NHS England

NHS 111

Commissioning Standards

June 2014

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NHS England

NHS 111 Commissioning Standards

First published: June 2014

Foreword

NHS 111 is a vital service in helping people with urgent care needs get the right advice in the right place, first time. It is an important building block within the urgent and emergency care system, and supports patients navigate round what they tell us is a very complicated system.

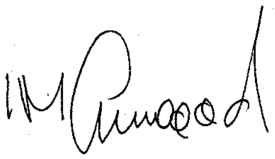
This free to use service is now available all over England, 24 hours a day, 365 days a year and call volumes are growing each month. The aim is to develop this service further and to respond to what people have told us, while ensuring that the safety and quality continue to be improved.

These Commissioning Standards, which have been developed with commissioners and providers, offer commissioners of NHS 111 services the opportunity to secure new services whilst signposting more work to further improve and develop NHS 111 services.

Further guidance to support procurement is being developed with CCGs and will be available during July 2014.

Dr Amanda Doyle

Chief Clinical Officer, NHS Blackpool CCG



Ian Greenwood

National Programme Director - NHS 111

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1 Introduction

1.1 NHS 111

NHS 111 is available across the whole of England, making it easier for the public to access urgent healthcare services when they need medical help fast. It is free to use and directs people to the right local service first time, or gives health advice that is best able to meet their needs. It is critical to improving the delivery of urgent and emergency care services, ensuring that patients get the right care, first time.

Around a million people a month use NHS 111 and are highly satisfied.

1.2 Purpose

This document sets out the Commissioning Standards for the NHS 111 service in England which has been jointly developed between CCGs and NHS England.

The standards describe the core requirements and quality metrics for NHS 111 services. The intent is not to prescribe how commissioners deliver these requirements but to ensure that patients can depend upon receiving the same high quality service wherever they live or access NHS 111 services in England.

1.3 Audience

The primary audience for this document is CCGs, as commissioners with responsibility for NHS 111 and the performance of local urgent care systems.

1.4 Local commissioning specifications

This document does not constitute a detailed specification for NHS 111; it describes the core requirements and standards. Commissioners may wish to enhance and add to these requirements to ensure that local specifications for NHS 111 are comprehensive and appropriate for their local area.

1.5 Roles and responsibilities

The full roles and responsibilities are outlined within Annex A. Below are listed the responsibilities of the commissioner.

Commissioners are responsible for the delivery of an NHS 111 service in line with the service description as referenced in section 2.2 and to deliver the following:

Procurement

- Provide NHS England with evidence that they have undertaken a robust procurement with an appropriate assurance process
- Assure NHS England that they have a contingency plan in place should the chosen provider fail to mobilise the NHS 111 service as contracted

- Ensure the effective mobilisation and operational delivery of an NHS 111 service that serves the CCG population, either directly or via joint commissioning arrangements
- Ensure that the Directory of Service (DoS) is fully up to date with the availability of local services and the agreed referral protocols with service providers
- Ensure that business continuity and disaster recovery procedures are in place in the event that disruption to the provision of the NHS 111 service occurs locally.

Operational service responsibility

- Monitor the impact of NHS 111 on local services so that over/under utilised services are identified and improvements to the urgent care system are made
- Performance manage the contract against national quality requirements
- Ensure strong clinical governance of NHS 111 as an integral part of the urgent care system
- Reporting on the quality, benefits and performance of NHS 111 services
- Ensuring that special patient notes and end of life care records are up to date and available to NHS 111
- Market NHS 111 locally.

1.5.1 Benefits

Commissioners are responsible for the measurement and delivery of the intended benefits for NHS 111.

The benefits are:

- Improve the public's access to urgent healthcare services
- Increase the efficiency and productivity of the NHS
- Drive the improvement of urgent and emergency care services
- Increase public satisfaction and confidence in the NHS.

The full benefits and measurement requirements are listed in Annex B.

1.6 Procurement

The NHS 111 service has to date been contested through competitive procurement processes and will, in the future, be a competitively procured service. Where contracts are due to expire in the next twelve months CCGs need to be looking to either extend where there are provisions for this or to commence re-procurement activities. NHS England will be supporting local procurement activity through the following phased approach:

- **Phase 1 Collaborative Procurement Support**: Facilitating joint working across the NHS and procurement experts to develop a series of good practice guides, document templates and model assurance processes
- **Phase 2 Framework Development**: Delivering a procurement framework that can be used as a mechanism to purchase NHS 111 services and related capability.

1.7 Procurement Assurance

Whilst commissioners are responsible for undertaking local procurement activity, they will be required to undertake clear and defined assurance processes at the following specific stages of procurement:

- Before the advert on the invitation to tender is published
- Post evaluation and before the contract is awarded
- Before the newly procured services go live.

Further details of commissioner responsibilities are detailed in annex A: roles and responsibilities.

1.8 Future requirements

This document sets out a series of standards that will enable CCGs to secure safe, high quality and stable NHS 111 service.

It also provides commissioners with an outline of developments and further improvements to the service offering that are highlighted as an *explanatory note* within the document. Commissioners should take account of these when commissioning local services.

2 Vision

2.1 Background

NHS 111 makes it easier for the public to access urgent healthcare and drives improvements in the way in which the NHS delivers that care.

The free to call 111 number and on-line services are available 24 hours every day, offering a personalised priority contact service that responds to people's healthcare needs when:

- You need medical help fast, but it's not a 999 emergency
- You don't know who to contact for medical help
- You think you need to go to A&E or another NHS urgent care service
- You require health information or reassurance about what to do next.

The NHS 111 service assesses the needs of people and determines the most appropriate course of action, including;

- People who can care for themselves will have information, advice and reassurance provided
- Where possible people will have their problem dealt with immediately over the phone by a suitably qualified clinician
- People requiring further care or advice will be referred to a service that has the appropriate skills and resources to meet their needs
- People facing an emergency will have an ambulance dispatched without delay
- People requiring services outside the scope of NHS 111 will be signposted to an alternative service.

The NHS 111 service also provides management information to commissioners regarding the demand for and usage of services in order to enable the commissioning of more effective and productive services that are designed to meet people's needs.

2.2 NHS 111 Service Description

The following core principles reflect the ambition for NHS 111 including those within the Urgent and Emergency Care Review. As the service evolves these core principles are likely to develop further. People contacting NHS 111 for urgent care needs expect the service to:

- Be always available, 24 hours a day, 365 days a year
- Be accessible, personalised and based on their individual needs
- Have knowledge of when they have previously contacted NHS 111 so they do not need to repeat their story

- Be able to connect them to a clinician with access to important health records and notes
- Be safe and give the right advice based on the best and most up to date clinical and medical knowledge available
- Definitively resolve health concerns without the need to go anywhere else
- Book appointments with the urgent care provider they need
- To dispatch an ambulance without delay
- Be able to access the service through digital or online channels both to give better access to information and to meet specific needs people have
- Make sure that specific health needs, such as palliative care, mental health and long term conditions are properly catered for.

NHS 111 should provide a consistently high quality service irrespective of the geographic area.

2.3 The Urgent and Emergency Care Strategy

An enhanced NHS 111 service is a key enabler for the system of urgent and emergency care envisaged in Sir Bruce Keogh's Urgent and Emergency Care Strategy. This vision states that:

For people with urgent but non-life threatening needs: We must provide highly responsive, effective and personalised services outside of hospital, and deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families;

For people with more serious or life threatening emergency needs: We should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery;

Specifically, an enhanced NHS 111 service will deliver one of the key changes needed to ensure the vision of improvements to patient care can be achieved. The NHS 111 service is critical to help people with urgent care needs to get the right advice in the right place, first time;

To make this happen NHS 111 needs to develop service protocols and underpinning technical functionality that will enable greater integration with all other elements of the urgent and emergency care system. This includes ambulance services, primary care (in hours and out of hours), urgent care centres, emergency departments and both community and hospital based services.

3 Standards

3.1 Access to records

Clinicians within the NHS 111 service must have access to relevant aspects of patients' medical and care information, where the patient has consented to this being available.

This must include knowledge about patients' contact history and medical problems; so that the service can help patients make the best decisions. Patients with special notes or a specific care plan must be treated according to that plan and, where patients have specific needs they must be transferred to the appropriate professional or specialist service.

Access to important patient information through the existing Summary Care Record (SCR) service must be the minimum standard. Commissioners should encourage NHS 111 service providers to develop wider sharing of records across the health care system.

Explanatory Note: Pilots and evaluations are in progress exploring how different approaches work. The pilots cover Special Patient Notes, SCR and access to full records (where fully integrated IT systems are in place). Additionally the pilots seek to bring together information from other areas such as mental health, community and end of life care into the NHS 111 setting. In time the intent is to explore how real time remote monitoring of biometrics could add to the existing patient records to inform the best possible care for a patient.

3.2 Ambulance dispatch

NHS 111 must be able to identify potentially life threatening problems and dispatch an ambulance without any delay or re-triage, and support the patient prior to the vehicle arriving.

This must include the ability to dispatch an ambulance from a provider other than the local ambulance provider – known by 'any to any' to 999 service providers – this will facilitate the rapid dispatch of an ambulance for callers from out of area.

3.3 Appointment booking

NHS 111 must be able to directly book patients an appointment at the urgent or emergency care service that can deal with their problem, that is as close to their location as possible.

By offering a booked appointment the NHS 111 service is better positioned to be able to guide the patient to the right point of access, this reduces the risk to the patient and unnecessary costs to the service associated with multiple interactions.

This appointment could include a booked call back from a GP, a pharmacist review at a local chemist, an appointment at an urgent care centre, an appointment with GPOOH, a home visit, or (in time) an appointment within a hospital emergency department.

Where a referral is not made through a direct appointment, detailed arrangements for the referral process must be put in place and agreed by the NHS 111 clinical governance lead. The full referral process must be visible to the NHS 111 service, including failsafe mechanisms.

Explanatory Note: Initial pilots looking specifically at booking into emergency departments will give greater clarity of where NHS 111 can and should be authorised to directly refer and book patient appointments. In time the intent is to explore how this could work for diagnostics, community services and other areas of urgent heath care.

3.4 Business continuity

All NHS 111 providers are expected to have arrangements in place so that in the event of fluctuations in demand, technical failure or staff shortages they can invoke contingency and continue to provide an acceptable level[a] of service to the population.

It is suggested that a collaborative provider to provider resilience network would be a pragmatic approach to this. If providers are looking at implementing this approach then this should be undertaken in conjunction with NHS England and the commissioner, so if required any changes that may be required to telephone call routing can be delivered.

Commissioners and providers should be aware of their responsibilities to support disaster recovery in the event of a 'force majeure' situation when a service provider is unable to take calls due to some catastrophic event. In these circumstances, all commissioners and providers would be expected to accept an appropriate proportion of calls in order to maintain national patient safety and neither funding nor performance penalties should be applied.

3.5 Call handler training and support

All staff involved in handling NHS 111 calls must undertake training that covers the following areas:

- Compliance with the licence requirements of the relevant Clinical Decision Support Software (CDSS)
- How to interact with urgent care services
- The use of Directory of Services
- NHS values
- Delivering excellent customer service
- Safeguarding.

[a] In this context 'acceptable' would normally mean achieving KPIs

The above should only serve as an indicator and commissioners may wish to specify minimum educational standards. Supervisory and clinical staff must be available in line with any CDSS licence. The procedures for seeking clinical advice and the handover protocols from a call handler to a clinician must be simple and clear with voice recording of all interactions.

3.6 Clinicians working in NHS 111

3.6.1 Clinical staffing model

Commissioners should consider how increased or faster access to clinical advice should be secured for their population. This should be in line with any recommendations from their clinical quality group and include how clinicians access patient records and how they ensure safe timely handover of patient care.

Explanatory Note: Pilots and evaluations of different clinical models are on-going and will inform future standards. Initial pilots are focused on access to GPs but future pilots will include a full range of clinical professions including nursing, pharmacy and mental health. Formal assessments of different models will use operational research techniques in order to establish what is most cost effective.

3.6.2 Training of clinical staff

In addition to standard NHS 111 training detailed in 3.5 above all clinical staff working in NHS 111 must be trained in line with the CDSS used in the operational service

Explanatory Note: Currently it is acknowledged that there may be the need to develop specific educational modules for clinical staff to undertake that will increase their knowledge and improve patient outcomes. NHS England in partnership with stakeholders is undertaking a piece of work to evaluate this and any recommendations will appear in later versions of the commissioning standards.

3.6.3 Clinical assessment process (telephony based)

Clinicians undertaking telephone assessment must work within a clearly defined operating model which reflects the different elements of the process within NHS 111. Specifically, this includes:

- Handover from call handler to clinician – this must be structured and any discussions must take place on recorded telephone lines
- Validation by the clinician of the call handler assessment
- Structured clinical telephone assessment with or without the aid of decision support software

Calls streamed direct to clinicians e.g. from health care professionals, without triage by the call handler must be managed in a similarly structured way.

3.7 Clinical Decision Support System (CDSS)

NHS 111 services must use approved clinical assessment tools/clinical content to assess the needs of callers. The provider of the service must ensure that they adhere to any licensing conditions that apply to using their system of choice. This must include the ability to link with the wider urgent and emergency care system.

NHS 111 commissioners should ensure that providers deploy any relevant CDSS upgrade/version, associated business changes, training and Directory of Service (DoS) profiling within any specified deployment windows for the chosen system(s).

3.8 Clinical Governance

Clinical governance arrangements must be in place to assure the clinical safety of the whole patient pathway, not just the NHS 111 call handling service. Strong relationships and partnership working must be established between all providers involved in the patient pathway so that issues can be identified and service improvements made. A good practice guidance for commissioners is included in Annex C.

3.9 Call handler and clinical staff continuous audit and improvement

Call handlers must undergo a continuous process of audit in line with the requirements of any clinical decision support system (CDSS) licence and as specified in this document. This must be a process which not only identifies where specific staff have gaps in skills and knowledge but also must allow for continuous improvement of all staff. The audit process should identify key areas where either additional training, modifications to existing training or feedback to software providers are needed.

The audit process itself should be quality assured, as a minimum; there should be both internal and external review of auditors.

The audit and development process outlined for call handlers above should be adapted to meet the needs of clinical advisors and applied in an equally rigorous and systematic way.

Audit by clinicians is preferable to reflect the wider assessment role provided by these individuals and should reflect the competences within the RCGP OOH audit toolkit.[1]

3.10 Directory of Services (DoS)

Commissioners should ensure that expert resources are available to effectively maintain the NHS 111 DoS. This involves regular, routine updating of services for accuracy, profiling, ranking and the addition of new services where appropriate. These activities must be undertaken in line with the Clinical Decision Support System (CDSS) licence requirements.

Commissioners should work with their providers to plan and agree the timing of CDSS version upgrades and consequent changes to DoS profiling. This should include regularly updated Standard Operating Procedures (as set out in section 3.7) for managing the day to day operation of the DoS, business continuity in the event of DoS failure, and approaches to dispositions that do not interrogate DoS.

3.11 Footprint

Commissioners need to consider the scale and construction of their local health care system when defining their NHS 111 service. Factors such as patient experience, patient pathways, economies of scale, long term affordability and interfaces with other services need to be key factors in local business cases.

3.12 Handling out of area calls

Out of area calls must be handled in the same way as in area calls.

3.13 Health Information

NHS 111 services should be able to provide health information and advice. If the process for this sits outside of the KPIs for NHS 111 then the commissioner should be assured of the process and its impacts.

3.14 Integration with digital services

The online health and symptom checkers, hosted on www.nhs.uk, where appropriate refers people to call NHS 111. NHS 111 services must have mechanisms in place to identify where this has been the start of the patient journey and have local scripts that explain the need to repeat questions.

Explanatory note: Pilots and evaluations are in progress to develop the approach for developing digital capability for NHS 111. The intent is that a patient journey will be able to operate seamlessly across multiple channels chosen by the patient. The pilots will help to understand the requirements for developing a more robust digital channel for NHS 111 that allows people to start their journey online, with seamless transfer to a voice call or to face to face care where needed.

3.15 Integration with Urgent and Emergency Care Systems

Commissioners have chosen different service models. Whichever service model is chosen there should be clear and agreed procedures that ensure that the best patient experience across the urgent and emergency care system. The procedure should ensure a coherent service model that delivers the best possible patient experience.

Whilst there are different types of provider, commissioners should explore different call handling models within NHS 111, including OOH and ambulance services.

3.16 Interoperability

Interoperability within the NHS 111 environment is detailed in the NHS 111 Interoperability Standards (formerly specification)[2]. The specification defines the technical standards that must be used for the transfer of data where applicable, to and from NHS 111 application systems and the applications that integrate with NHS 111 service providers.

The following outcomes are required for all NHS 111 services:

- All NHS 111 applications must connect directly with the SPINE and have followed the CAP Process
- All NHS 111 applications must connect with the Summary Care Record to ensure access to patient records is achieved as a minimum
- NHS 111 services must submit and retrieve data from the National Repeat Caller Service
- NHS 111 services must to follow the NHS 111 IM and T assurance toolkit[2]
- Commissioners must ensure that providers use NHS 111 accredited software systems. NHS 111 systems functionality[2].

The following outcomes have flexibility in the approaches to how they are commissioned from a technical perspective:

- All NHS 111 services must be able to book in either an integrated manner, or using Interoperability Standards into OOH services
- All NHS 111 services must be able to dispatch ambulances in either an integrated manner locally, or using Interoperability Standards when dispatching to a separate application or Out of Area 999 service
- NHS 111 services must be able to determine where patients are being referred/transferred to and transmit the data for all OOH services and all 999 services
- NHS 111 services must have access to Special Patient Notes including Out of Area
- NHS 111 services must connect to a single common DoS data layer but may use its own middleware application layer.

3.17 Metrics

Commissioners should ensure the data required to populate NHS 111 minimum datasets is collected. This data should comply with current metrics in line with MDS Provider Specification[3].

Explanatory note: Consultation will occur in line with National Statistics Guidelines[4] regarding the usefulness and completeness of the current collection. As part of this new alternate and in some cases additional metrics will be proposed under the following principles:

- Future metrics for assessing performance and impact of NHS 111 are likely to be grouped under the quality framework: efficiency, safety and patient experience. For example,

    a. Efficiency – call handling standards, episode duration

    b. Safety – reported incidence of harm

    c. Patient experience – reported levels of satisfaction and compliance with advice

- We will make every possible use of centrally collected patient level data. Therefore, it will be important for commissioners to seek to influence the completeness and quality of information in A&E Secondary Use Service (SUS), NHS Pathways Clinical Quality Indicator (where it is used), General Practice Extraction Service (GPES) and National Reporting and Learning Service (NRLS)

- The finalised data collection will be taken through Information Standards Board (ISB) and Review of Central Returns (RoCR) and subsequently mandated.

Furthermore, the Urgent and Emergency Care Review will set the direction of travel for the development of Urgent and Emergency Care system-wide metrics that track patient outcomes as well as service performance. Commissioners should ensure NHS 111 providers comply with these metrics once they are agreed.

3.18 Patient experience

Commissioners should ensure NHS 111 providers have a systematic process in place to regularly seek out, listen to and act on patient feedback on their experience of using the service, ensuring that they deliver a patient centred service. This must include:

- Clear and well-publicised routes for both patients and health professionals to feedback their experience of the service

- Provide 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 NHS 111 service

- Systems in place 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

- Wherever possible the whole patient feedback process needs to be fully transparent. It is important that commissioners adopt an approach that allows users to see the views and experiences of other patients and service users and the responses made by the service.

3.19 Public Health England

Public Health England (PHE) uses information from NHS 111 services to identify health hazards and emergencies caused by infectious disease, hazardous chemicals, poisons or radiation.

NHS 111 must enter into an information sharing agreement with PHE for the secure supply of specified anonymised real-time data for public health surveillance purposes and ensure that a data sharing agreement is included within contracts with providers of the NHS 111 service.

Appropriate governance arrangements should be in place to ensure that all NHS, third sector or commercial organisations participating in the NHS 111 service are committed to supplying a near real-time specified data-set to PHE.

3.20 Repeat and frequent callers

Where a patient (or their carer) calls the NHS 111 service three times in 96 hours, the third call should only be assessed to determine whether or not an ambulance is required. If the outcome is not to send an ambulance, then the call must result in a 'Speak to GP within 1 hour' disposition and the GP must be alerted to the fact that this is the third time in 96 hours that the caller has made contact with the NHS 111 service and they should therefore complete a thorough re-assessment of the patient's needs. The GP should be sent details of all 3 calls.

An exception to the above is for the small minority of people who regularly make frequent calls to the same service and where there is an agreed care plan for the particular patient (e.g. palliative care, long term conditions etc.)

Commissioners should ensure compliance with the above standard and ensure that it is part of processes and exception reporting.

3.21 Service capacity

The capacity of NHS 111 services should be sufficient to meet call volume and fluctuations in demand, in line with the National Quality Requirements.

3.22 Single call resolution

Patient calls to NHS 111 should be resolved in a single contact. In situations where clinical safety dictates divergence from this approach the commissioner must ensure that safety, effectiveness and patient experience are maintained.

3.23 Statutory requirements

Commissioners must ensure that providers of the NHS 111 service are registered with the Care Quality Commission and comply with the requirements of registration and any other statutory and legal requirements.

Commissioners must ensure that providers adhere to statutory and local safeguarding requirements.

3.24 Telephony

Commissioners must ensure the following:

- Calls to the NHS 111 number must be received on a specific direct dial in (DDI) number that is devoted to 111, enabling the calls directly to NHS 111 to be counted. Where calls to NHS 111 are redirected from other numbers (e.g. from a GP or an OOH numbers) they must be sent to a different DDI
- Calls to both DDI numbers can be treated the same way and dealt with by the same staff using the same process and sit in a common queue. DDI numbers cannot be “non-geographic” numbers, such as 0300, they must be a landline
- NHS 111 services must have reliable telephony provision that allows calls to be networked across all their call centres. In the event of the loss of call answering at any one location, calls can then be sent to other centres
- NHS 111 services must have telephony systems that provide management information as defined in the NHS 111 Minimum Data Set
- Recorded announcements must be compliant with the NHS 111 Brand Guidelines[5]
- All inbound and outbound calls to NHS 111 must be recorded. Calls from adults must be retained for 8 years and calls from or about children must be retained until their 26th birthday
- NHS 111 providers are required to ensure that systems are in place to comply with regulation concerning child protection and vulnerable adults
- In order to cope with the very high level of demand that occurs on some days there must be at least three times the number of lines available compared to the maximum number of advisers.

Annex A

Roles and Responsibilities

NHS England

NHS England is responsible for:

1. Monitoring the performance of NHS 111 and compliance with national requirements, quality and performance standards
2. Monitoring the impact of NHS 111 with the urgent care system
3. Assuring that CCGs are managing their responsibility for quality and safety
4. Commissioning and management of NHS 111 national telephony infrastructure and IT systems including repeat caller service, NHS Pathways and DoS
5. Liaison with Ofcom over the use of the 111 number
6. Accreditation of NHS 111 Clinical Decision Support System(s)
7. National communications and media handling
8. Ownership of and development of the NHS 111 brand, core values and guidelines for usage
9. Ownership of the NHS 111 Commissioning Standards and governance of any changes
10. Identifying and sharing lessons learned and good practice across local areas
11. Assuring national business continuity and CCG's contingency arrangements for managing unforeseen surges in demand
12. Approving key decisions, plans, deliverables and any changes to the NHS 111 service design
13. Overseeing interdependencies with related initiatives and programmes outside the scope of NHS 111
14. Assuring that the interests of key stakeholder groups are represented
15. Providing a formal escalation point for the NHS and other stakeholders for issues and concerns relating to NHS 111
16. Periodically providing assurance to the NHS England Board
17. Supporting CCGs' re-procurements of NHS 111 contracts and the transition of NHS 111 services from their current state to any new provider

Clinical Commissioning Groups (CCGs)

CCGs are responsible for:

1. Commissioning NHS 111 as an integral part of the urgent care system according to the national requirements and standards
2. Providing NHS England with evidence that they have undertaken a robust procurement with an appropriate assurance process
3. Assuring NHS England that they have a contingency strategy in place should the chosen provider fail to deliver the NHS 111 service as contracted
4. Monitoring the impact of NHS 111 on local services so that over/under utilised services are identified and improvements to the urgent care system are made
5. Ensuring the effective mobilisation and operational delivery of an NHS 111 service that serves the CCG population, either directly or via joint commissioning arrangements
6. Performance managing the contract against National Quality Requirements
7. Reporting on the quality, benefits and performance of NHS 111 services
8. Ensuring that the Directory of Service (DoS) is fully up to date with the availability of local services and the agreed referral protocols with service providers
9. Ensuring that special patient notes and end of life care records are up to date and available to NHS 111
10. Ensuring clinical governance of NHS 111 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.
11. Publicising NHS 111 locally
12. Local stakeholder communications and media handling
13. Ensuring that business continuity and disaster recovery procedures are in place in the event disruptions to the provision of the NHS 111 service locally

Annex B

Benefits

Benefit	Related objectives	Measures
• Improve the public's access to urgent healthcare services	• Providing a memorable, free to call, three digit number that is available 24 hours a day, 365 days a year • Directing people to the local service (or self-care) that is best able to meet their needs • Arranging an appointment (either by telephone or in person) to access further help, where this is required	• Availability of service nationally • Public awareness • Patient survey • Call handling standards • Compliance with NHS 111 Commissioning Standards • Access to special notes and end of life registers
• Increase the efficiency / productivity of the NHS	• Rationalising urgent care call handling arrangements • Assessing a person's needs once and directing them to the right local service (or self-care), first time • Where appropriate, resolving the health concerns without onward referral • Where onward referral is required, providing the patient with a definite appointment to access further care	• Investment in urgent care call handling • Clinical appropriateness of dispositions • Professional feedback on referrals • Impact of NHS 111 on the wider urgent and emergency care system • Proportion of calls that recommend further service input completed with an appointment

Benefit	Related Objective	Measures
• Drive the improvement of urgent and emergency care services	• Enabling commissioners to appropriately match services with demand profiles • Identifying services which are over or under utilised • Identifying gaps or duplication in services	• Availability of local services • Completeness of DOS • Availability of DOS to health professionals • Availability of management information and intelligence to commissioners • Robust clinical governance arrangements in place
• Increase public satisfaction and confidence in the NHS	• Improving the public's experience accessing urgent healthcare services • Providing an entry point to the NHS that is simple to use and focused on the public's needs • Where possible, facilitate or provide advice and clinical support to callers to meet their health or information needs as close to the location of the patient as possible. • Minimise the hand-offs that patients experience before getting their needs met	• Patient satisfaction • Patient feedback • Complaints and serious incidents

Annex C

Clinical Governance Guidelines

A good clinical governance process is required to ensure a safe, high quality service that shares good practice, evidences learning and strives for continuous quality improvement.

The following is suggested good practice for NHS 111 clinical governance;

1. The appointment of a local NHS 111 clinical governance lead (CGL). This lead should be appropriately skilled and trained for the role.

    - The CGL role involves the development of relationships across the whole urgent care network and the individual should be clinically credible in order to work effectively in this complex environment
    - The CGL will be responsible for holding the provider to account for clinical standards
    - The CGL must have clearly defined links to the regional and national NHS 111 clinical governance structures
    - A minimum expectation is for the lead to have a day a week to dedicate to this role.

    More detailed guidance on the person specification and role, including a model job description is available in the Clinical Governance Toolkit which will be available by summer 2014.

2. A local clinical governance group, under strong clinical leadership and with clear lines of accountability to the commissioners of the NHS 111 service, working alongside and closely with the contracting team. The local governance group should bring together the NHS 111 service itself with all the NHS and social care providers to whom patients may be referred, enabling all to develop a real sense of ownership of their local service

    More detailed guidance on the role of local clinical governance groups, including model terms of reference and membership is available in the Clinical Governance Toolkit which will be available by summer 2014.

3. Clarity about lines of accountability within the NHS 111 service

4. A policy setting out the way in which adverse and serious incidents will be identified and managed, ensuring that the clinical leadership of the NHS 111 service plays an appropriate role in understanding, managing and learning from these events

5. Clear and well-publicised routes for both patients and health professionals to feedback their experience of the service, ensuring prompt and appropriate response to that feedback with shared learning between organisations
6. Regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional insight into the quality of the NHS 111 service
7. Regular review by the CGL of the quality of the calls, with the involvement of other partner organisations, especially where their outcomes have proved problematic
8. Provision of accurate, appropriate, clinically relevant and timely data about the NHS 111 service to ensure that it is meeting the NHS 111 Commissioning Standards.

References

1. Urgent and Emergency Care Clinical Audit Toolkit

   www.rcgp.org.uk/clinical-and-research/clinical-resources

2. IM & T Standards Overview

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   - NHS 111 System Functionality

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3. NHS 111 Minimum Dataset - Providers v0-9

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4. Code of practice for official statistics" Edition 1.0 January 2009, Protocol 1

   www.statisticsauthority.gov.uk/.../code-of-practice/code-of-practice-for- official-statistics.pdf

5. NHS 111 Branding Guidelines

   http://www.networks.nhs.uk/nhs-networks/nhs-111-communications-network/nhs-111-marketing-and-branding/NHS%20111%20Identity%20Guidelines%20FINAL.pdf/view