patient compliance with advice from NHS 111.

IUC services are regulated by the Care Quality Commission (CQC). The CQC approach when reviewing services is to consider: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? The KPIs and standards described in this document will contribute to the information the CQC uses when conducting service reviews.

[1] Five year Forward View (Oct 2014) P4

A Note on Definitions:

Throughout this document the term 'provider' is used to mean any organisation providing IUC services under an NHS Standard Contract (or legacy contract if an NHS Standard Contract is not yet in use); or a GMS/PMS/APMS contract.
Thus this may be:

- A provider organisation with whom a NHS commissioner has a contract to provide IUC services.
- A GMS or PMS practice that chooses not to transfer responsibility for the provision of IUC services and either provides the service itself or sub-contracts the service to another provider.

IUC services include:

- The assessment and management of patients by telephone who have called NHS 111.
- The face-to-face management of patients in any treatment centre (dealing with urgent care); the patient's residence or other location if required.

1.1 Integrated Urgent Care

Health care in the UK can be categorised in various ways, primary and secondary; urgent and emergency; planned and unplanned; in and out of hours; in and out of hospital; acute and chronic. These categories are convenient ways to differentiate between different services e.g. in terms of skills and diagnostics available, temporal differences, location and provider type. However, these differences are not clear cut and often involve considerable overlap. Generally, IUC can be defined as:

"…the provision of a functionally integrated 24/7 urgent care access, clinical advice and treatment service (incorporating NHS 111 and out of hours services)"[2]

The above definition mentions two key services: NHS 111 and out of hours. Both of these services have been developed discretely to this point. NHS 111 was launched as a new service to replace NHS Direct in 2010 and GP out of hours services have been in existence in one form or another since the introduction of the concept of a family doctor or GP. Both of these services are now part of the larger service which we describe as Integrated Urgent Care; the aim being to ensure a seamless patient experience with minimum handoffs and patient access to a clinician where required.

2 The Historical Context of the Measurement of Out of Hours Services

Since November 2002, all providers of out of hours (OOH) services have had to comply with national OOH Quality Standards; these Quality Standards were replaced by National Quality Requirements (NQRs) in the delivery of OOH services on 1st January 2005.

The primary medical care contracts introduced in April 2004, stipulated that all those who provided OOH services (including GP practices that did not transfer their responsibility for OOH services) had to meet the National Quality Requirements.

[2] Integrated Urgent Care Service Specification (August 2017)

Chronology of Out of Hours/IUC Quality Standards Documents

- 2000 Raising Standards for Patients New Partnerships in Out of Hours Care ('Carson report')
- 2002 Standards for Better Health
- 2005 National Quality Requirements
- 2006 Revised NQRs published
- 2016 IUC KPIs published
- 2018 IUC KPIs revised

This document replaces the 2006 NQRs. Some of KPIs are taken directly from the NQRs, these standards will be aligned with other parts of the urgent care system and developed in liaison with stakeholders.

3 Measurement of Integrated Urgent Care

In October 2016 NHS England introduced a set of Key Performance Indicators for Integrated Urgent Care. These indicators built on the existing out of hours NQRs revising the way some elements were measured and introduced some new KPIs reflecting the development of the IUC model.

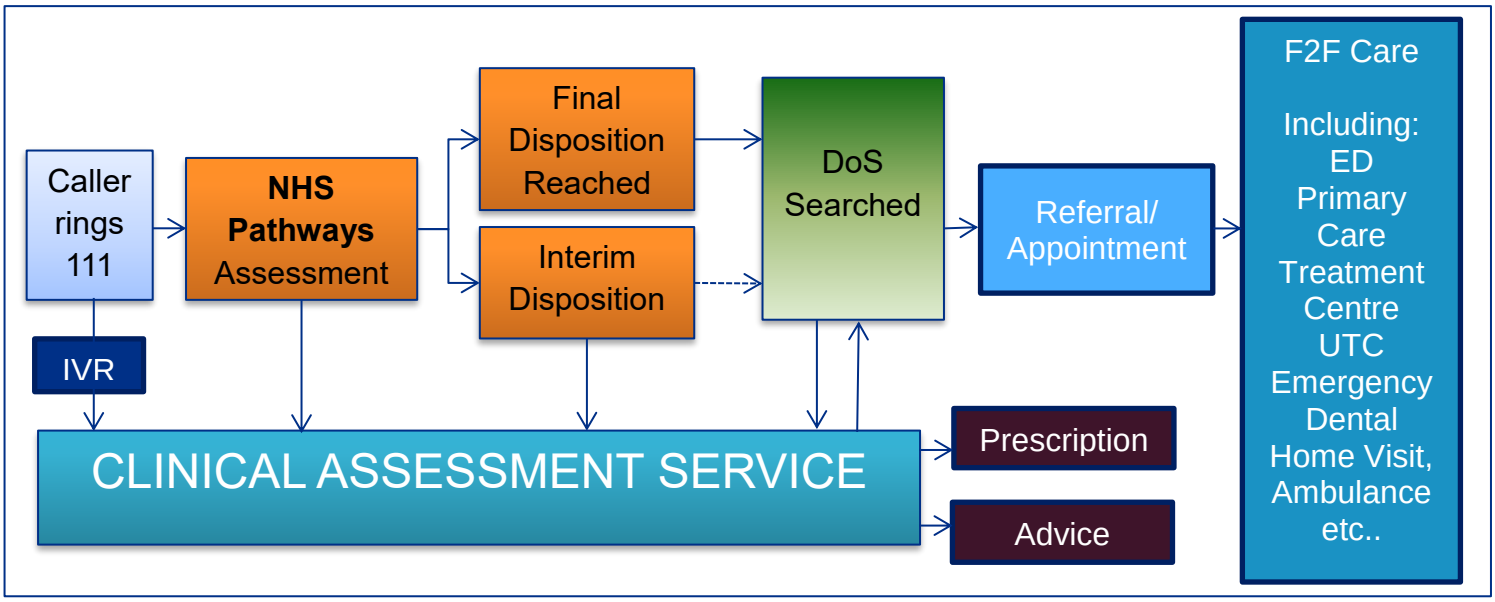
Integrated Urgent Care is provided by a variety of organisations, this includes ambulance services, private companies, not for profit organisations and NHS trusts.

IUC is not limited to the provision of care at certain times or in a particular place.

The KPIs apply to parts or the whole of the patient journey and data needs to be compiled to allow them to be measured, managed and reported irrespective of any organisational boundaries. Providers will need to cooperate so that this is achieved even when they operate under separate contracts.

The IUC model is described in detail in the IUC specification which was published in August 2017 and can be found here.

Diagram 1: IUC Call Flow



Different steps in this journey may be provided by different organisations

4 GMS/PMS/APMS Contract Requirements

The 2017 IUC Service Specification contracts for Primary Care (GMS/PMS/APMS[3]) all stipulate that out of hours services must comply with the NQRs. This will change in future to compliance with the IUC KPIs.

From 1st January 2005, those GP practices that did not choose to transfer the responsibility for the provision of OOH services, have also had to comply with the NQRs for the service that they provide to their patients. GP practices that subcontract their OOH services to another provider are also bound by the contractual requirement to ensure that the services delivered to their patients meet the NQRs.

In future all providers of Primary Care out of hours services will need to comply with The Integrated Urgent Care KPIs. The services will be referred to as IUC services going forward.

Previously commissioners have had some flexibility in the application of the NQRs relating to telephony to individual practices. However, due to advancements in telephony technology there is now no reason why individual practices cannot now report against the telephony derived KPIs where this applies.

[3] The Alternative Provider Medical Services Directions 2016
NHS England Standard Personal Medical Services Agreement 2016/17
NHS England Standard General Medical Services Contract 2016/17 (v3)

5 The Integrated Urgent Care Key Performance Indicators

This section contains the Key Performance Indicators (KPIs) to judge the performance of the Integrated Urgent Care (IUC) service.

5.1 Table A1: Summary list of KPIs

KPI	Title	Domain	Freq.	%
1	Proportion of calls abandoned	Safety	Monthly	≤5%
2	Proportion of calls answered in 60 seconds	Pt Experience	Monthly	≥95%
3	Proportion of calls where person was called back within 10 minutes by a clinician	Pt Experience	Monthly	≥50%
4	Proportion of calls where caller given an appointment with an IUC Treatment Centre or extended hours GP	Pt Experience	Monthly	≥95%
5	Proportion of calls where caller given an appointment with a UTC	Pt Experience	Monthly	≥50%
6	Proportion of calls initially given a category 3 or 4 ambulance disposition that are revalidated	Effectiveness	Monthly	≥50%
7	Proportion of calls initially given an ED disposition that are revalidated	Effectiveness	Monthly	≥50%
8	Proportion of callers recommended self-care at the end of the Health Advisor input	Pt Exp./ Effectiveness	Monthly	≥15%
9	Proportion of callers recommended self-care at the end of clinical input	Pt Exp./ Effectiveness	Monthly	≥40%
10	Proportion of calls where prescription medication was issued	Pt Experience	Monthly	≥80%
11	Directory of Services: no service available other than ED (ED catch-all)	Effectiveness	Monthly	≤3%
12	Average time to telephone assessment outcome	Effectiveness	Monthly	N/A
13a/ b/c	Proportion of patients receiving a face-to-face consultation in an IUC Treatment Centre	Effectiveness	Monthly	≥95%
14a/ b/c	Proportion of patients receiving a face-to-face consultation within their home residence within the specified period	Effectiveness	Monthly	≥95%
15	Proportion of calls assessed by a clinician	Pt Exp./ Effectiveness	Monthly	≥50%

6 Integrated Urgent Care Quality Standards

It is also our intention to continue collecting a number of urgent care quality standards, as outlined below.

6.1 Table A2: Summary list of Proposed Quality Standards

QS	Title	Domain	Area	Freq.	%
1	Serious Incidents	Safety	Assessment	Monthly	N/A
2	End to End Reviews	Safety	Assessment	Monthly	N/A
3	Helpfulness of advice	Patient Experience	Advice	Twice a year	N/A
4	Satisfaction	Patient Experience	Advice / Treatment	Twice a year	N/A
5	If 111 was not available	Patient Experience / Effectiveness	All	Twice a year	N/A

The IUC Service Specification[4] describes standards for the service. For clarity these two standards are reiterated and clarified below.

7 Clinical Governance

The NHS England IUC Clinical Leads network oversees IUC governance and conducts site visits with providers and commissioners. In particular there are two areas where compliance is required:

1. Serious incidents
2. End to end reviews

8 Workforce

The development of the workforce is essential to the achievement of the IUC model. Progress in workforce development will be measured separately to the KPIs.

9 Face-to-Face Patient Treatment

Providers must ensure that patients are treated by the clinician best equipped to meet their needs, especially at periods of peak demand such as Saturday mornings, in the most appropriate location. Where it is clinically appropriate patients must be able to have a face-to-face consultation with a clinician including, where necessary, at the patient's place of residence. Where patients self-present at a treatment centre, providers must have a robust system for identifying all immediate life-threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

[4] Integrated Urgent Care Service specification August 2017

10 Treatment Centres

Treatment centres where patients receive face-to-face consultations must clinically suitable for the assessment and treatment of patients and conveniently located for patient access.

Services must be provided in environments which promote effective care and optimise health outcomes by being:

- a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and
- supportive of patient privacy and confidentiality.

11 Identification of Life-Threatening Conditions

Providers must have a robust system for identifying all immediate life-threatening conditions and, once identified, those calls must be either electronically transferred to the ambulance service (instantaneously), or the ambulance service must be manually contacted within 1 minute of identification and the case details verbally given to them.

12 Call Audit

Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits.

The audit sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a clinician with suitable experience and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service. Providers must cooperate fully with commissioners in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organisation.

13 Audit of Face-to-Face Assessment and Treatment

Episodes of care which involve patient assessment/treatment in a face-to-face scenario should be subject to audit. This must be conducted by a suitably qualified and experienced clinician, using the record of the patient encounter; an audio/video recording of the encounter (if available) and by directly questioning the clinician involved. The RCGP toolkit[5] is a useful guide to good practice in this area.

14 Attribution of Dispositions

Whether determined by CDSS or by the skill and experience of a clinician, it is important that the patient outcome in terms of a recommended point of care and any timescale allocated to further assessment/treatment (i.e. the disposition), is undertaken with due consideration of the patient's condition and ability to comply with any referral/recommendation. Consideration of the correct attribution of disposition to the patient should be part of the call audit process.

[5] RCGP Urgent and Emergency Care Clinical Audit Toolkit 2010

15 Appendix A: Description and Definitions of the KPIs

KPI	Title	ADC Ref	Frequency	Assesses
1	**Proportion of calls abandoned**	**13/1**	**Monthly**	**NHS 111 Call Receiving Organisation**
Rationale	Abandoned calls represent an unquantifiable clinical risk since, by definition, the needs of the caller are not established.			
Numerator	13 Number of calls abandoned			
Denominator	1 Number of calls received			
Source	Management Information System			
Standard	≤5%			
Notes	This KPI is essentially unchanged from how abandonment has always been measured, however, the clock start point has changed.			

KPI	Title	ADC Ref	Frequency	Assesses
2	**Proportion of calls answered in 60 seconds**	**12/3**	**Monthly**	**NHS 111 Call Receiving Organisation**
Rationale	The length of time before a call is answered is an important contributor to the overall patient experience. Prolonged delays in call answer time result in increasing rates of calls abandoned which generates clinical risk.			
Numerator	12 Number of calls answered in 60 seconds			
Denominator	3 Number of answered calls			
Source	Management Information System			
Standard	≥95%			

KPI	Title	ADC Ref	Frequency	Assesses
3	**Proportion of calls where person was called back within 10 minutes by a clinician**	**41/43**	**Monthly**	**NHS 111 Call Receiving Organisation/CAS**
Rationale	Patients should be assessed within a reasonable time, therefore, time to call back (where this is required) should be monitored.			
Numerator	41 Number of calls where person was called back within 10 minutes by a clinician			
Denominator	43 Number of calls where person was offered a call back by a clinician			
Source	Management Information System			
Standards	≥50% of calls called back within 10 Minutes			

KPI	Title	ADC Ref	Frequency	Assesses
4	**Proportion of calls where caller given an appointment with an IUC Treatment Centre or extended hours GP**	**110+112/ 109+111**	**Monthly**	**System**
Rationale	This will measure whether patients have an appointment arranged by the IUC service at an IUC treatment centre or extended hours GP service.			
Numerator	110 Number of calls where caller given an appointment with a GP extended hours service 112 Number of calls where caller given an appointment with an IUC Treatment Centre			
Denominator	109 DoS selections – GP extended hours service 111 DoS selections – IUC Treatment Centre			
Source	Management Information System			
Standard	≥95%			

KPI	Title	ADC Ref	Frequency	Assesses
5	**Proportion of calls where caller given an appointment with a UTC**	**114/113**	**Monthly**	**System**
Rationale	This will measure whether patients have their primary care appointment arranged by the IUC service at an Urgent Treatment Centre (UTC).			
Numerator	114 Number of calls where caller given an appointment with a UTC			
Denominator	113 DoS selections – UTC			
Source	Management Information System			
Standard	≥50%			

KPI	Title	ADC Ref	Frequency	Assesses
6	**Proportion of calls initially given a category 3 or 4 ambulance disposition that are revalidated**	**97/96**	**Monthly**	**System**
Rationale	Activity needs to be managed reduce the number of inappropriate ambulance dispositions.			
Numerator	97 Number of calls initially given a category 3 or 4 ambulance disposition that are revalidated			
Denominator	96 Number of calls initially given a category 3 or 4 ambulance disposition			
Source	Management Information system			
Standard	≥50%			

KPI	Title	ADC Ref	Frequency	Assesses
7	**Proportion of calls initially given an ED disposition that are revalidated**	**100/99**	**Monthly**	**System**
Rationale	Activity needs to be managed reduce the number of inappropriate ED dispositions.			
Numerator	100 Number of calls initially given an ED disposition that are revalidated			
Denominator	99 Number of calls initially given an ED disposition			
Source	Management Information System			
Standard	≥50%			

KPI	Title	ADC Ref	Frequency	Assesses
8	**Proportion of callers recommended self-care at the end of the Health Advisor input**	**68/26**	**Monthly**	**System**
Rationale	Urgent and Emergency Care Review (UECR) requirement for IUC to manage more callers without onward referral (‘Consult and Complete’).			
Numerator	68 Number of callers recommended self-care at the end of the Health Advisor input			
Denominator	26 Number of calls where person triaged by a Health Advisor			
Source	Management Information System			
Standards	≥15%			

KPI	Title	ADC Ref	Frequency	Assesses
9	**Proportion of callers recommended self-care at the end of clinical input**	**81+94/27+28**	**Monthly**	**System**
Rationale	Urgent and Emergency Care Review (UECR) requirement for IUC to manage more callers without onward referral ('Consult and Complete').			
Numerator	81 Number of callers recommended self-care[1] at the end of the Clinical Advisor input 94 Number of callers recommended self-care[1] at the end of any non-Pathways Clinician input			
Denominator	27 Number of calls where person triaged by a Clinical Advisor 28 Number of calls where person triaged by a Clinician			
Source	Management Information System			
Standards	≥40%			
Notes	[1] Refer to Disposition Mapping.			

KPI	Title	ADC Ref	Frequency	Assesses
10	**Proportion of calls where prescription medication was issued**	**118+119/117**	**Monthly**	**System**
Rationale	Patients who require prescription medications should be able to access them without undue delay[1].			
Numerator	118 Number of calls where prescription medication was issued within your service 119 Number of calls where a referral to NUMSAS was made for prescription medication			
Denominator	117 Number of calls where prescription medication was required			
Source	Management Information System			
Standards	≥80%			
Notes	[1]The patient must be able to obtain their medication directly from a pharmacy without any intermediate steps.			

KPI	Title	ADC Ref	Frequency	Assesses
11	**Directory of Services: no service available other than ED (ED catch-all)**	**103/102**	**Monthly**	**System**
Rationale	IUC effectiveness is dependent on commissioning of adequate urgent care services and their inclusion in the Directory of Service (DoS), so that the Emergency Department catch-all is not needed.			
Numerator	103 Directory of Services: no service available other than ED (ED catch-all)			
Denominator	102 Calls where the Directory of Services is opened			
Source	Management Information System			
Standard	≤3%			

KPI	Title	ADC Ref	Frequency	Assesses
12	**Average time to telephone assessment outcome**	**23/24**	**Monthly**	**System**
Rationale	Callers to urgent care services want an answer to their concerns as soon as possible.			
Numerator	23 Total time to telephone assessment outcome			
Denominator	24 Number of calls where person triaged			
Source	Management Information System			
Standard	N/A			

KPI	Title	ADC Ref	Frequency	Assesses
13a/b/c	**Proportion of patients receiving a face-to-face consultation in an IUC Treatment Centre**	**127/137, 128/138, 129/139**	**Monthly**	**System**
Rationale	Patients need to be seen within a timescale appropriate to their condition.			
Numerator	127 Consultations received within 1 hour (Emergency) 128 Consultations received within 2 hours (Urgent) 129 Consultations received within 6 hours (Less Urgent)			
Denominator	137 Consultations required within 1 hour (Emergency) 138 Consultations required within 2 hours (Urgent) 139 Consultations required within 6 hours (Less Urgent)			
Source	Management Information System			
Standard	≥95%			

KPI	Title	ADC Ref	Frequency	Assesses
14a/b/c	**Proportion of patients receiving a face-to-face consultation within their home residence within the specified period**	**122/132, 123/133, 124/134**	**Monthly**	**System**
Rationale	Patients need to be seen within a timescale appropriate to their condition.			
Numerator	122 Consultations received within 1 hour (Emergency) 123 Consultations received within 2 hours (Urgent) 124 Consultations received within 6 hours (Less Urgent)			
Denominator	132 Consultations required within 1 hour (Emergency) 133 Consultations required within 2 hours (Urgent) 134 Consultations required within 6 hours (Less Urgent)			
Source	Management Information System			
Standard	≥95%			

KPI	Title	ADC Ref	Frequency	Assesses
15	**Proportion of calls assessed by a clinician**	**30/24**	**Monthly**	**System**
Rationale	Patients whose condition requires it should have the ability to speak to a clinician.			
Numerator	30 Calls assessed by a clinician			
Denominator	24 Number of calls where person triaged			
Source	Management Information System			
Standards	≥50%			

16 Appendix B: Related Data

Aside from the KPIs and the rest of the monthly collection, commissioners and NHS England will need other management information for various purposes.

16.1 Workforce Data

Integrated Urgent Care providers are expected to comply with the NHS Digital Workforce Minimum Data Set collection. If a provider does not use the Electronic Staff Record system (from which the NHS Digital will be able to directly extract the data), then the provider should supply workforce information, every six months, through the NHS Digital secure internet data collection system. Access and other instructions are available from: workforce.standards@nhs.net.

Some workforce data is already available for Ambulance Service staff here.

In 2015-16 NHS England proposed to NHS Digital improved categories for this publication for the types of employees in Ambulance Services. However, NHS Digital will not be able to publish data for these improved categories before 2017.

For the independent sector, NHS Digital only publish such data aggregated across organisations, and will only share such data for an individual organisation if that organisation provides explicit approval to NHS Digital.

16.2 Patient Experience Data

The existing NHS 111 survey will continue for now. NHS England will assess how best to collect patient experience for Integrated Urgent Care and the wider urgent and emergency care system in future.