Appendix L: OPEL 2024 - 2026 NHS 111 Additional Information V1.0

## Assumptions

* That technical enablers for regional call management are available in all regions, with the ability to implement / enact regional call sharing either in BAU or as part of a dynamic system response.
* That Single Virtual Contact Centre (SVCC) has been tested and adopted in all regions.
* That 111 providers can share their OPEL level with the System Coordination Centre (SCC) daily using their existing reporting mechanisms.
* Any additional narrative required to support a provider’s OPEL declaration will be provided on the daily reporting into the UEC operations room via SCCs.
* The national call routing plans to provide the quickest answering response times will be available to the providers/regions and would be considered in OPEL 4 only and agreed with a provider/ region in advance. Depending on the severity of the pressures across all NHS 111 providers (e.g. Strep A, COVID) then the national Integrated Urgent Care (IUC) team will be consulted to discuss ways of working in crisis with the UEC team and the region/regions involved.
* The national telephony team is responsible for invocation of national call plans, regions will have the ability to share calls within their respective regions, where the design function is in place and suitably agreed by lead ICB and region.
* Local/regional demand management is undertaken, supported by national modelling where appropriate (e.g. cross cutting with UKHSA and broader systems in regions).
* NHS 111 providers have real time management tools and systems in place to manage local demand surges, including the implementation of busy messages and their own local procedures to bring in additional staff at short notice and move staff to match the demand on the service.
* NHS 111 providers meet the 2017 specification for business continuity escalation.
* The national resilience contract is in addition to the standard support and managed separately.
* The national contingency request process will stay the same.

## Clinical and operational monitoring

Regions should deliver robust operational plans to manage capacity, be that front end call handling or clinical queue pressures and this document sets out some high-level considerations for appropriate clinical safety planning. This is consisting of:

* Overall governance of SCC/UEC reporting in line with OPEL framework.
* Levels of escalation and thresholds to support.
* Set of guidelines to use when determining clinical safety at a point in time.

Clinical Safety Planning (CSP) is an approach for NHS 111 providers and IUC systems to review their call taking capacity and their clinical capacity management collectively. It enables ICBs and a region to manage the front end (call taking) and the back end (clinical queue management) to be delivered safely within NHS 111 providers.

Regional CSP is something that regions could develop with lead ICBs to enable safe clinical plans across the region within NHS 111 services and link the clinical need of patients to the integrated services downstream, for example CAS and or other face to face or virtual settings.

While it should be acknowledged that most localities are yet to implement Regional CSP, it would act as an enhancement of existing local provider plans.

The levels of escalation for NHS 111 providers can be written as several additional steps or actions to take when reporting system pressures from an NHS 111 service and ensures regions are all reporting with a level of consistency into the SCC and UEC teams. The triggers support:

* Consistency.
* Provider alignment.
* Delivery of a set of measures to provide understanding that levels are similar across all providers/regions.

There are three levels of Clinical Safety Planning:

* National
* Regional and,
* Local

National CSP is designed to be implemented where operational demand has exceeded regional mitigation actions and plans. It aims to ensure consistency in the use of national contingency for operational pressure, or clinical escalation, to allow for additional actions in addition to ICB and NHS England regional CSPs. These need deployment in the event of full NHS 111 system pressure such as Covid/Strep A, technical failure or other catastrophic system failure that cannot be controlled at local/regional level.

## NHS 111 Providers - requirements

The provider must participate in regional call management interactive voice response (IVR) testing. This will all be led by regions / ICBs.

* Providers to have regional IVR in place (already achieved)
* Providers and regions should plan to enable the ability to switch-on the regional call management at times of escalation.
* Regions will agree with ICBs and providers how each region will use the regional call management (RCM) tools and call management can be established with regional procedures in place.
* Regions need to test the RCM and SVCC then decide whether to have it:
	+ always on in the background or
	+ reactively switch it on when needed.
* It is safer and more responsive for the patient if automatic thresholds are pre-agreed and always in in the background to move callers to a wider call taking pool at times or regional pressure.
* All NHS 111 providers must allow ICBs and Regions access to the relevant data items to report OPEL levels of escalation collectively

To maximise clinical capacity, resources for call queues is considered not just within the core NHS 111 service but that clinicians have been maximised (matched to the call back demand within clinical queues) across the CAS and SPOA services before escalation of clinical safety has been considered.

NB: where providers have dual trained clinical and call handling staff, standard practice should be to maximise capacity at local level, sharing of clinical queues with the wider CAS systems, before moving to regional support.

NHS 111 providers and regions should determine when they use IVR messages to inform callers if the region or provider is busy. The welcome/in queue messaging will continue to allow providers to utilise local busy messaging, that will sit underneath the national busy message facility.

## Special patient notes (SPN)

Special patient notes are often held by NHS 111 or out of hours (OOH) providers or in local data repositories for some of the population they cover.

In circumstances of escalation calls may need to move to another provider/s in the region or even somewhere else in the country.

Some limited notes are held in Summary Care Record, however SPN may only be held by local NHS111 providers.

SCR is only accessible by a clinician and cannot be used for the detail some SPN hold locally in proprietary systems.

Call networking agreements within region should consider that SPNs are held locally and NHS111 providers can agree how to manage these on a case-by-case basis, should they be dealt with in an out of area care setting within or outside of the region. Systems/regions could consider technical enablers to support this for all their commissioned NHS111 provision.

At a minimum, the SCR contains important information about:

* current medication
* allergies and details of any previous reactions to medicines
* the name, address, date of birth and NHS number of the patient

In addition, details of long-term conditions, significant medical history, or specific communications needs, is now included by default for patients with an SCR, unless they have previously told the NHS that they did not want this information to be shared. Other additional Information that should be held in the SCR includes reason for medication and end of life care information