Classification: Official

Integrated Urgent Care Service Specification addendum: NHS 111 First

A new way to manage access to emergency departments

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

An Equalities and Health Inequalities Impact Assessment has been produced and will be reviewed periodically.

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Context

During the months of the first peak of the 2020 coronavirus pandemic the number of people attending Emergency Departments (EDs) reduced dramatically, particularly those seeking help for minor illnesses.

Due to social distancing and infection prevention precautions, the space in EDs has reduced. We must inform the public to make the right healthcare choices and ensure their safety, as well as making sure they get the right treatment in the most appropriate place.

NHS 111 will make it **easier and safer for patients** to get the right advice or treatment when they urgently need it and they will be able to book into a service that is right for them.

Why do we need change?

Around 70% of ED attendances are made up of walk-in patients, so as patient numbers have increased, the NHS aims to keep patients safe despite the reduced space in waiting rooms. We also know that a significant proportion of those attending EDs could be seen elsewhere, for example in a primary care facility or at an Urgent Treatment Centre (UTC).

In the future this should help the public in choosing the right service and if they are unsure, be confident in contacting NHS 111.

NHS 111 is ideally placed to do this

Working as part of the NHS family, NHS 111 will increasingly be able to make direct appointments at GP surgeries, pharmacies and Urgent Treatment Centres - as well as send an ambulance should the patient's condition be serious or life-threatening.

NHS111 is now able to book a timed slot for patients that need an Emergency Department**,** to ensure patients are seen as safely and conveniently as possible. **Public confidence in NHS 111 is high.** In recent surveys, over 87% of people were very or fairly satisfied with NHS111 and 86% of people said the advice given by NHS 111 was helpful.

1. What is NHS 111 First?

'NHS 111 First' is about offering people a different way of accessing and receiving healthcare, including a new way to access Emergency Departments.

As a programme it means:

- that NHS 111 or a GP practice are the first places a patient should contact when they experience a health issue that is not immediately life-threatening
- reducing the need for a patient to go to a physical location when accessing healthcare
- embracing remote assessment and the technology that supports it
- avoiding risk of nosocomial (hospital-acquired) infection by ensuring fewer less urgent patients attend ED waiting rooms
- ensuring patients get clear direction on what they need to do and where they need to go to resolve their health issue
- protecting those most at risk (e.g. people who are extremely clinically vulnerable from COVID-19) by giving them an enhanced service.

In short: NHS 111 First aims to build on and embed the beneficial changes in the way patients have been accessing healthcare during the COVID-19 pandemic.

1.1 Keeping patients safe

To reduce risk of hospital-acquired infection, crowding in EDs must not be allowed to return to pre-pandemic levels, but asking patients to queue outside an ED is not an acceptable means of ensuring social distancing. As such, we must ensure that:

- ED is reserved for emergency patients
- patients who do not need to attend ED are directed elsewhere
- patients who need to access hospital services go directly to the appropriate department in the hospital, and not via ED.

1.2 Urgent action to address health inequalities

COVID-19 has highlighted the health inequalities that persist in our society. It has had a disproportionate impact on people in areas of high deprivation, on people from Black, Asian and Minority Ethnic communities (BAME), older people, men, those with a severe mental illness, people with a learning disability and autism and other inclusion health groups.[1] It risks further compounding inequalities.

The reduction of inequalities in access and outcomes should be central to the development of NHS 111 First. Local commissioners and providers should make explicit in their plans how they have considered the duties placed on them under the Equality Act 2010, and their duties with regard to reducing health inequalities as set out in the Health and Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities.

1.3 Develop digitally enabled care pathways in ways which increase inclusion

During the response to COVID-19, the health and care system saw unprecedented levels of uptake of digital tools and services, helping keep patients, carers, friends, relatives and clinicians safe and ensuring that essential care can continue. Digital tools and services provide an opportunity to create a more inclusive health and care system, creating more flexible services and opening up access for people who might otherwise find it hard to access in person.

The shift to digital may risk exacerbating health inequalities for those who are digitally excluded due to barriers such as access, connectivity, confidence or skills. All NHS organisations are asked to ensure that no matter how people choose to interact with services, they should receive the same levels of access, consistent advice and the same outcomes. To achieve this, new care pathways should be tested to achieve a positive impact on health inequalities, starting with: NHS 111 First, total triage in general practice, digitally enabled mental health, and virtual outpatients. Support for local systems is available at https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/what-digital-inclusion-is#barriers-to-digital-inclusion.

[1] For example, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

2. A co-ordinated response to care

For the NHS to make the most of its resources, different providers and different areas of the service must collaborate. Commissioners and Integrated Care Systems (ICSs) need to design the delivery of care to their populations in such a way that patient pathways achieve the optimum outcome in the quickest and most straightforward way.

Patients should not find it difficult to navigate their way through the NHS to achieve the best care; nor should they have to identify for themselves where the best care can be obtained.

To access healthcare patients can go to NHS 111 online, call their GP or NHS 111; whichever route they choose should provide a similar experience. The NHS needs to take control at the beginning of the patient journey and help patients get the best and most appropriate care.

NHS 111 makes it easier and safer for patients to get the right advice or treatment when they urgently need it and increasingly, by being able to book direct appointments/time slots into a service that is right for them.

Our approach is summed up in the Communications message: “Help US Help You”.

3. Developing access and creating capacity

To achieve NHS 111 First, we need to expand the capacity within the current NHS 111 service. This means looking at the current workforce and skill sets to evaluate where extra capacity is needed, and whether there are opportunities for alternative service delivery to take into account local population health needs, while maintaining quality and achieving service standards.

It is important when increasing frontline capacity to refer to the IUC workforce blueprint to identify any other resources that will need to be increased to maintain an effective and safe service, including those for audit, coaching, supervision, management, training, and health and wellbeing.

Providers will need to consider whether they can provide safe working environments for staff that meet social distancing requirements; if not, extra capital investment may be required. Remote/home working can support this and should be a fundamental part of the workforce plan. The pandemic has shown there is tremendous scope for increasing the number of staff – particularly clinical staff – who are based at home some or all of the time, and this can enhance work flexibility and satisfaction, and make it easier to recruit staff over a wider geographical area.

Consideration must be given to the wider operational supervision and training staff will need to work from home, and the appropriate investment for ICT and to overcome the social isolation this potentially brings. This mode of working will not suit all staff.

The development of local clinical assessment services (CAS), in which clinical staff from across urgent care contribute to telephone triage, has provided NHS 111 services with extra clinical resources.

The use of NHS 111 online must be considered in determining what additional resource may be required. Areas should decide what service or instruction they offer online patients who reach ED outcomes, this should include validation call-backs and direct booking.

4. Getting patients to the right place

The following will improve the patient journey from initial presentation to outcome:

- Inform patients that by visiting NHS 111 online, telephoning NHS 111 or contacting their GP, they will get a better experience than if they present at an ED or UTC. Specifically, we need to ensure that patients using NHS 111:
  - Receive a timely response
  - Are assessed safely and effectively
  - Are directed to the right point of care for them (and in such a way as they will follow this direction)
  - Can be directed to the full spectrum of available health services (e.g. pharmacy, urgent dental services and voluntary services, as appropriate)
  - Have an overall patient experience of NHS services that is as good as it can be
  - Have a mechanism to feedback if they were inappropriately directed
  - Ensure patients can go directly to the centre or clinic they need rather than via an intermediary department (e.g. ED).
- Ensure that if patients are given an indicative booked time slot and that they are seen within an acceptable timeframe (without this, patients will not be incentivised to keep the appointment).
- Manage the flow of patients to ED by developing existing technical solutions, and where required, designing new ones (see Appendix 1).
- Have IT systems that allow providers to share patient information where appropriate.
- Have comprehensive, accurate and up-to-date service information that is available across healthcare.
- Ensure the needs of the whole population are considered, including clinically vulnerable groups, and that any proposed changes enhance the patient experience.

Above all, we must deliver on public expectations of the service. If we do not have sufficient capacity to provide direct referral and access to specialist departments, or to deliver high-quality remote consultation, we will lose public confidence and the progress we have made. Therefore, we need good demand and capacity systems across all parts of the system to manage appropriate demand, and the agility to respond to rising demand to avoid overwhelming our services.

We need an ongoing communications strategy to ensure the public clearly understands how to access the most effective and safe care for them.

Hospitals will need to consider the optimum operational model for directing patients to the right department, for managing those patients safely, and for ensuring the appropriate referral mechanisms are in place. Walk-in to ED must remain available for those patients who require direct access – for example, not all patients will have use of a telephone or an internet connection.

Commissioners and providers should consider how the current IT infrastructure can be improved to allow timely interchange of data. This may mean consolidating the existing multiplicity of IT systems in use. All necessary information governance requirements should be taken into account, including data sharing agreements being put in place where appropriate.

4.1 The Patient Pathway

The steps in the NHS 111 First patient pathway are as below:

NHS 111 telephone pathway

1. Patient contacts NHS 111 and is assessed by health advisors/clinical advisors using NHS pathways.

2. Assessment results in an ED disposition.

3. The ED validation should be undertaken by the CAS unless clinical intervention is unlikely to change the outcome (i.e. where symptom grouper/ discriminator deems essential ED attendance).

4. For patients who are initially assessed as ED or are unchanged following CAS validation:

   a. patients with a one-hour disposition should be asked to attend ED straight away, and be booked into the current ED slot
   b. patients with dispositions longer than one hour should be booked into an appropriate future ED time slot.

5. Patients should be given safety netting advice and any instructions specific to the ED (taken from the DoS).

6. If available, the patient should receive ED referral confirmation via SMS text message.

NHS 111 online pathway

1. Patient accesses NHS 111 webpage (111.nhs.uk).

2. Patient undertakes self-assessment.

3. Patient reaches ED disposition and either:

   a. is advised to attend ED (and offered the opportunity to Book)

   b. offered a call-back from a clinician (ED validation).

Systems should consider implementing clinician call-back (validation) for ED dispositions, if this is not already usual practice in their area. Implementation managers are available to help commissioners and IUC providers add call back following an ED disposition (see Appendix 3).

NHS 111 online allows providers to exclude ED cases prompting validation, via DoS profiling.

NHS 111 online now allows patients book an ED attendance time slot directly, and to send the details of their case to hospital. All systems should look to implement online booking as soon as locally agreed.

4.2 ED disposition validation

Many NHS 111 providers already validate a proportion of their ED dispositions. This is key to ensuring patients are correctly assessed, and only those who must attend ED are sent. NHS 111 providers should clinically validate as many appropriate ED dispositions as possible for both telephone and online patients (this will exclude ED dispositions where validation would be unlikely to change outcome).

4.3 Mental health self-attenders to ED

People who self-present at ED with mental health needs should be treated seriously and compassionately. They should not be made to feel they are wasting anyone's time and must not be turned away from ED; this could present a risk to their safety.

Action:

Self-attenders with mental health needs should be referred to the hospital's liaison psychiatry service for assessment by a mental health professional. If necessary, facilitate access to the most suitable care outside or inside the hospital.

4.4 Patient non-attendance at emergency departments

When making a referral to ED, the referring service (i.e. NHS 111) should routinely consider the potential clinical impact of non-attendance and any relevant safeguarding issues.

Commissioners and Providers should agree a local process for managing patients who do not attend their booked appointment made via NHS 111.

The responsibilities to consider are:

- NHS 111 is responsible for the correct assessment, advice if symptoms worsen and appropriate onward referral/advice.

- The patient (or their guardian) is responsible for following the recommendations of NHS 111.
- ED is responsible for reviewing the referral message from NHS 111 and the timely management of the patient from when they present.

NHS 111 should flag any concerns about the patient in the information sent to the ED. This could include concerns about vulnerability or safeguarding and include any other pertinent information which might make attendance at ED a necessity.

If NHS 111 is contacted by an ED to inform them that the patient has not attended and raises a concern about the patient, the NHS 111 service should follow its normal safeguarding assessment process.

Each NHS 111 provider should have an easily accessible point of contact for EDs to use.

For every patient who does not attend where there is an immediate clinical or safeguarding concern, the ED must ensure the most appropriate action is taken. A competent clinician within the ED should make a decision at the point the non-attendance is identified as to whether immediate action or if a follow up is required and take the appropriate action as necessary. Not all non-attendances will require any form of follow up. The action taken when a non-attendance is identified by either the ED or NHS 111 should be clearly described in the locally agreed process[1] along with organisational responsibilities.

[1] For example, The Midlands Region Th111nk_DNA_WNB_procedure

5. Requirements for health services and organisations

5.1 NHS 111/IUC providers

NHS 111 providers must refer patients to ED in a controlled way to spread demand, with patient safety of uppermost priority and patients treated in a timely way appropriate to their need. We have determined that patients will be referred to ED in two-hour time slots running one after another.

NHS 111 providers (and other IUC providers) must implement a system that shows how many patients can be allocated to each ED time slot. This may be shared use of proprietary software. NHS 111 providers should consider how patients are allocated to slots according to their disposition timescale. All patients with a one-hour disposition should be asked to attend ED straight away and allocated a place on the current time slot.

NHS 111 providers must implement a mechanism to send information to the relevant ED about patients they refer. This can be sent via a proprietary system, but as a minimum by sending an email from the provider's host system. The message must contain patient demographic information (e.g. name, DoB), basic details of their condition, and the time slot they have been allocated. The patient's NHS number should be used as the unique patient identifier to ensure records can be matched.

NHS 111 providers must consider how patients requiring enhanced protection can be flagged on their host system.

NHS 111 providers must consider (working with the hospital(s)) what should happen when a slot is at maximum capacity – e.g. use alternative waiting areas. NHS 111 must continue to be able to refer patients to ED if this is deemed necessary.

Patients who call an NHS 111 provider and are assessed as needing to attend an ED, but are outside that provider's contracted area, should be advised to attend ED

without regard to the slot arrangements detailed above; until a wider solution for referral into ED nationally is available.

Consideration must be given to including any extra information about a hospital in the DoS, e.g. mental health crisis services.

Where technically possible, NHS 111 providers should send an SMS text message to the patient confirming they have been referred to ED.

Capacity

The principal task that NHS 111 providers need to consider is how to expand capacity within their service, and whether this can be achieved with the current roles in the service or if new roles need to be introduced. NHS England and NHS Improvement will work with providers as part of the NHS 111 First programme to understand the required extra capacity, both nationally and by individual provider.

Once this is known, NHS 111 providers must evaluate the availability of their local workforce and plan recruitment and training. At the current time, remote interviews and remotely delivered training are likely to be required. We will work with NHS Digital, the NHS Pathways team and providers to look at how current remote training can be used more fully by providers and to increase the amount of other training available remotely.

The capacity generated by local NHS 111 providers will contribute to the overall national requirement. Although the service will remain locally commissioned, each provider needs to be part of a coherent national system that equalises demand across the country to allow a consistent, safe and high-quality patient experience to be delivered, regardless of where the patient lives. This may require greater networking of calls across the country and supplementing local capacity with nationally delivered services.

Remote working/consultation

We have found during the COVID-19 pandemic that remote working can be effective for staff in the NHS 111 service. Providers should consider what proportion of their staff should work remotely and what adjustments they need to make to accommodate this.

NHS 111 providers already provide remote consultation successfully, and we now need to enhance this model by implementing video consultation facilities and text confirmation (e.g. following referral to a point of care).

Provider collaboration

NHS 111 providers should therefore look at how they can work alongside other providers (e.g. general practice) to make calling patients a key part of managing their care. This will particularly apply to patients in the 'clinically extremely vulnerable' 'group as well as frail and vulnerable patients.

Patients will be increasingly managed in the community rather than in secondary care. This will require more proactive contact, such as with those who have recently been discharged, to guarantee patients' healthcare needs are being met and their health does not deteriorate to a point where a secondary care admission is needed.

Collaboration and co-operation with providers in primary and secondary care will be crucial if the improved offer to the public is to be fulfilled. NHS 111 providers should liaise with their commissioners and other providers to determine how their local area will implement the national requirements of the NHS 111 First programme.

5.2 Hospitals

It is essential that EDs know when a referred patient will attend, and are given some basic information about the patient.

Hospitals should implement the following patient pathway:

- On arrival at ED a patient's acuity must be assessed and recorded by an experienced, trained clinician (e.g. Band 6). This assessment will ensure that the patient is assigned the appropriate priority.
- Following this assessment, higher acuity patients may be:
  treated in ED
  streamed to an appropriate alternative on-site service (e.g. SDEC)
  asked to wait in a waiting area until they are further assessed/treated.

- Lower acuity patients (i.e. level 4/5) who have not been streamed to an alternative on-site service and do not require immediate treatment may be invited to use NHS 111.

In addition, hospitals should make the following provisions:

- Have arrangements in place to regularly review the patient information sent by NHS 111. This information must be viewed in a secure area that complies with information governance standards.
- Consider arrangements for transferring the information received in an NHS 111 message into their host system.
- Record the ED attendance on the ECDS; and where the technology allows, select NHS 111 (preferably split between NHS telephony and NHS 111 online) as the referral source.
- Have manual processes available to record patient attendance in the event of technical failure.
- Determine how many patients they can safely manage within each booking time slot. This will depend on:
  - waiting room capacity with social distancing
  - size of any capacity ring-fenced for self-presenting patients.
- Ensure waiting areas (in ED and other departments) must enable social distancing
- Allow patients to be referred/directed by general practice and NHS 111/IUC CAS to hospital departments, avoiding ED where there is no benefit to patients.
- Provide the technical capability for NHS 111 and GP practices to directly book into ED and other departments.
- Where required, make specialist clinicians are available for remote clinical assessment
- Ensure people who self-present at ED with mental health needs are treated seriously and compassionately. They should not be made to feel they are wasting anyone's time and must not be turned away from ED; this could present a risk to their safety.
- Consider alternative arrangements for dealing with patients requiring enhanced protection (e.g. a separate entrance into ED, direct referral to

other departments). Hospitals must detail any special arrangements they have for this group of patients on their DoS profile.

- Hospitals must ensure that signposting to patients who have booked an appointment in ED is clearly sign posted on arrival.
- Hospitals should ensure an 'arrivals co-ordinator' meets and greets the pre-booked patient on arrival at ED, and patients who are shielding should be directed to a separate waiting area, where available.

Hospitals also need to:

- Investigate ways to alert the wider system when social distancing is threatened
- Educate patients about how to access healthcare
- Learn why patients may choose to walk-in
- Ensure for reporting purposes that the most up-to-date version (6.2.2) of the Emergency Care Data Set (ECDS) has been implemented.

- Ensure patients can be referred/redirected to alternative services, e.g. UTC, or hospital departments, e.g. SDEC, where ED is not the right place for them to receive care.
- Provide materials in waiting areas that inform patients about alternative forms of care to ED, and how to access them.

Overall, hospitals must ensure that the ED is suitably equipped and designed to receive patients during the pandemic and thereafter.

5.3 General practice

The COVID-19 pandemic has transformed how consultations are conducted; fewer face to face and more remotely, thanks to online and video consultation that has now been almost universally adopted to complement telephone consultation options.

NHS 111 and general practices have worked increasingly closely to manage COVID-19 symptomatic patients, with many GPs offering their time to provide remote care through the NHS 111 Coronavirus Clinical Assessment Service.

We want to build on this experience to continue to develop a model of seamless population care 24/7, with NHS 111, IUC providers and practices all working together closely.

NHS 111 can support practices by assessing and, if appropriate, giving advice to those patients who are assessed as not needing to speak to a practice clinician. Should a patient be assessed as needing to see a clinician in their practice, a mechanism will need to be in place for direct booking/referral between NHS 111 and the practice.

A patient's choice to phone NHS 111 or to book an appointment with their practice to access healthcare should not influence the care they receive. Local discussion between practices and their NHS 111 provider is essential to determine the operating model that works best for both parties.

Practices should consider whether any additional information for patients needing enhanced protection should be included in 'special patient notes' and shared with IUC providers.

5.4 Urgent treatment centres

UTCs provide an essential alternative to ED for patients with minor illnesses or injuries requiring treatment. To maximise the benefits of a consistent model of access to urgent treatment nationally, local systems should finalise the designation and delivery of UTCs where this has not already happened.

Systems will need to consider the aim of a predominantly booked appointment model in their service design: how this will support reduced attendance at ED and be complemented by other primary care and community services locally. Systems will also wish to consider learning from any temporary service changes enacted in the COVID-19 response.

Urgent treatment centres – principles and standards (July 2017) set the direction for NHS 111 to introduce appointment booking. To support the NHS 111 First model and to protect patients from nosocomial infection, it is now vital that all UTCs are fully enabled to deliver direct booking from NHS 111 and general practice as soon as is practicably possible.

We know that lack of functionality in some services' IT systems has been a barrier to doing this. To enable booking, NHS Digital has developed and published a new national information standard for urgent and emergency care (UEC) appointment booking (known as Care Connect), available at https://developer.nhs.uk/apis/uec-appointments/. This standard will ensure that all IT systems providers can deliver a consistent model that works across all services.

For UTCs to support appropriate referrals and decision-making, the Directory of Services (DoS) must be accurately maintained to help maximise pathways for conveyance by ambulance to locations other than an ED where appropriate. Advice should be sought from local DoS leads where necessary to ensure services are appropriately referred into where available.

To protect patients from nosocomial infection, social distancing in waiting areas and the management of the patient flow into UTCs should be implemented in line with infection prevention and control (IPC) guidance.

5.5 Ambulances

Working as part of the broader system response, ambulance services should be supported to maximise treatment at scene and, where appropriate, conveyance to settings other than EDs, such as UTCs. Pathways should be agreed that support direct admission to other hospital departments where appropriate.

The NHS 111 First programme, through reduced attendance where clinically appropriate and improved patient flow, will help reduce delayed handovers of patients conveyed by ambulance to EDs, in turn improving patient experience and freeing up valuable ambulance resources.

Consideration should be given to how 999 and NHS 111 pathways can be better integrated. This will support 'hear, treat and refer' and ensure equity of access to right care, first time regardless of which number is called – 999 or 111.

5.6 Mental health services

The principles of NHS 111 First also apply to those with mental ill health. Many such people may have a better experience by speaking to a mental health professional on the phone before presenting to ED, or by being directed to another more appropriate service for mental health assessment.

In response to COVID-19, all NHS mental health trusts have established 24/7 urgent mental health helplines that are open to the public. These public facing local helpline numbers can be found on the new service finder on the 'where to get urgent help for mental health' page of the new service finder on the NHS.UK website.

In the medium term, the NHS Long Term Plan commits to making these urgent mental health services accessible via NHS 111; services are working towards this aim.

6. The expectations of commissioners/ICSs

To successfully implement this programme's necessary changes, provider organisations will need to follow certain steps. Responsibility for ensuring these steps are taken will lie with system leaders in ICSs and clinical commissioning groups (CCGs). This may require variation to contracts but also local discussion about implementation.

A key enabler to the NHS 111 First programme will be providers having the necessary IT infrastructure in place. Consideration must be given to interoperability of systems and, if necessary, the move to single systems if needed to facilitate appropriate data interchange.

It is essential that commissioners/ICSs take a whole system view to invest in areas that will have greatest impact in terms of cost–benefit and patient outcomes. This should be done as part of a wider discussion of the urgent and emergency care system to understand patient flows, identify efficiencies and maximise organisational performance. Commissioners should pay close attention to the results of the NHS 111 First evaluation both in terms of analysis of impact but also in terms of patient experience.

7. Monitoring

There will be national monitoring of NHS 111 First. The completeness, quality and timeliness of routine national data collections such as ECDS will be critical to this.

Areas should consider extra monitoring of the effectiveness of their local implementation of NHS 111 First, particularly of locally determined elements of their model, and identify improvements.

This includes understanding the effectiveness of their local approach to ED self-presenters and communications; for example, where a patient does self-present at ED, it would be useful to understand whether they had considered alternative points of care. To this end, patient surveys of self-presenters should be considered.

Other parts of the healthcare system should also be monitored to understand impact across the system and determine any negative unintended consequences.

8. Communications and media campaigns

There is an overarching national strategy for NHS 111 First communications.

In addition, local areas can instigate local communications. Local areas should ensure:

- Communications narrative/messaging are in line with national communications narrative/messaging
- Any local campaign creative is developed to align with the national campaign, to lever maximum effect.
- Comprehensive local stakeholder and staff engagement plans are in place.
- There is no messaging saying or implying that unheralded patients will be turned away when walking into ED

Local communications plans should be shared with the national communications team to ensure consistency of approach.

Every UTC/ED will require a facilitated system at the front door to ensure that patients remain safe, and the risk of nosocomial infection is kept to a minimum.

For the avoidance of doubt, every ED will remain accessible to patients who present unannounced.

9. Appendix 1: Technical

The introduction of NHS 111 First requires the adaptation of existing workflows, the introduction of new workflows and, most importantly from a technical perspective, interoperability between IUC and ED systems (and SDEC).

Call volumes will increase, and the emphasis will switch to conducting assessments remotely and, where necessary, directing patients seamlessly to the most appropriate location for the care they need. This will require a mixture of existing and new technologies will be required to 'bring the service to the patient', rather than the 'patient to the service'.

While areas will need tactical solutions, longer-term strategic solutions must be operationally efficient; avoid manual transposition of data; and be designed with average handling time in mind.

In advance of the development of strategic Care Connect standards-based solutions, NHS Digital have developed a system called Emergency Department Digital Integration (EDDI), information relating to this system can be obtained from NHS Digital.

Digital priorities

- **Streaming**: a Pathways Lite module for NHS 111 to handle injuries, and further development of the Pathways Reception module to stream patients at the front door of ED.
- **Phone booking:** ability to use the voice channel to book patients into ED, SDEC and using open standards.
- **Online booking:** ability to use the online channel to book patients into ED, SDEC and using open standards.
- **Referral:** ability to electronically refer patients along with the necessary information, including (but not limited to):
  - demographic information (e.g. name, Date of Birth)
  - NHS number
  - basic details of their patient

  - the time slot to which they have been allocated
  - a post event message (PEM) to the patient's GP.

- **Online validation:** to enable clinical validation of Emergency Treatment dispositions where warranted to ensure appropriateness.
- **Video consultation:** to allow clinicians to establish an on-demand video session with the patient by sending them a link via e-mail or SMS. This link can be opened on any common browser without the patient needing to download any software or apps onto their device. The video can be one or two-way, and the audio is recorded via existing contact centre systems and therefore voice recorded.
- **GP booking:** complete the roll out of standards-based GP booking across the country, allowing IUC providers to book out-of-area callers into their local practice.
- **Ambulance dispatch:** to enable IUC providers to electronically dispatch ambulances for out-of-area callers (retiring the less efficient warm transfer process).
- **DoS enhancements:**

  introduction of road-based searching to reduce the reliance on local knowledge and potentially inform time slot allocation by identifying travel time to ED

  analytical tools that identify gaps in local service provision and inform intelligent commissioning

  real-time capacity information to inform referral decisions.
- **Pathway enhancements:** other modules such as clinical consultation support and training enhancements, in conjunction with modifications to the licence to allow home working.
- **Data linkage:** to inform commissioning and clinical content development through outcome mapping.

Working in conjunction with NHS Digital NHS E/I has developed a support package to guide systems through this digital transformation (via NHS England IUC mailbox).

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