NHS 111

Quality and Safety Report

July 2014

Document Purpose	Resources
Document Name	NHS 111 Quality and Safety Report
Author	Mike Durkin, Director Patient Safety, NHS England
Publication Date	July 2014
Target Audience	CCG Clinical Leaders, CCG Chief Officers
Additional Circulation List	N/A
Description	NHS 111 Quality and Safety Report
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	For information
Timing / Deadlines (if applicable)	N/A
Contact Details for further information	england.nhs111@nhs.net

NHS 111

Quality and Safety Report

First published: July 2014

Contents

Foreword

During 2013 Dr Mike Durkin, Director of Patient Safety, NHS England was asked to conduct a review into the quality and safety of NHS 111, and to inform the delivery of safe and sustainable services for the future.

As a GP and as the national medical advisor for NHS 111, I welcome this report and the recommendations contained within it. Whilst the service experienced many problems in the early part of 2013 the service is now performing well overall and I have every confidence it will continue to improve.

Around a million people a month are now using NHS 111 and it is critical to improving the delivery of urgent and emergency care services across the country. Sir Bruce Keogh's comprehensive review into urgent and emergency services proposes an even greater role for NHS 111 to help alleviate the growing pressures on NHS services. This important report is very timely therefore, as we seek to re-organise how we provide urgent and emergency care services in England.

The review has provided a unique opportunity to listen to individuals and organisations about their experiences. It has shown examples of extremely good practice across the country, however this is not universal and it is our aspiration to raise standards across the whole service.

I would like to thank Dr Mike Durkin for his leadership in taking this review forward and to the rest of the review team for the time and effort they have dedicated to this important piece of work.

I believe that NHS 111 has a lot to offer the urgent and emergency care system. I am absolutely committed to continually improving and developing NHS 111 making sure that patients receive a consistently high quality service and a positive experience.

Dr Ossie Rawstorne
NHS 111 National Medical Advisor

1. Executive Summary

1.1. This report was commissioned to provide assurance on the quality (safety, effectiveness, equity and patient experience) of NHS 111 services to support effective decision-making. The review consisted of two phases.

Phase 1: Review of reported incidents, complaints and issues

1.2. Phase I of the Quality and Safety Review focused on the clinical governance of the NHS 111 implementation, especially on the key rollout phase over the period January to June 2013. The operational and staffing challenges associated with the new service led to some delays in assessment and call back, and potentially inappropriate call centre outcomes. The review found a clear indication that the NHS 111 service was safe and there were clear signs of learning from the rollout phase. There were good examples of clinical governance and of collaboration between organisations across the urgent and emergency care system which had traditionally worked in isolation from each other.

Phase 2: Review of clinical governance

1.3. The following sections summarise the findings from the four key areas of the second phase of the review:
   - NHS Pathways and Directory of Service (DoS)
   - Service Review
   - Confidentiality and Information Governance
   - Clinical governance costs

Review of NHS Pathways and the Directory of Services (DoS)

1.4. NHS Pathways supports initial telephone assessment by NHS 111 and underpins access to the delivery of urgent (non-emergency) health care to the population. This part of the review examined the current governance arrangements, reviewed the problems identified and highlighted areas of good practice.
1.5. Whilst there is a clear governance structure in place in NHS Pathways, the understanding of responsibilities, the limited schedule of meetings and resource constraints do affect the ability of NHS Pathways to be able to respond to issues and new developments in a timely manner. There needs to be greater clarity of the requirements and responsibilities on the requirements of the NHS Pathways licence, in particular the responsibility for monitoring compliance and managing non-compliance. The review recommends that NHS Pathways, in conjunction with other stakeholders, reviews and revises the clinical governance structures and processes for the future.
1.6. There is an issue with availability and access to data and information to enable providers and commissioners to assess the quality of their services, although this is improving, most notably through the development of the Intelligent Data Tool (IDT) which is in progress.

1.7. NHS Pathways have been operating with a significant number of vacant posts over the last 12 months. This has limited the capability and capacity of the programme to take on development work.

1.8. An up-to-date and accurate DoS is vital to ensure a safe and good quality service. When operating well, it ensures that patients are directed to the right service, at the right time and in the right place. It is also a fundamental aspect of a patient or other service user's experience of the quality of the service received. The review found wide variation in the resources and leadership given to the maintenance of the DoS and the subsequent impact that this had on its quality.

Service Review

1.9. The service review provided a unique opportunity to visit local leads and listen and learn about local clinical governance experiences in relation to NHS 111. A total of eleven service reviews were conducted, and 50 self-assessment questionnaires were completed by local clinical leads. By talking directly to staff, the review enabled significant insight from the perspective of clinical leads, providers and commissioners.

1.10. The review highlighted the importance of good clinical leadership for improving quality. There was a variance in time commitment from clinical leads across the country (ranging from half a day to two days per week). The support from the Clinical Commissioning Groups also varied (CCG), with some leads highly engaged and embedded within the CCG, and others with minimal support and no reporting mechanisms. There were no clear expectations regarding seniority or suitability for the role. The service review recommends clear clinical governance role definitions and role outline.

1.11. The review found that good engagement with clinicians and other partners is important in improving the delivery of NHS 111. The clinical lead role is critical in engaging other clinical stakeholders. This is important as many areas reported difficulties in engaging with local Accident and Emergency Departments. The relationship between NHS 111 and the OOH provider was cited as being pivotal for overall care for patients and clinical leadership.

1.12. End-to-End Reviews were considered to be effective aids to learning and service improvements but many areas no longer use them due to constraints from information governance guidance which prevents sharing of named patient data. The review highlighted the importance of reviewing additional data sources, for example, complaints, NHS Pathways Continuous Quality Improvement (CQI) and Serious Incidents.

1.13. The review has identified examples of good practice in terms of clinical governance processes, tools and templates, but with variation across the country.

Confidentiality and Information Governance

1.14. The review clearly highlighted the tension around achieving an appropriate balance between the protection of patient information, and tracking data safely across boundaries for the purpose of improving services for patients.

1.15. The provision of urgent care often involving two or more providers and so a number of providers may hold information for the same patient's episode of care. The current interpretation of confidentiality rules means that providers do not share patient identifiable data without patient consent. The review identified concerns that data is not shared and as such is reducing the ability to improve quality and safety within NHS 111 and the wider care system.

1.16. The report identifies a number of options for NHS 111 in addressing the confidentiality problem, and a series of recommendations. These include exploring an application for Section 251 exemption for the clinical governance elements of NHS 111.

1.17. The report also identifies the problems associated with accessing important information held about patients which directly impacts on their care and recommends a nationally agreed process for sharing Special Patient Notes is developed.

Integration of NHS 111

1.18. NHS 111 has enormous significance for the operation of emergency and urgent care systems and resources. It is important to reflect that the integration of NHS 111, NHS Pathways and the Directory of Service is vital in terms of a whole system approach and the wider NHS system.

Engagement with patients and members of the public

1.19. Section 7 includes an overview of the latest patient experience data received from postal questionnaires to NHS 111 service users.

2. Introduction

2.1. The purpose of NHS 111 is to make it easier for the public to access urgent healthcare and drive improvements in the way in which the NHS delivers that care.

2.2. The Quality and Safety Review was commissioned to assess and assure the quality (safety, effectiveness, equity and patient experience) of NHS 111 services and to inform a programme of work to deliver safe sustainable services in the future.

2.3. The review was conducted in two phases. Phase 1 focused upon the clinical governance of the NHS 111 implementation and learning from reported incidents. A summary of the key findings and recommendations are included in Appendix A.

2.4. The methodology used to assess the safety of NHS 111 focused on three main areas: clinical governance; performance and service delivery, and a review of serious incidents. The methodology used is detailed in Appendix B.

2.5. This report presents Phase 2 of the review. The report reviews the clinical governance arrangements that underpin the NHS 111 service and incorporates information from the rollout phase of NHS 111 from April to December 2013. The report concludes with a series of recommendations to inform the development of the new NHS 111 commissioning standards.

2.6. The key tasks were to:

- Review all reported incidents in urgent care networks where NHS 111 was in operation to identify lessons for the wider care system
- Review the clinical governance processes in place in established NHS 111 areas to identify best practice
- Consider NHS England clinical governance requirements within the NHS 111 core service specification
- Review the procedures within NHS 111 and referrals to other services to ensure appropriate level of clinical input is in place

3. Service Review

3.1. The aim of the national service review was to understand the clinical governance of NHS 111 from the perspective of clinical governance leads, commissioners and providers, and to identify good practice to inform wider learning. The review was intended to put into action the principles laid out by the [1]Francis and Berwick reports in terms of learning and sharing to improve patient care.

3.2. The following sections provide an overview of the findings for the following theme areas: clinical governance processes; complaints and professional feedback; patient and staff feedback; Special Patient Notes and the relationship between Out of Hour (OOH) providers and NHS 111 services.

---

[1] Robert Francis QC, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Don Berwick, Report on Improving the Patient Safety of Patients in England, August 2013.

Clinical governance processes

3.3. Clinical governance processes vary widely across the country to fit with locally agreed systems and processes. All areas have a clinical governance lead, and a small number have a deputy. The local NHS 111 clinical governance lead provides leadership for the clinical governance meetings, making sure the right people are involved. The lead has an important role in improving quality - most clinical governance leads have visited NHS 111 local call centres and continue to do so, in order to understand issues.

3.4. The time commitment for the role varies from half a day per week, to two days per week. There is also wide variability regarding the clinical governance lead contract, with no clear expectations regarding length of contract, hours required, seniority or suitability for the role. Few clinical leads received any specific training, and many had requested national training, particularly for Root Cause Analysis. The clinical governance lead role is similar across the country, although there is no single role description.

3.5. Engagement between clinical governance leads and their hosting Clinical Commissioning Group (CCG) is highly variable. Some leads are also urgent care leads, well engaged and respected and employed by the CCG, whilst others are not embedded within their CCG, have no CCG support and no formal reporting mechanisms into the CCG.

3.6. Providers have engaged willingly and openly in the whole review process. It was noted in several face to face reviews that providers are very keen to engage with local A&E's as feedback is essential in order to improve A&E dispositions. Providers are also keen on quality benchmarking data being available, when not constrained by commercial confidentiality.

3.7. Regional clinical governance leads have provided an important link between the local leads and the central NHS 111 team. They provide significant input where the local clinical governance lead needed additional support and development.

3.8. It was recognised that effective clinical governance processes and engagement can improve delivery of NHS 111 services. Many areas struggle to get meaningful engagement with local Accident and Emergency Departments (A&Es) with generally poor attendance at NHS 111 clinical governance meetings.

3.9. Effective End-to-End Reviews can increase inter-organisational understanding, improve patient pathways and facilitate learning about the whole urgent care pathway. Often the reviews are focused on patient complaints as the logistics regarding patient consent are not an issue in these cases. These reviews are effective where used regularly but many areas have stopped them due to information governance issues preventing sharing of named patient data. Recent feedback from a major NHS 111 provider confirms that they have virtually stopped undertaking the reviews because of the information governance issues involved.

3.10. The review found that there is a lack of clarity regarding responsibility for the outcomes of the reviews. Attendance is not always compulsory for providers and other relevant stakeholders. The review did identify some providers with dedicated clinical governance teams using an audit cycle to lead their continuous improvement plan.

Complaints and Health Professional Feedback

3.11. The NHS 111 clinical governance specification was detailed in its expectation regarding the identification, processing and learning from complaints regarding the NHS 111 service. Many areas set up separate mechanisms including Health Professional Feedback (HPF), however these were found to be unmanageable if they differed from the standard CCG complaints processes and so many areas have now aligned these. After being deluged with HPF at 'go live'; most providers report a decrease in numbers. The vast majority of forms related to the Post Event Message (PEM) which was considered too long and clinically irrelevant (this has now been updated and is more acceptable).

3.12. The review found that most clinical governance leads are informed within twenty-four hours of potential serious incidents, but the acknowledgement of complaints via Health Professional Feedback (HPF) forms can be between 3 – 28 days, with providers taking a long time to resolve complaints. The specification that any HPF response would be countersigned by both clinical governance lead and provider has not been fully embedded across the service.

3.13. The review identified that no clinical governance lead had responsibility for ensuring the identification, reporting and investigation of agreed Serious Incidents (SI's). The national Quality and Safety Workstream has experienced difficulties in searching through national reporting mechanisms for details regarding SI's linked to the NHS 111 service. Whilst providers and commissioners have a responsibility for leading investigations, the review led to the conclusion that clinical leads should take responsibility for monitoring that investigations are adequate, recommendations are clear and action plans for implementation are made. They should also monitor that actions are completed and learning shared.

3.14. The review specifically aimed to identify processes for collection of patient and provider staff feedback to inform the governance process. Services expected HPF to capture most patient feedback (via their GP), however many acknowledged that it was sometimes difficult for patients to supply feedback. A variety of methods were used including a patient focus group and the complaints process.

3.15. Much of the risk at the initiation of the NHS 111 service was due to the sheer volume of patients trying to get through the system, and it was significantly compounded by the reorganisation of the NHS at the same time. The review demonstrated that there is a vast improvement since 'go live' at Easter 2013, with some areas reporting more patient compliments than complaints.

3.16. In the absence of a single electronic record, Special Patient Notes (SPN's) are used to share patient information and ensure the best service for patients. SPN's are used to describe information recorded about patients with complex healthcare needs, and health care professionals cannot safely meet the needs of these patients without additional information being made available in advance of, or at the time of, consultation. Whilst SPN's are invaluable, the review found that there is not universal use of the system due to inter-operability issues regarding sharing, updating and cleansing SPN's, nor GP willingness or ability to reliably load SPN's onto the appropriate site.

Relationship between OOH providers and NHS 111

3.17.   The interviews revealed a great deal of information regarding the relationship between these two pivotal providers. In areas where the relationship is strong and trusting, the resulting transparency has led to quick and effective improvements in the smoothing of patient pathways, supporting interactions at particularly busy times, and triangulation of learning.

3.18.   However, some reviews highlighted little communication between the two providers and also importantly the local ambulance service, which resulted in generally poor clinical governance procedures across the service. In this case, commissioners used contracting and clinical governance processes to support the clinical lead to improve matters.

3.19.   In areas with the most difficulties, recovery plans were often not shared, staffing issues misleading and poor sharing of complaints and outcomes became crucial issues. Clinical leads were often 'fire-fighting' rather than developing improvement plans for clinical governance.

3.20.   The role of the clinical governance group, particularly using End-to-End Review audit tools, is important as they aided the understanding of pathway problems and the often wrong attribution of blame to the NHS 111 service, when in fact another provider had failed the system. However, the 'blame' of NHS 111 and the accompanying loss of reputation is still a significant issue for many providers despite recent improvements in service.

3.21.   The relationship with the OOH provider is pivotal for good overall care for patients. The clinical governance lead role is important here.

Summary of key findings

a.   The local clinical governance lead needs a clear role description, with sufficient time and leadership qualities to influence and support a range of local 'urgent care' providers.

b.   There needs to be common understanding as to the responsibilities of the role and the current post holder should have the administrative and senior CCG support to deliver effectively.

c.   The lead should Chair a regular monthly clinical governance meeting which is separate to, but aligned with the operational contracting meeting. The clinical governance meetings should include all stakeholders, and deputies should be sent if necessary.

d.   The use of End-to-End Reviews is the mainstay of the clinical governance group workload, but other data is required to be reviewed in order to assure the group of the safety and quality of the service. This data includes NHS Pathways audit and CQI data, quality benchmarking data, complaints data, Serious Incidents, Health Professional Feedback and regular staff feedback.

e. The clinical governance group should champion the use of Special Patient Notes across the NHS 111 system to ensure they remain appropriate and helpful for the patients' journey. The clinical governance lead must endeavour to develop trusting, transparent and reliable relationships across all providers involved in the service to enable maximum learning and sharing of good practice locally, regionally and nationally.

f. It is clear from the variable responses about responsibility for recording and monitoring Serious Incidents (SI's) related to NHS 111 and the difficulty encountered when trying to investigate them, that there is no single national process in place. The responsibility for recording SI data needs to be clarified. One option would be for the clinical governance lead to manage this, including the necessity to inform the NHS 111 National Medical Advisor and Regional Lead as soon as practically possible.

g. Regional groups can be a repository of learning which feed up to a national level and share experiences quickly down to local level End-to-End Reviews to ensure standardised process and aid sharing of learning.

h. Monthly pathways audit and Clinical Quality Indicator (CQI) data needs to be strengthened by additional metrics and this needs to be used throughout the NHS 111 system with CQI data as a tool for continuous improvement. However it is important to add to these metrics and ensure timely sharing of all benchmarking factors between clinical governance leads and commissioners, and where necessary other providers.

The outcome of this review has shown that whilst there are examples of extremely good practice across the country, it is by no means universal. A portfolio of 'best practice' was collected that could be utilised to support future clinical governance specification development.

Summary of recommendations

a. *Develop clear clinical governance lead role definitions and role outline.*

b. *Identify clinical governance structures and processes that will promote and support clinical leadership*

c. *Develop the capability for shared learning and continuous improvement beyond the clinical governance network and across the whole health community*

d. *Develop a universal system for reporting serious incidents and complaints in order to improve information retrieval for incidents relating to NHS 111, and to support dissemination of learning and information-sharing as widely as possible*

e. ***Develop a package of best practice examples of clinical governance models for regional dissemination***

4. NHS Pathways and Directory of Service

4.1. NHS Pathways is by default the sole national supplier of clinical content to every NHS 111 service and some 999 and OOH services in England. It therefore underpins the delivery of urgent (non-emergency) health care to almost all the population.

4.2. This review of the governance of NHS Pathways and the Directory of Services (DoS), which underpins the NHS 111 service, was conducted to provide clarity on the current governance mechanisms. The primary objective was to see if these arrangements were adequate to assure ourselves on the quality and safety of the NHS 111 service being offered through multiple providers across the country. This section of the report details the current governance arrangements, reviews problems that have developed, highlights areas of good practice that have been identified and make recommendations on the basis of these observations.

NHS Pathways governance structure

4.3. The current overall governance of NHS Pathways is divided between three bodies;
  - National Clinical Governance Group (NCGG)
  - Corporate Health and Social Care Information Centre (HSCIC)
  - NHS England

4.4. The NCGG has responsibility for overseeing almost all of the clinical governance aspects of NHS Pathways. This includes oversight of the development of Pathways between version releases and resolving problems reported through the issues log or other mechanisms. Strategic decisions are made by the NHS Pathways Programme Board hosted within HSCIC and NHS England.

4.5. NCGG meetings are held every six months and are planned to support the two main NHS Pathways release cycles. By comparison, most local 111 Clinical Governance Groups, Regional NHS 111 Groups and the National NHS 111 Clinical Leads Group meet on a monthly basis.

4.6. The NCGG reviews ongoing issues between the scheduled meetings, since it recognises that one day is insufficient to review all clinical content and reference other clinical expertise. There is also scope within the NCGG members terms of reference to enable them to be called upon during the year should an issue requiring urgent clinical review and sign-off arise. This can be done outside the two scheduled face-to-face meetings.

4.7. The NCGG is central to the clinical governance of NHS Pathways. It provides the national clinical community with the assurance that it has direct clinical control over the NHS Pathways development process and content development. Anything that undermines the confidence it generates will limit the future credibility of the 999 and 111 services. However, the task of providing scrutiny over the volume of calls received in 111, 999 and OOH environments is now an order of magnitude greater than the role for which the NCGG was designed. The structure of the group and frequency of meetings should be reviewed to ensure it remains fit for purpose.

4.8. NHS Pathways has grown from supplying four initial NHS 111 pilot sites to almost national coverage. A redesign of the operative management processes within NHS Pathways was conducted in 2012 and team structures redesigned to support and deliver the new, expanded service. Confirmation of the agreed structure is being sought to provide assurance that the resources are/will be in place to enable the benefits of the proposed redesign and restructure to be realised.

4.9. This review has highlighted a number of areas that NHS Pathways has struggled to respond to. This is most evident when dealing with reported issues, a key part of service delivery. Both the reporting and feedback mechanisms require redesigning to cope with supporting a national NHS 111 service. A mechanism should be developed to enable sites to be made aware when a particular problem is identified and to indicate if that problem affects them as well so that the scale of the problem can be seen. There should also be a proactive mechanism, such as a clinical bulletin or online library, for sharing resolved issues so that local NHS 111 providers and commissioners can review when necessary and maximise learning.

4.10. Whilst P1 (top priority) issues are dealt with in a timely fashion, there are periods, especially around update releases and lock down periods when clinical authoring is necessary, when the response time for other issues is impacted negatively.

4.11. The NHS Pathways team, together with stakeholders from within NHS 111, 999 and OOH should review the existing governance arrangements and develop one or more options for the future governance of NHS Pathways which is able to respond effectively to its current pattern and frequency of use.

4.12. There are plans to reinstate specialist forums such as the DoS and Capacity Management Forums. However, without each having a named responsible lead, adequate resource, a clear purpose and terms of reference they may struggle to fit into the overarching governance structure.

4.13. The experience of NHS 111 clinical governance groups has shown that more frequent meetings provide a realistic and responsive approach to good ongoing governance. The frequency of NCGG meetings appears to be insufficient to be able to provide assurance around the quality, safety and responsiveness of the service that NHS Pathways provides.

4.14. The NCGG should therefore consider whether increasing the frequency of meetings is now an appropriate course of action. This will enable the central collation of important clinical and developmental requests and issues from NHS 111 before submitting to NHS Pathways. It will strengthen clinical governance links between NHS 111 and NHS Pathways and enable updates and interim fixes to be dealt with more efficiently. Working collaboratively with the NHS 111 NCGG members, issues could be fully discussed and worked up prior to submission to the formal NCGG meetings.

Status of NHS Pathways and licence requirements

4.15. The current status of NHS Pathways lacks clarity. Is it a supplier? Is it a preferred option? Is it the recommended or mandated option? What exactly is the position of NHS Pathways to NHS England now that it has migrated to the Health and Social Care Information Centre (HSCIC)?

4.16. NHS Pathways is currently the only software in use for clinical triage in the NHS 111 service. It is also the only software capable of interfacing with the Directory of Services (DOS). It is conceivable that other suitable products may emerge from the market. NHS England needs to determine if NHS Pathways is mandated as the sole supplier of a clinical decision support system (CDSS), or, if not, what arrangements are in place for authorising alternative systems.

4.17. Providers and commissioners are unclear of their responsibilities for ensuring that the licence requirements of NHS Pathways are being met. The format of the licence itself is a barrier to understanding the requirements and responsibilities for compliance. NHS Pathways has processes in place to monitor some elements of licence compliance. However, these arrangements should be strengthened and give NHS Pathways a clear remit to monitor and report licence compliance as part of its overall governance. This would provide commissioners with a minimum level of assurance on licence compliance and breaches should be notified to them by NHS Pathways.

NHS Pathways training

4.18. There are two types of NHS Pathways training. The first is the training of trainers, who then go on to train call advisors and clinical advisors to utilise NHS Pathways. This element of training is currently sub-contracted to third party contractors.

4.19. This report has identified problems with the quality of trainer training currently being delivered.

4.20. The other type of training is the six weeks call advisor and clinical advisor training programmes that are delivered by providers, usually through in house trainers. Recent audits indicate that call advisors and clinical advisors continue to develop their skills over a period of nine months after completing Pathways training. Therefore, ongoing supervision is required especially during the first twelve months following training. This is in addition to the ongoing monthly CQI programme of call reviews and call metric data.

4.21. Courses for call advisors and clinical advisors should be reviewed and strengthened; with regular update courses incorporated, linked to the NHS Pathways version releases.

4.22. Consideration should also be given to the development of a "foundation year 1" programme for call advisor and clinical advisor training. This needs to be conducted in the initial first year after NHS Pathways training is completed. It would support call advisors and clinical advisors to develop and mature their skills and abilities. This could form the basis of an academic accreditation encompassing all components of training and supervision over this period. This would aid staff retention and create recognition of staff ability.

4.23. Experience of End-to-End reviews has shown that some calls highlight issues, which, if shared could benefit all staff to manage similar calls more effectively. Consideration could be given to developing a national library of such calls that could be shared across all providers, whilst providing anonymity for the staff involved. This would help to share learning regarding the use of NHS Pathways in practice.

4.24. A more robust mechanism of centrally holding all call advisor and clinical advisor training and CQI updates should be developed, similar to the online ability to check either a doctor or nurses credentials via the General Medical Council and Nursing and Midwifery Council.

The role of Regional DoS leads

4.25. An up to date and accurate DoS is vital to ensure a safe and good quality service. When operating well, it ensures that patients are directed to the right service, at the right time and in the right place. It is also a fundamental aspect of a patient or other service user's experience of the quality of the service received.

4.26. Currently, there is varied regional DoS leadership present according to previous Strategic Health Authority boundaries which has affected DoS maintenance and development. It has been found that in those regions where a regional DoS lead exists; there is a more robust system of DoS governance, maintenance and development that works alongside the regional clinical lead networks. This drives both quality of DoS data and positively impacts patient journeys through the urgent care network.

4.27. Consideration should be given to re-establishing the regional DoS leads network. For the future development of the DoS, as well as current maintenance perspective, this would create a network of DoS expertise which would link up with individual DoS leads across the country. These individual leads would then be responsible for ensuring quality of the DoS and driving forward innovative changes.

Summary of recommendations

a. *NHS Pathways should be fully resourced to support the current 111 and 999 service. Its governance structure and meeting schedule should be reviewed and redesigned to facilitate more collaborative and responsive links between key stakeholders, including local and regional subgroups, the National 111 governance group, and the NCGG supported by a devolved NHS Pathways specific group.*

b. *Reporting and feedback mechanisms should be reviewed to enable real time feedback and sharing of information to maximise both local and national learning.*

c. *NHS England should clarify the position of NHS Pathways and the DOS in relation to 111 by either mandating NHS Pathways as the only suitable system, or developing an accreditation process for alternative systems. It should also determine the status of future DOS interoperability with other providers of software e.g. GP systems, OOH systems and Ambulance service systems and hence review the relationship between NHS Pathways and DOS.*

d. *An easy to understand version of the Pathways licence should be produced and NHS Pathways should develop a reporting mechanism to feedback directly to commissioning organisations if a provider is failing to meet their contractual licence requirements.*

e. ***The mechanisms for the delivery and accreditation of training and the assurance of its quality should be reviewed to ensure that standards are well-defined and are upheld. A central repository of training information and CQI data should be developed and maintained.***

f. ***The re-establishment of the regional DOS network should be considered, including the funding requirements.***

5.   Confidentiality and Information Governance

5.1. The review recognised that protecting the confidentiality of patient information is vital to maintaining the relationship of trust between NHS services and patients. The approach taken by NHS 111 to the confidentiality of patient data is for patient wishes for the sharing of their data to be checked at the end of each contact and acted upon in accordance with their wishes and the law. Trust is therefore maintained in the system and there is no evidence that people have been discouraged from calling because of potential confidentiality issues.

5.2. The review identified problems with sharing and tracking data across provider boundaries and considered options for improving it across the whole system, not just NHS 111.

5.3. With the arrival of the NHS 111 service, the provision of urgent care now usually involves at least two providers (often more) and all the interfaces between them. Many of these provider interfaces are new and relatively untested and understanding where changes are required involves all the data about each case from all involved parties.

5.4. Several providers may hold information on the same patient's single episode of care, most of it different. These data can only be linked to provide a view of the whole pathway with an appropriate legal basis. Whilst relevant information must be made available to providers delivering care to individuals ie follow the patient's care pathway, this information sharing occurs with the patient's consent implied as part of their consent to examination, treatment and referral. Disclosure for other purposes needs a secure legal basis either through statute or explicit consent. The review found that providers simply will not share. Patient Identifiable Data (PID) unless patient consent has been obtained as to do so would be a breach of confidentiality, and therefore also a breach of the Data Protection Act 1998[21] and also not compliant with the recommendations of the Caldicott Review 2013[2]. This approach appears to stem from a failure to consider what legal basis might apply to support the disclosure of data for clinical audit to provide assurance on the safety and quality of individual patient dispositions and outcomes.

5.5. Near misses or quality failings are not always identifiable from a single provider record of events and neither do they necessarily give rise to formal complaints. They rarely draw

---

[1] The first DPA principle requires that data are processed fairly and lawfully and a breach of confidence therefore also constitutes a breach of the DPA

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

attention to themselves except by chance and are therefore untraceable for practical purposes. This means that a systematic approach to identifying them is not possible.

5.6. The clinical governance process of NHS 111 is therefore only able to effectively monitor those events which have failed. It has been heavily restricted in its ability to prospectively mitigate against failure by learning from current problems.

Summary of findings

5.7. There is a need to develop secure and lawful data linkages across care boundaries. This is effectively a new skill the NHS is developing in caring for patients and its safety must be tracked.

Analysis of confidentiality issues

5.8. A full breakdown of options for handling confidential data which might be available to NHS services are detailed in Appendix C .

5.9. The way to find out whether the five stages of the patient journey are being implemented successfully might be through complaints, healthcare professional feedback and gap analysis of data from NHS Pathways. However, the less hard measures of *potential* failures often do not reveal themselves by these methods. End-to-end analyses of calls enable the service to assess the clinical governance of the systems in place and to learn from potential near misses.

5.10. These cases need to be tracked over the boundaries between providers by identifying the patient as an individual and then re-assembling the record from all involved in the case. Gaining consent for the numbers of patients involved is not practical, so theoretically the NHS 111 teams should consider Caldicott Recommendation 10 *"The linkage of personal confidential data, which requires a legal basis, or data that has been de-identified with reasonable effort, from more than one organisation for any purpose other than direct care should only be done in specialist, well-governed, independently scrutinised and accredited environments called 'accredited safe havens'."*

5.11. For practical purposes, getting a worthwhile number of safe havens up and running quickly is unrealistic and likely to take some considerable time, and yet the need is for practical and information governance-acceptable data linkage now, in view of the evident safety and patient experience gaps.

Information governance within NHS 111

5.12. Information governance includes the complete chain of information across the five stages of the patient journey, during which passage that information must be available, comprehensible, comprehensive and appropriate to the job of caring for the patient safely and thoughtfully.

5.13. **Special Patient Notes (SPNs):** SPNs are very helpful in speeding up calls, getting more appropriate outcomes for patients and improving their experience of the service. However, they are poorly populated at present and there is no prescribed standard way of dealing

with them. This causes problems with boundary issues and changing from one provider to another.

5.14. Full details of the information chain are detailed in Appendix D.

Summary of recommendations

Recommendations for improving confidential information flows within NHS 111:

a. ***Explore an application for Section 251 for the clinical governance elements of NHS 111***

b. ***Introduce practical open-source pseudonymisation as a strategic approach to data sharing***

c. ***Disseminate agreed statements regarding the sharing of PID to support patient safety once the position is clear***

d. ***The Independent Information Governance Oversight Panel to review the impact of current restrictions on data handling for patient safety***

Recommendations to improve clinical information flows in NHS 111:

a. ***Organise a programme for the development of nationally agreed standards for Special Patient Notes, congruent with GP contract changes and training and considering the use of the enhanced GP summary Care Record as the data source***

b. ***NHS England to provide strategic clinical and technical oversight of NHS 111 to address a number of detailed recommendations included in Appendix F***

6.   Service costings

6.1   Clinical governance costings information was gathered using the self-assessment questionnaires from the Service Review. Specific questions relating to staff roles, costs and time commitments to support the clinical governance function were included. Of the 50 responses there were sixteen duplicates or responses that had significant overlap with those from a neighbouring area. There were significant issues with variability in data quality.

6.2   Following cleansing, data was considered for thirty-four sites.   However, due to the quality of the data and the number of key assumptions required, the results cannot be utilised in their present form. Further data gathering and analysis could be undertaken if required.

6.3   Further information regarding the service cost analysis produced to date, is available in a separate report.

7. Reporting and Learning

7.1 Phase 1 of the Quality and Service Review examined a range of data and information to ascertain the safety of the service. One element of this was to review the patient safety incidents reported through the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS). The regional clinical governance group has kept an oversight of patient safety through their review of health professional feedback, issues and serious incidents. Full details of the incidents reported to the National Reporting and Learning System are detailed in Appendix E.

7.2 In order to investigate potential NHS 111 related incidents effectively there is a need to clarify reporting requirements and mechanisms and ensure that governance leads have access to the whole range of issue/incident data available.

7.3 The responsibility for reporting serious incidents is set out in the Serious Incident Framework (NHS England, March 2013) http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf. The next iteration of the framework will aim to clarify the responsibilities for reporting incidents in the 111 and urgent care settings.

Patient experience of NHS 111

7.4 Patient experience data is collected over a six month period by postal questionnaire. The last reported data for levels of patient satisfaction is from April 2013 to September 2013. The national figures show that 84% of patients are very or fairly satisfied with the service. This is down from 92% in the previous reported 6-months of data. This was expected given the difficulties experienced by the service. The next data is due to be published in June 2014.

7.5 The last reported data for levels of patient compliance is from April 2013 to September 2013 where 82% of patients report fully complying with advice, with 5% not complying with advice. Both of these figures are higher than the previous data (74%, 2% respectively).

Recommendations

a. *It is recommended that potential NHS 111 related serious incidents should be shared with the NHS 111 National Medical Advisor to follow up in order to maximise learning.*

b. *The Serious Incident Framework and service specification should clarify reporting requirements.*

8. Conclusion

8.1 The review has highlighted some examples of good practice, as well as high levels of variation in clinical governance arrangements. The findings highlighted the following broad areas for consideration and further development:

8.2 The clinical governance lead network has proved vital and it has provided invaluable insight into the current clinical governance of the NHS 111 service across the country. It is clear

that there is value in retaining and developing this expertise, although a review of the structure and requirements should be conducted to ensure its fit with the current NHS and NHS 111 structures.

8.3 During the review, it became apparent that there are a number of key roles within the NHS 111 governance system that are pivotal in ensuring safety and quality and are key in informing future requirements. There is a wide variation across the country in the amount of time and emphasis put on these roles. Some have a clear job description and a remit to conduct these activities as part of their job; others have had these responsibilities added to already busy roles. Having clear and explicit roles and responsibilities will improve the quality and safety of the system and enable providers and commissioners to obtain further assurance on the governance of the service.

8.4 The lack of data and information to enable providers and commissioners to assess and assure the service being provided has been a recurrent theme throughout the review. The Intelligent Data Tool which is currently in development is one improvement. However, other important sources of learning such as end-to-end reviews are either not conducted at all or not shared because of the information governance issues between different organisations.

8.5 Information Governance has continued to create a barrier to both the effective day to day running of a quality service and the ability to audit and learn from a patient's journey through the urgent care pathway. A lack of access to patient notes or records at each stage of the patient journey creates, at best, frustration for the patient in having to repeat the same information to a range of different people. At worst, the lack of access to information on a patient's history or their personal wishes could result in a poor outcome or even harm.

8.6 There is evidence of learning and improvement in some areas, particularly in response to the problems encountered during the key rollout phase in March/April 2013. However, there is very little evidence at this stage of any sharing of this in order to maximise learning and continuous improvement more widely.

8.7 A summary of recommendations identified from the review are included in Appendix F.

8.8 The review included some preliminary analysis on clinical governance costings and due to the lack of data it has not been possible to draw conclusions.

8.9 The review was asked to consider the point and level of clinical intervention in the NHS 111 service. Within the timescale available, it was not possible to conduct the research required to give a definitive answer on this. There were a range of views expressed and there seems to be a view from a number of people that certain conditions may need an earlier clinical intervention i.e. chest pain.

8.10 The NHS Futures Programme is testing a number of hypotheses related to enhanced clinical interventions in the NHS 111 service and results of these will inform future commissioning standards.

Review Team

Dr Mike Durkin, *Review Chair*
Dr Helen Thomas, *Regional Clinical Governance Lead South West - Clinical Governance*
Dr Vishen Ramkisson, *Regional Clinical Governance Lead East of England - Pathways and DoS*
Dr Grant Kelly, Joint *Regional Clinical Governance Lead Kent, Medway, Surrey and Sussex*

Acknowledgements

Appendix A: Summary Phase 1 Quality and Safety Review

NHS 111 Quality and Safety Workstream

Summary of Phase 1 Safety Review September 2013

1. Purpose of the Phase 1 Safety Review

Phase 1 of the NHS 111 Quality and Safety review focused on the clinical governance of the NHS 111 implementation and learning from reported incidents, particularly those considered serious. Phase 1 focused on three main areas: clinical governance; performance and service delivery, and review of serious incidents, reviewing data from four sources during the key rollout phase over the period January to June 2013 including: regional clinical governance reports, incident reports, the NHS 111 minimum data set and complaints received by the NHS England Customer Contact Centre.

The aim of this phase was to answer two important questions namely:

- Was the NHS 111 service safe at the national handover period around Easter 2013, and
- Is the service safe at present?

The evidence that was reviewed by the Quality and Safety Workstream Group gives a clear indication that the NHS 111 service is currently safe. It is difficult however to confirm whether the service at the end of March through to April was safe or unsafe. There was evidence evaluated to confirm that clinical governance mechanisms and processes were in place and that serious incidents were reported and these were subsequently investigated. The number of incidents was small but it has proved difficult to determine whether there was a causal relationship between the outcome of these incidents and the involvement of NHS 111.

2. Summary of key safety findings

2.1. The operational and staffing challenges associated with the new service led to some delays in assessment and call-back, and potentially inappropriate call centre outcomes which may have led to patient harm. The problems are not inherent to the NHS 111 system itself, and point more towards providers underestimating the capacity required to meet the demand.

2.2. The evidence shows that the issues described above have steadily improved, although performance needs to be continually monitored to ensure effective learning from the roll out as new sites come on-line, and to maintain strong clinical governance arrangements.

2.3. The analysis of the clinical governance reports was favourable, and augers well for the long term. The reports provide a good insight into the day-to-day clinical leadership that is required to ensure that patient safety is maintained and, most importantly, that mechanisms ensuring a high quality and improving service are being developed. Patient safety is maintained largely as a result of the high standards of ongoing governance being provided by the local clinical governance groups, which in turn network with the regional governance groups.

2.4. This indicates a positive patient safety culture at organisational level, which should pay dividends in the medium to long term. The large variation in the number of healthcare professional feedback forms received seem to be related to teething problems with the rapid rollout phase, as identified in the clinical governance analysis, rather than issues detrimental to patient safety.

2.5. In addition, there are real benefits from NHS 111 clinical governance groups drawing on a wide membership from across urgent and emergency care systems that have traditionally worked in isolation from each other. They are now working together to develop quality of care for local patients with unplanned health needs.

2.6. Overall, delays in the system including response times and 'Incorrect call centre outcome', would appear to be the main areas of concern. For the period covered by this review, these issues appeared to be particularly acute during bank holidays and weekends, although further analysis may be needed to verify this. In the medium to long term, clinical governance processes would appear to be setting a positive patient safety culture on which to build, once the issues indicated have been addressed.

3. Conclusions

3.1. There was no doubt that performance failures resulted in potential delays and unmet patient expectations around the period of the launch in April 2013. Following this, the relevant performance indicators appear to have improved across most sites as reflected by the MDS data. Continuing assessment and analysis will help to identify if there are problems in a particular region, with a provider or within the NHS 111 system as a whole.

3.2. There are clear lessons to be learnt from the rapid rollout phase of NHS 111 and the attendant consequences of doing this during a time that coincided with the end of winter and the Easter period with its predictable bank holidays. It is recommended that a detailed benefits realisation analysis is conducted by those sites planning to mobilise to go live in the remainder of 2013 with winter and Christmas holiday pressures fast approaching.

3.3. The impact of the rapid rollout was clearly significant, and whilst we can be confident that the service is now operating safely, there are lessons to be learnt for this and other programmes that are to be released during periods of rapid change in demand, such as public holidays.

3.4. The concept for NHS 111 was to provide a better, more responsive telephone based urgent care service. However, from the quality performance data that was available it was not possible to benchmark this performance directly to NHS Direct.

3.5. On the data reviewed and information currently provided we have found that patients who accessed NHS 111 were not provided an unsafe service. In fact there is now in place a locally developed and clinically governed service which with further support can develop to provide a more robust service.

Appendix B: The review methodology

- The methods used to gather data aimed to produce the best available evidence within the limited time available for the review. The methodology varied with each workstream subgroup.

- The review of the **NHS Pathways and Directory of Service (DoS)** was conducted by a subgroup of regional and local clinical leads and NHS Pathways and DoS leads. After identifying specific issues, the group conducted a literature search, review and analysis of key documents linked to the governance process.

- The **Service Review** involved three data sources: completion of 50 self-assessment questionnaires from local clinical leads; site visits to eleven local areas (interviews with commissioners, providers and clinical leads) and summary evidence from clinical readiness visits to twelve sites. The self-assessment questionnaires included a section on **clinical governance costings**, which provided data for the costings sections of the report.

- **Confidentiality and Information Governance** data and analysis was informed by a range of discussions with subject matter experts and clinical leads.

Appendix C: Detailed analysis of the confidentiality problem

What options are available to enable NHS 111 to track patients through the system whilst maintaining confidentiality?

- **Gain consent from patients.** For service development, at present this would involve writing to approximately 1000 patients for each region to cover the last three months. This has to be considered unrealistic as, over time, skills will develop in data-handling which will increase the number of audits requested and proven to be of value. This is at best only a stop-gap option and not a good one at that.

- **Rely on clinical staff only to view records.** If the data was appropriately assembled for them, then it would maybe be possible for clinical staff to examine PID from other Caldicott domains on the basis that as registered and regulated healthcare practitioners, their potential loss of registration might act as sufficient reassurance for the process. That unfortunately does not take account of the large number of non-clinical staff needed to assemble and sort the data. It is also the case that a Caldicott Guardian from one domain may not be entirely comfortable with the assurances received from another, a situation already experienced. This approach cannot therefore be viewed as a solution.

- **Rely on qualitative reports and comments.** This is the current process of service improvement across care interfaces, largely based on anecdote and agreement or argument. Whilst better than nothing, it cannot be seen as a way forward.

- **Develop safe havens.** This is unrealistic unless there is a running process in an area. The commercial agreements will be slow and it likely that a high degree of frustration will develop in the commissioning side at having to embed staff to explain the interface requirements and audits on a continuing basis. Although there is a view that centralised information can be queried sufficiently well to inform clinical audit, this would only work adequately with data from a single provider at present because of the difficulty of constructing queries. The development of safe haven querying techniques is not therefore seen as providing an adequate answer to the clinical safety of NHS 111.

- **Voice stripping software.** On a selected case basis, it is possible for someone in the NHS 111 provider to strip out any identifying features from a voice call before it is listened to. However, the voice transcripts from all the providers involved need to be assembled for a true end-to-end analysis, and that means the Caldicott Guardians of all the involved providers being certain they are not in breach of the DPA by handing over the data to the NHS 111 provider. Their only option is to strip the data before handing it over and this means that the work involved renders the process unmanageable at scale. It also fails to address the need to examine written records from, for example OOH or Emergency Departments. Regrettably therefore, this process is not often used and voice stripping is therefore limited to occasional specified use.

- **Pseudonymisation.** The requirement for pseudonymisation in record linkage has been formally recognised since 2004. Techniques are known, can be based on the NHS number, and open-source software exists. Training is minimal and it is a strategic possibility rather than a bespoke solution or reliant on a single software house.

- **Section 251 of the Health & Social Care Act (originally Section 60).** Section 251 could be used within the Clinical Governance world of NHS 111. Gaining Section 251 exemption could follow if the 111 service was able to show there was sufficient need for the data to be exempted from consent and if there was no other viable means of obtaining the necessary data functionality. 'Viability' would be dependent on a balance of risk, needs, and time to completion of any other possible methods.

- If NHS 111 was to apply for Section 251 exemption for the clinical governance aspects of 111 as opposed to the commissioning aspects of 111, then there is a reasonable chance of this being granted to the service on grounds of patient safety.

There is a caveat in that even if the case is made, the process is slow even under the rapid application rules that exist. Exemption is also time-limited in the expectation of more appropriate answers developing.

Appendix D: Information chain

The chain of information across the five stages of patient journey include:

- The telephone systems;
- The multiplicity of provider systems;
- The Patient Demographics Service (PDS);
- The mobility, selection, formatting, display, storage and transmission of clinical data;
- Special Patient Notes;
- Repeat Caller Service;
- The Repeat Caller Database;
- NHS Pathways;
- Directory of Service

- It finishes with the Interoperability Toolkit (ITK) links necessary to forward accurately compiled event data onwards to other recipient providers. Within this chain there is no room for error. Recognition that assuring patient safety in this system was a substantial task led to the development of a unique form of clinical governance around NHS 111 as described in the main section of this report.

- **Telephony**: The review found that most of the telephone problems experienced in March 2013 have now settled down and are unlikely to recur, being products of large-scale change and inexperience.

- **GP surgeries and warm transfers**: This refers to the process whereby a patient is directly transferred to NHS 111 on ringing the GP surgery out of hours. Whilst previously regarded as the desirable mode of transfer to OOH services (to prevent patients having to take down a long and possibly unfamiliar number before redialling), it is now advised that this is replaced with a message to re-dial NHS 111). This has a number of benefits for patients, for example the call is free. In some cases calls redirected from the GP system may be cut off at around eight minutes, which may prevent full triage and require the patient to re-contact the service and 'start all over again'.

- **Transfer from one NHS 111 area to another:** The nature of a national service means that calls may be answered outside of the 'local' provider call centre. This occurs particularly with calls from mobile telephones and in border areas, as well as during periods of high demand when re-routing occurs to provide resilience. Special Patient Notes are not currently transferable between areas and differences in call handler training and local protocols may lead to changes in final disposition and therefore unpredictable results. End to end review and complaint tracking may be more difficult for those calls answered 'out of area'.

- **Patient Demographic Service (PDS):** This is vital to the business of NHS 111 as it enables the correct population of the patient's identify, address and surgery details,

allowing the system to forward the eventual disposition via ITK. All call-handlers should be using their smart cards for PDS lookup all the time under the national minimum specification for provision of NHS 111 service.

- **ITK prevalence:** Transmitting the information from an encounter with NHS 111 on to the subsequent provider or to the GP is a critical function of NHS 111. ITK enables accurate immediate transfer of clinical information between systems in a structured manner using internally-accepted formats and templates. However it is not yet fully incorporated in all NHS 111-related systems.

- **Post-Event Messaging (PEM):** The useful information in a PEM is obscured by a large amount of irrelevant information. Recently the PEM format was changed which means GPs now receive better-selected information from NHS 111.

Appendix E: Incidents reported to the National Reporting and Learning System

1 Incidents reported to the National Reporting and Learning System

1.0 During the period 1 January to 30 November 2013 there were 530 incidents where NHS 111 was involved and were reported to the NRLS. At the time of preparing this report (early January 2014) there were only three incidents that have been received into the 'cleansed' NRLS (this is not considered to be a complete month's data) and so the month of December has been excluded in order not to give inaccurate figures for this month.

1.1 As with all data, analyses need to be interpreted with caution due to potential incident under-reporting and associated biases. It should be noted that high reporting rates are usually associated with a good patient safety culture rather than being an indicator of poor practice or systems. It is also important to note that the number of incidents reported does not necessarily indicate the scope of the problem, but simply the number of incidents reported.

1.2 In the Phase 1 report it was noted that the spike in reported incidents in March coincided with a rapid increase in call volume. Figure 4 shows that in October there was a similar (though lesser) spike in reported incidents and again this appears to coincide with a rapid increase in call volume. However, figure 5 shows that the reported occurrence of severe harms and deaths has been less and over a shorter time period than in March.
In the Phase 1 report

Figure 4 NRLS incidents reported by month, January to November 2013 with calls received by NHS 111
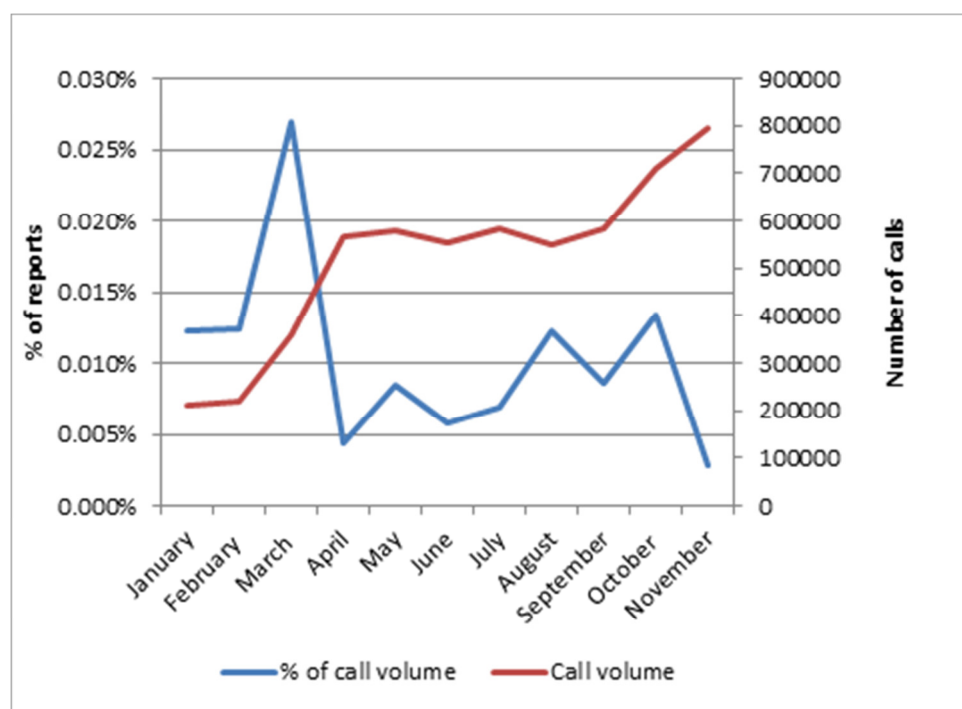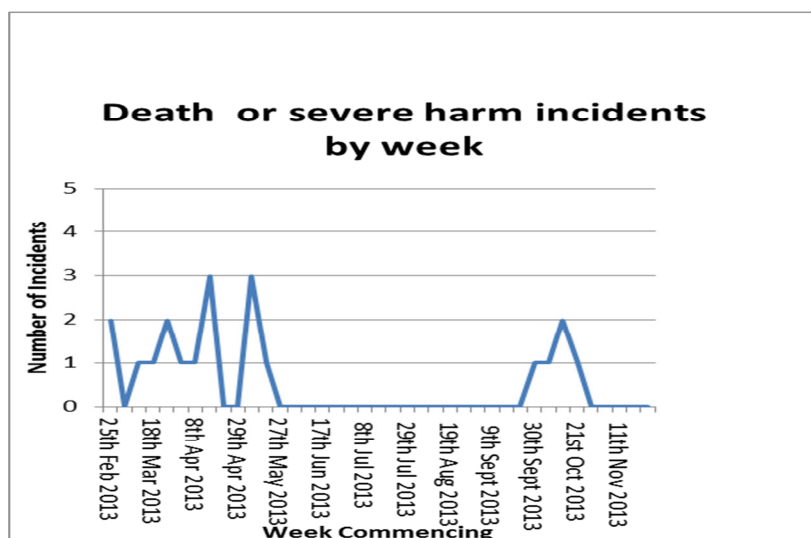
Figure 5 Number of incidents reported to the NRLS as death or severe harm by week

1.3 Table 1 shows the number of reported incidents by region. There appears to be substantial regional variation with very little reported harm in the Midlands and East or London. These regions account for 46% of the year-to-date call volume and yet only 12% of reported incidents. This may reflect a difference in culture of reporting, rather than necessarily regional variations in patient safety, and may represent a greater availability of informal routes to deal with issues occurring. Table 2 indicates the degree of harm as stated by the reporting organisation.

Table 1 Number of reported incidents to NRLS by region

Region	Number of reported incidents to NRLS
North	218
South	243
Midlands and East	46
London	20
Wales	1
Unknown	2
TOTAL	**530**

Table 2 Degree of harm as stated by the reporting organisation.

Reported degree of harm	Numbers
Death	8
Severe harm	7
Moderate harm	67
Low harm	128
No harm	320
TOTAL	**530**

1.4 It is important to note that it is difficult to assess from the incident reports alone whether patient harm would have been avoided with an earlier or a different response (it is the function of serious incident investigations and inquests to try and establish this).

1.5 Figure 6 shows the category of incidents reported, both on weekdays and at weekends and bank holidays. It can be seen that the most frequent categories are "delay in passing call details on" and "incorrect call centre outcome." From reported incidents, it seems that delays in passing call details on are more likely to occur at the weekend whereas incorrect call centre outcomes are more likely to occur during the week.

1.6 There are over 300 million patient contacts in primary care in England each year, with around 4,000 incidents reported to the NRLS. In contrast to this, there are 15 million admissions to acute care and 1.4 million incidents reported to the NRLS. NHS 111 and other providers along the urgent care pathway have a long way to go before their incident reporting culture is mature and providing the rich source of learning that this data can afford. Improving incident reporting is a key focus of the Primary Care Strategy Group.

Figure 6 Number of incidents by category reported to NRLS from 1.1.13 to 30.11.13
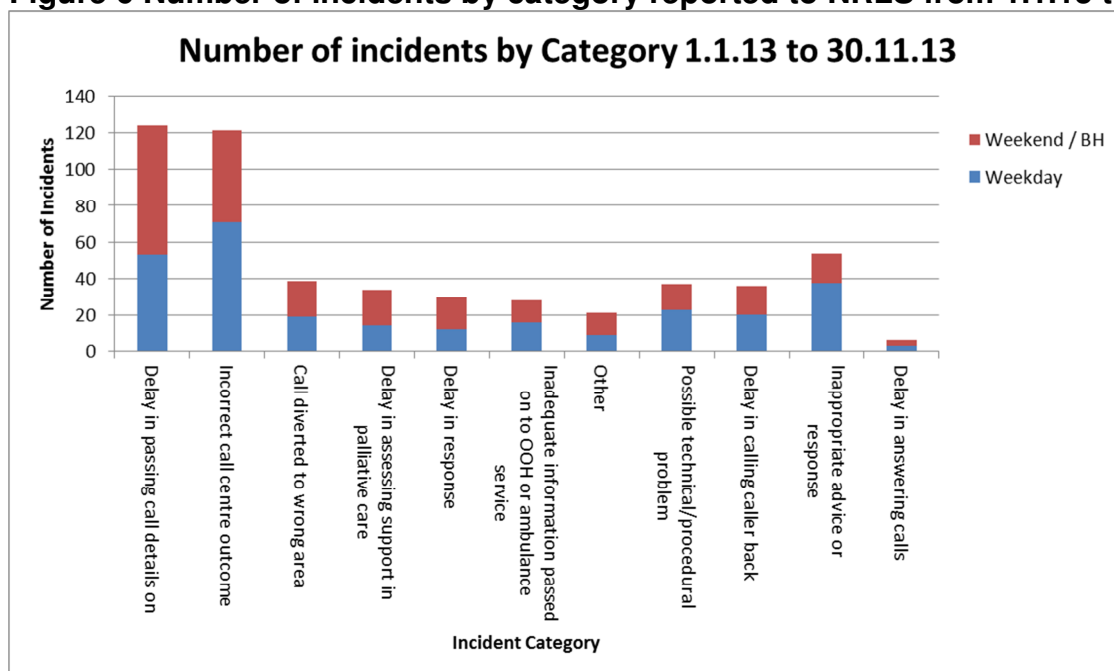
Appendix F: Summary of Recommendations
The table below includes a summary of the high-level recommendations included in the main body of the report, and allied recommendations.

Summary of Recommendations from NHS 111 Quality and Safety Phase 2 Review		
No.	**Recommendation**	**Lead Responsibility**
1	Review and redesign the NHS Pathways governance structures in collaboration with key stakeholders (NHS 111, 999 and OOH) to maximise the ability of NHS Pathways to learn from the experience of its use in these settings.	HSCIC/NHS England
2	Ensure mechanisms are in place to facilitate and encourage reporting of local patient safety incidents to the National Reporting and Learning System (NRLS) to maximise both local AND national learning	NHS England – NHS 111 National Medical Advisor and Director of Patient Safety
3	Clarify the position of NHS Pathways and the Directory of Service (DoS) in relation to NHS 111 by: a. Developing an accreditation process for alternative systems b. Determine the status of future DoS interoperability with other providers of software e.g. GP systems, Out of Hours and ambulance service systems	NHS England - Futures Workstream
4	Produce an easy to understand version of the NHS Pathways Licence and develop a reporting mechanism to feedback to commissioning organisations on licence requirements and compliance	HSCIC - NHS Pathways Team
5	Consider amendment of the NHS Pathways Licence for the CQI data tool to allow commissioners access, rather than using separate licences	HSCIC - NHS Pathways
6	Review the delivery, accreditation and assurance of the quality of training and develop and maintain a central repository of training information and Continuous Quality Improvement (CQI) Data	HSCIC - NHS Pathways Team NHS England – NHS 111 National Medical Advisor

No.	Recommendation	Lead Responsibility
Summary of Recommendations from NHS 111 Quality and Safety Phase 2 Review		
7	Re-establish the regional DoS network; clarify the DoS lead role and responsibilities; determine funding requirements	NHS England
8	Develop clear clinical governance role definitions and role outline	NHS England – NHS 111 National Medical Advisor
9	Identify clinical governance structures that will promote and support clinical leadership	NHS England – Futures Workstream
10	Develop the capability for shared learning and continuous improvement beyond the clinical governance network and across the whole community	NHS England – NHS 111 National Medical Advisor
11	Develop a universal system for reporting serious incidents and complaints in order to improve information retrieval for incidents relating to NHS 111, and to support wide dissemination of learning and information-sharing	NHS England – NHS 111 National Medical Advisor and Director of Patient Safety
12	Develop a package of best practice examples of clinical governance models for regional dissemination	NHS England – Futures Workstream
13	Explore an application for Section 251 exemption for the clinical governance elements of NHS 111	NHS England – NHS 111 National Medical Advisor
14	Organise a programme for the development of nationally agreed standards for Special Patient Notes; congruent with GP contract changes and training and considering the use of enhanced GP Summary Care Record as the data source	NHS England – Futures Workstream
15	Provide strategic clinical and technical oversight of NHS 111, to include the following: a. Inclusion of PDS lookup and matching, as part of NHS 111 central data returns and approach at all times b. Inclusion of the number of NHS 111 faxes despatched as part of the NHS 111 central data returns to enable NHS England to be aware of the potential failure that faxing introduces c. Further develop Post-event Messaging (PEMS) to provide more appropriate and concise information for clinicians	NHS England – Futures Workstream and NHS 111 National Medical Advisor

Summary of Recommendations from NHS 111 Quality and Safety Phase 2 Review		
No.	**Recommendation**	**Lead Responsibility**
16	To share knowledge and raise awareness within the NHS 111 clinical governance community, to include the following: a. Disseminate statements agreed with the Independent Information Governance Oversight Panel regarding patient identifiable data in order to support patient safety (once the position is clear) b. Provide advice to GP surgeries to avoid the use of 'call forwarding' from surgery telephone numbers when surgeries are closed and handing over to NHS 111 c. Disseminate clear advice regarding action to take in the rare event of an Interoperability Toolkit (ITK) failure	NHS England
17	Share potential NHS 111 related serious incidents with the National Medical Advisor to follow up in order to maximise learning	NHS England – National Director of Patient Safety and NHS 111 National Medical Advisor
18	Clarify reporting arrangements in the Serious Incident Framework within NHS 111	NHS England