

# **Integrated Urgent Care Service Specification for**

**East Surrey CCG,  
Guildford & Waverley CCG,  
North West Surrey CCG, and  
Surrey Downs CCG**

DRAFT

OFFICIAL–SENSITIVE: COMMERCIAL

Version Control

This specification has incorporated all of the mandated elements within v0.23a of the NHS England (NHSE) Integrated Urgent Care Specification

Version	Updates	Date	Reviewers
0.1	First draft with content from standard NHS documents and NHS 111 OOH Service Description	Jan 2017	Lyn Reynolds
0.2	Comments made on first draft	Jan 2017	Dr Peter Stott Dr Philippa Woodward Gillian Barnes Liz Patroe Dan Lorusso Dr Charlotte Canniff
0.3	Inclusion of East Surrey	April 2017	Lyn Reynolds
0.4	Comments made following further national guidance development	August 2017	Dr Peter Stott Perminder Oberai
0.5	Comments incorporated and merged into national service specification template v0.20f	August 2017	Lyn Reynolds Rachael Graham
0.6	Comments incorporated and document re-structured	August 2017	Lyn Reynolds
0.7	Document updated following final national service specification template release v0.23a and some members of the Clinical Reference Group	1 <sup>st</sup> Sept 2017	Lyn Reynolds Dr David Eyre-Brook Dr Peter Stott Dr Charlotte Canniff Jane Lovatt
0.8	Further comments incorporated from Clinical Reference Group members and other subject matter experts.	6 <sup>th</sup> Sept 2017	Lyn Reynolds Holly Hamilton-Glover Dr David Hill Dr Simon Williams Dr Charlotte Canniff Dr David Eyre-Brook Rebecca Matthews Steve Abbott
0.9	Comments incorporated from Medicine management lead and Mental Health Lead	12 <sup>th</sup> Sept	Linda Honey Dr Julia Chase Dr Andreas Pitsiaeli Dr Nicola Kirby Shelley Eugene

## Contents

1. Service Specification .....	9
1.1. Introduction .....	9
2. National/local context and evidence base .....	10
2.1. National Context .....	11
2.2. Local Context .....	12
3. Outcomes .....	15
3.1. NHS Outcomes Framework Domains & Indicators .....	15
3.2. Locally defined outcomes .....	16
4. Scope .....	19
4.1. Aims and objectives of service .....	19
4.2. Service Description/Operating Model – 111 Call Handling .....	20
4.2.1. NHS 111 Call Handling Process .....	21
4.3. Clinical Decision Support System (CDSS)/Clinical Triage and Assessment .....	29
4.3.1. Operational Principles .....	29
4.3.2. Role Based Workflow .....	29
4.3.3. The Future of CDSS: Clinical Triage Platform .....	30
4.3.4. Commissioning and Procurement of CDSS .....	31
4.3.5. Safety Standards .....	31
4.3.6. Governance .....	31
4.4. Operating Model – Clinical Assessment Service .....	32
4.4.1. Streaming .....	32
4.4.2. Low acuity Ambulance Validation .....	33
4.4.3. Rapid Access to GP (star-line) – Clinical Support .....	33
4.5. Operating Model - Face to Face Consultation and Treatment (Out of Hours Period) .....	34
4.5.1. Clinical Principles .....	34
4.5.2. Patients Requiring Out of Hours Care following a Call from HCP Line/CAS Intervention – Clinical .....	36
4.5.3. Face-to-Face Consultation and Treatment - Clinical .....	36
4.5.4. Home Visits .....	38
4.5.5. Prison visits .....	39

OFFICIAL–SENSITIVE: COMMERCIAL

4.5.6.	Out of Hours Intermediate Care and Residential Cover.....	40
4.5.7.	Vehicles.....	40
4.5.8.	Medical Equipment and Supplies.....	40
4.5.9.	Near Patient Testing.....	41
4.5.10.	Pathology.....	41
4.6.	Directory of Service (DoS) & Capacity Management.....	48
4.7.	Workforce.....	49
4.7.1.	Introduction and underlying principles.....	50
4.7.2.	Non-clinical telephone/remote workforce.....	51
4.7.3.	Clinical telephone/remote workforce.....	51
4.7.4.	Staff Mental Health and Wellbeing.....	53
4.7.5.	IUC Clinical Assessment Service (CAS) workforce.....	53
4.7.6.	IUC CAS / NHS 111 Workforce Blueprint.....	54
4.7.7.	Recruitment, Retention and Vacancies.....	55
4.7.8.	Medicines and Poisons training.....	55
4.7.9.	Workforce Education and Training.....	55
4.7.10.	Health Advisor Training, Call Co-ordinator (CAS) and Support (Non- Clinical).....	57
4.7.11.	Staff training and support (non-clinical).....	58
4.7.12.	Clinical Training and Support.....	58
4.7.13.	Other Specialist Training.....	58
4.8.	Interoperability.....	58
4.8.1.	Referrals and Transfers (covering Sending, Receiving, Content, and Endpoints).....	59
4.8.2.	Transferring/Referring Patients between Services.....	59
4.8.3.	Directory of Services.....	60
4.8.4.	Appointment Booking.....	60
4.8.5.	Ambulance Requests.....	60
4.8.6.	Continuation of Triage.....	61
4.8.7.	Repeat Caller Service (RCS).....	61
4.8.8.	Post Event Messaging.....	61
4.8.9.	Online/Digital Services.....	62
4.9.	Telephony & IT Systems.....	62

OFFICIAL–SENSITIVE: COMMERCIAL

4.9.1.	The function of the national 111 telephony platform.....	62
4.9.2.	Receiving calls from 111.....	64
4.9.3.	Local provider telephony and IT .....	65
4.9.4.	Security.....	67
4.9.5.	British Sign Language (BSL) .....	67
4.9.6.	4.9.6 Front End Message .....	67
4.10.	Referral to Other Services.....	67
4.10.1.	Ambulance Services.....	67
4.10.2.	Primary Care Response .....	68
4.10.3.	Dental Services.....	69
4.10.4.	Other Services .....	70
4.11.	Appointment Booking .....	70
4.11.1.	Booking Workflow .....	71
4.11.2.	Technical Interoperability .....	71
4.11.3.	Cancellations and Amendments .....	71
4.11.4.	Notifications and Reminders .....	71
4.11.5.	Reporting and Data .....	71
4.12.	Access to Records .....	72
4.12.1.	Patient Demographic Service (PDS) .....	72
4.12.2.	Summary Care Record (SCR) .....	72
4.12.3.	Permission to View (PTV) .....	72
4.12.4.	Patient Flags/Special Patient Notes (SPN) .....	72
4.12.5.	Access to Patient Records .....	73
4.13.	Medicines Management .....	74
4.13.1.	Prescribing .....	74
4.13.2.	Repeat prescriptions.....	74
4.13.3.	Electronic Prescription Tracker .....	75
4.14.	Post Event Messages (PEM) .....	75
4.14.1.	Overview .....	75
4.14.2.	Format.....	75
4.14.3.	Content.....	75
4.14.4.	When to send.....	76
4.14.5.	Recipients .....	76

OFFICIAL–SENSITIVE: COMMERCIAL

4.14.6.	Never Send Lists .....	76
4.15.	Access and Hours of Operation .....	76
4.15.1.	Access Channels .....	76
4.15.2.	Mapping service boundaries .....	77
4.15.3.	Opening hours .....	77
4.16.	Population covered.....	77
4.17.	Acceptance and exclusion criteria and thresholds.....	78
4.18.	Interdependencies with other services/providers.....	78
4.19.	Intelligent Commissioning .....	78
4.19.1.	Local Pathways.....	78
4.19.2.	Integrated Urgent Care Service .....	79
4.19.3.	In-Hours GP and Primary Care Services .....	80
4.19.4.	Ambulance Services .....	81
4.19.5.	Accident and Emergency (A&E) Departments (Secondary Care) .....	81
4.19.6.	Urgent Treatment/Care Centres (UTCs/UCCs), Minor Injury Units (MIU) and Other Providers .....	<b>Error! Bookmark not defined.</b>
4.19.7.	Local Out of Hours Treatment Centres/Community Nurse Teams/ Mental Health Team Providers .....	82
4.19.8.	Social Care providers .....	82
4.19.9.	Community Hospitals.....	83
4.19.10.	Community Pharmacists, Dentists and Optometrists .....	83
4.19.11.	Other Partners, Voluntary Sector and Other Service Providers.....	83
4.19.12.	System Resilience, Transformation and Urgent Care Networks .....	84
4.20.	Improved patient experience.....	84
4.21.	Communications, engagement and marketing.....	85
4.22.	Staff and Patient Feedback Surveys .....	87
4.23.	IUC for Carers .....	88
4.24.	Service development and changes.....	88
4.25.	Future Technology .....	89
4.25.1.	Access to Service Information.....	89
4.25.2.	NHS 111 On-line.....	89
4.26.	New Services/Helplines .....	89
5.	Applicable Service Standards .....	90

OFFICIAL–SENSITIVE: COMMERCIAL

5.1. Applicable national standards .....	90
5.2. Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges) .....	90
5.3. Statutory Duties .....	90
5.3.1. Information Governance <sup>2</sup> .....	91
5.3.2. Safeguarding Children and Vulnerable Adults.....	93
5.3.3. Care Quality Commission .....	95
5.3.4. Serious Incidents.....	95
5.3.5. Health and Safety .....	96
5.3.6. Infection control.....	96
5.3.7. Complaints .....	97
5.3.8. Record keeping.....	97
6. Applicable quality requirements and CQUIN goals .....	97
6.1. Applicable Quality Requirements/Standards .....	97
6.2. Applicable CQUIN Goals .....	98
6.3. Clinical Governance Quality Requirements .....	98
6.3.1. Governance Arrangements .....	100
6.3.2. End to End Reviews and Process to Share Learning .....	101
6.4. Privacy Impact Assessment (PIA).....	102
6.5. Equality Impact Assessment .....	102
6.6. Performance Management.....	102
6.6.1. Principles.....	103
6.6.2. Reporting and coverage .....	103
6.6.3. IUC Minimum Data Set.....	104
6.6.4. Data Submissions .....	104
6.6.5. Disposition and Outcome monitoring .....	104
6.6.6. Staff and Patient Feedback and Surveys.....	104
6.6.7. Staff and Financial Metrics .....	105
6.7. Syndromic Surveillance .....	105
6.7.1. Remote health advice syndromic surveillance system.....	105
6.7.2. Integrated Urgent Care surveillance system.....	105
6.8. Technical Standards.....	105
7. Local Provider Premises .....	105

OFFICIAL–SENSITIVE: COMMERCIAL

8. Business Continuity/Resilience .....	108
8.1. Business Continuity .....	108
8.2. Response to a Major Incident.....	108
Appendix A – Evidence Base.....	110
8. These results are consistent with results from Staffordshire. In Staffordshire the proportion of callers advised to attend A&E fell from 7.8% to 6.8% as a result of the CAS. However, there was no statistically significant impact on type 1 A&E attendances from NHS 111.....	111
Appendix B - Clinical Governance Tool Kit .....	112
Appendix C – Low Acuity Ambulance and ED Disposition Validation.....	113
Appendix D – IT Standards.....	119
Appendix E – DoS Standards hypertext link .....	120
Appendix F – Telephony Messaging Strategy .....	121
Appendix G – Urgent Treatment Centre Standards hyper-text link.....	122
Appendix H – IUC for Carers .....	126
Appendix I – Future Technology.....	128
Appendix J – Roles and Responsibilities .....	132
Glossary.....	135
Document Reference .....	140

## 1. Service Specification

<b>Service Specification No.</b>	
<b>Service</b>	Integrated Urgent Care Service
<b>Lead/Awarding Commissioner</b>	NHS North West Surrey CCG
<b>Contracting Authorities</b>	NHS East Surrey CCG, NHS Guildford & Waverley CCG, NHS North West Surrey CCG and NHS Surrey Downs CCG
<b>Provider</b>	TBC
<b>Period</b>	(5 years), with 1 optional contract extension for up to 36 months.
<b>Date of Review</b>	After 12, months' operation, and then every 12-months until contract expiry.

### 1.1. Introduction

As set out in Equity and Excellence: Liberating the NHS, the Government is committed to developing a coherent 24/7 integrated, urgent care service throughout England that makes sense to patients when making choices about their care and the NHS Five Year Forward View which clearly sets out the need to redesign the NHS urgent care 'access points', moving towards a 'consult and complete' model.

This specification includes the NHS England (NHSE) guidance issued in September 2015 Integrated Urgent Care Commissioning Standards (gateway 04020) and Next Steps on the NHS Five year Forward View – A National Service Specification for Integrated Urgent Care Services (gateway 07150). Surrey Commissioners will require providers to be able to adapt, respond to and implement recommendations from NHSE as they are released.

The provider is expected to deliver the National Core Specification for NHS 111 services produced by NHSE, the NHS 111 Commissioning Standards published by NHSE (September 2015), all other associated NHS 111 guidance and associated Technical guidance and the relevant Out of Hours (OOH) National Quality Requirements (NQRs), and Care Quality Commission - Inspection plans for Integrated Urgent Care (NHS 111) services (June 30<sup>th</sup> 2015) [http://www.cqc.org.uk/sites/default/files/20150630\\_nhs111\\_provider\\_handbook.pdf](http://www.cqc.org.uk/sites/default/files/20150630_nhs111_provider_handbook.pdf) and any revisions to these requirements.

This specification has been written on behalf of the following Clinical Commissioning Groups (CCGs) which will be referred to as 'Surrey':

- NHS East Surrey Clinical Commissioning Group
- NHS Guildford & Waverley Clinical Commissioning Group
- NHS North West Surrey Clinical Commissioning Group
- NHS Surrey Downs Clinical Commissioning Group

This specification is for an Integrated NHS111/GP Out-of-Hours Urgent Care Service (latterly referred to as the Integrated Urgent Care Service (IUC) Service). This is an essential component of a landscape of multiple providers and services who by working together can offer optimal urgent care provision for people. The IUC Service needs to provide:

OFFICIAL–SENSITIVE: COMMERCIAL

- A free to call NHS 111 telephony service, call handling and initial assessment for callers (and users)
- A Clinical Assessment Service (CAS)
- GP OOHs face to face consultation (at the patients home or nominated base)
- Strong and clear pathways of care and integrated governance processes which ensure safe and optimal transfer of people’s care in instances where additional or specialist care is provided.

The CAS will contain:

- A range of multi-disciplinary clinicians/healthcare professionals (as the service/activity profile requires);
- A Senior CAS Clinician on shift 24/7; and
- Have access to a GP 24/7 to assist the Senior CAS Clinician (when this is not a GP).

This service specification outlines the requirements for a Surrey IUC Service for the following:

Hours of Operation	GP OOH	NHS 111	Clinical Assessment Service including clinical navigation
Mon – Fri 8.00 am – 6.30 pm	X	✓	✓
Mon – Fri 6.30 pm – 8.00 am	✓*	✓	✓
Sat – Sun & Bank Holidays 8.00 am – 8.00 pm	✓*	✓	✓
Sat – Sun & Bank Holidays 8.00 pm – 8.00 am	✓*	✓	✓
<b>Key</b>			
Included in Service Specification			✓
Excluded in this Service Specification			X
Staffing and service model must be commensurate with local demand profile and work flexibly through negotiation with any local primary care seven day working initiatives			✓*

**Comment [RL1]:** Need to clarify with primary care/overall strategy: 1815pm start/shoulder time? Future GP Fed development inclusion and dovetail into emerging/established extended hours either from April 2019 or sometime during the life of the contract

This integrated service shall be provided with components of telephony via NHS 111 24/7, 365/7 days a year (366/7 in a leap year) offering health advice, coordination, multi-disciplinary clinical assessment over the phone and face to face treatment (during the out-of-hours period) and signposting to other services (where appropriate).

During the Out of Hours period the provider shall offer a Clinical service that provides telephony and includes GP/Clinician speak to and face to face consultations (either at a nominated base location or at the patients home/location) to treat all registered and temporarily resident patients, and those visitors who require immediate treatment in the Commissioners area. This includes all individuals who are, or believe themselves to be, acutely ill with a condition that requires urgent attention, such that their immediate care needs cannot safely be deferred until the next day or to the end of the out of hours period. It is required to be sustainable, based on a service model that is clinically and commercially robust, that can attract and retain suitably qualified competent practitioners, integrated with other services and able to deliver the service to a high standard.

## 2. National/local context and evidence base

## 2.1. National Context

The fundamental principles for an IUC Service is free to call; through NHS 111 and is available 24 hours a day, 7 days a week, to respond to the population of Surrey with a personalised contact service when patients:

- Need medical help fast, but it's not a 999 emergency;
- Don't know who to call for medical help;
- Are unsure if they need to go to A&E or another NHS Urgent Care service;
- Need health information or reassurance about what to do next; or
- Require continuity of care when in hours GP services are closed.

The IUC Service must be designed around the patient's expectations that:

- Their problem is dealt with on the initial call;
- The assessment will be quick and not involve unnecessary questions;
- In an emergency an ambulance will be dispatched without delay;
- Their call will be warm transferred to a clinician where clinically appropriate (even if that resource is not co-located);
- Ability to transfer clinical assessment data to other providers by ITK/direct transfer;
- Directly book appointments into OOH's where necessary;
- Directly book appointments into primary care/other services where possible;
- Where required locally the CAS to have conference call facility to allow other specialists to join a call;
- When a call back is necessary during periods of peak demand any call back is within safe timescales;
- Where appropriate and possible their call is completed on the telephone (consult and complete);
- The IUC service has accurate up-to-date information regarding the 'locations of care' and pharmacies in their locality including but not limited to knowing opening times and services offered;
- The service has accurate and up-to-date information regarding local capacity and to offer options relating to waiting times;
- Provides support to patients<sup>i</sup> where English is not their first language;
- Provides support to patients with hearing impediment, sensory impairments, physical disabilities, communication difficulties and/or with mental health issues.
- Any prescription required will be sent directly to a convenient pharmacy where appropriate;
- If further care or advice is required they will be referred automatically (electronically), or signposted to another service that has the appropriate skills and resources to meet their needs including those outside the scope of IUC.
- Access to urgent social care input
- Ability to book urgent OPD in acute trusts
- Electronic Prescribing
- IT Interoperability – shared care records
- EoLC Medication
- Equality, Diversity and hard to reach groups

Where the caller would benefit from further clinical intervention and for calls from other registered healthcare professionals (including but not limited to paramedics and ambulance technicians, community healthcare, End of Life/palliative care specialists, GPs, mental health practitioners and pharmacists), for the call to be warm transferred to the Clinical Assessment Service (CAS) which will provide additional clinical advice to these professionals and to

OFFICIAL–SENSITIVE: COMMERCIAL

patients transferred from Integrated Urgent Care (NHS 111) services.

The Integrated Urgent Care service will provide extensive management information to the commissioners regarding the demand for and usage of services in order to enable the commissioning of more effective and productive services that are designed to meet people’s needs. The provider will ensure that the management information can be provided at CCG level as well as contractual level.

A series of pilots have been undertaken to build an evidence base relating to benefits associated with the provision of additional clinical input. A full report can be found in Appendix A.

## 2.2. Local Context

The combined population of Surrey for this procurement is approximately 1,081,000 patients. Surrey has a much larger population aged 40 – 65 and 75+. Over the next 5 years the number of people aged 85+ will go up by 30% and the population aged 65+ will increase by 13%. Historic and forecasted population increases have been analysed and the commissioners predicted a total 1% per year population growth.

East Surrey CCG	Guildford & Waverley CCG	NW Surrey CCG	Surrey Downs CCG
Pop, 182,000 18 GP practices	Pop. 221,000 21 GP practices	Pop. 371,000 41 GP practices	Pop 307,000 31 GP practices
Surrey & Sussex Hospital	Royal Surrey Hospital	Ashford & St Peters Hospital	Epsom St Helier, Surrey & Sussex Hospital (Kingston hospital also used)

- HMP High Down )
- HMP Downview )
- HMP Send ) – 2,460 prisoners
- HMP Coldingley )
- HMP Bronzefield )

The service will provide care during the hours that the service is operational to:

- Any person within Surrey, whether registered with a practice or not, who is in need of immediate and necessary treatment.
- Any person occupying a bed in a Community Hospital, Nursing Home, Care Home, Mental Health or Residential Facility registered with a GP in Surrey, who is appropriately referred to the service as requiring clinical attention, commensurate with that described in this specification during the out of hours period.

**Comment [BG2]:** Needs to dovetail with the community and mental health service specifications in particular for out of hours service provision, so that we are not duplicating this provision.

OFFICIAL–SENSITIVE: COMMERCIAL

- The commissioner would expect the provider of the Integrated Urgent Care service to treat all registered and temporarily resident patients and those visitors who require immediately necessary treatment in the commissioning area, including prisoners (during OOHs). These patients will be assessed as acutely ill or believe themselves to be acutely ill and/or do not feel based on their condition, that they can wait to see their registered GP, during their GPs normal in-hours service.
- As with all Integrated Urgent Care services and the NHS 111 element there is likely to be calls received that do not originate from within the commissioners area. These are to be answered in the same fashion as any other call and directed appropriately through the national DoS. There may be a need for the service to contact the appropriate service (ambulance, out of hours) for that patient. These will be included in the call volume and will be reported to the commissioner as out of area calls.

The expected activity levels are circa 197,000 (calls offered) NHS111 calls per annum, circa 72,000 GPOOHs contacts per annum and circa 22,000 incoming speak to GP and incoming HCP episodes during the out of hours period per annum.

**Comment [RL3]:** The dataset needs to include  
 Call volumes:  
 -Weekday  
 -Weekend  
 -Bank holiday  
 Intraday call profiling  
 Case mix  
 Average handling time

The expected activity levels across the service split in terms of access, type of call, outcome by CCG are outlined in detail within schedule 2b of the contract /Indicative activity plan/activity – Appendix XX .

Historic call volumes have been analysed along with historic and forecasted population growth and the commissioners predict a 1% increase in call volume growth per year.

Acute hospital services based in this area are:

- Ashford and St Peters NHS FT
- Royal Surrey County Hospital NHS FT
- Surrey and Sussex Healthcare NHS Trust (East Surrey)
- Epsom and St. Helier University Hospitals NHS Trust.
- Kingston Hospital NHS foundation Trust is also used, but not located within the commissioners' area.

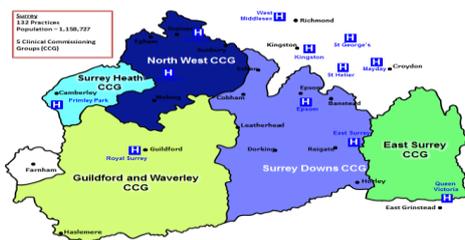
The adults community service providers are:

- Virgin Healthcare
- First Community
- Central Surrey Health

Most mental health services are provided by Surrey and Borders Partnership NHS FT. Ambulance services and 111 are provided by South East Coast Ambulance NHS FT and GP Out of Hours are provided by Care UK and IC24. Social care services are provided by Surrey County Council. Surrey covers 8 District/Borough Councils.

The map below outlines the Surrey information/locations:

Surrey Clinical Commissioning Groups



- 1 H.M.P. Send (282)
- 2 H.M.P. Bronzefield (205)
- 3 H.M.P. Downview (355)
- 4 H.M.P. Coldingley (513)
- 5 H.M.P. Highdown (1,103)

OFFICIAL-SENSITIVE: COMMERCIAL

Public Health England has published the area health profiles. The profile for Surrey is outlined in the table below:

Compared with benchmark: Better (Green), Similar (Yellow), Worse (Red), Lower (Blue), Higher (Orange), Not Compared (Grey)

Worst/Lowest 25th Percentile Benchmark Value 75th Percentile Best/Highest

Indicator	Period	Surrey		Region England		England		Range	Best/Highest
		Recent Trend	Count	Value	Value	Value	Worst/Lowest		
Deprivation score (IMD 2015)	2015	-	-	9.4	-	21.8	42.0		5.7
Children in low income families (under 16s)	2013	↓	19,705	9.4%	13.7	18.6	34.4%		6.1%
Statutory homelessness	2015/16	-	80	0.2*	0.8*	0.9	8.9		0.1
GCSEs achieved	2014/15	-	6,790	65.7%	59.8	57.3	42.0%		71.4%
Violent crime (violence offences)	2015/16	↑	16,147	13.9	16.8	17.2	36.7		6.7
Long term unemployment	2015	-	818	1.1	2.3	4.6	15.7		0.7
Smoking status at time of delivery	2015/16	↓	704	5.8%	9.7	10.6*	26.0%		1.8%
Breastfeeding initiation	2014/15	-	10,841	84.7%	78.0	74.3	47.2%		92.9%
Obese children (Year 6)	2014/15	↔	1,315	13.2%	16.4	19.1	27.8%		10.5%
Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	-	270	35.7	34.5	36.6	92.9		10.9
Under 18 conceptions	2014	↓	287	14.2	18.8	22.8	42.4		8.4
Smoking Prevalence in adults	2015	-	-	14.0%	15.9	16.9	26.8%		9.5%
Percentage of physically active adults	2015	-	-	62.0%	60.2	57.0	44.8%		69.8%
Excess weight in adults	2013 - 15	-	-	60.9%	63.3	64.8	76.2%		46.5%
Cancer diagnosed at early stage	2014	-	2,158	46.0%	48.9	50.7	36.3%		59.7%
Hospital stays for self-harm	2014/15	-	1,781	155.9	193.1	191.4	629.9		58.9
Hospital stays for alcohol-related harm	2014/15	-	5,446	484	519	641	1,223		379
Recorded diabetes	2014/15	↑	49,006	5.0%	5.7	6.4	8.9%		3.7%
Incidence of TB	2013 - 15	-	203	5.8	7.6	12.0	85.6		1.2
New sexually transmitted infections (STI)	2015	-	4,627	630	649	815	3,263		287
Hip fractures in people aged 65 and over	2014/15	-	1,406	577	560	571	743		379
Life expectancy at birth (Male)	2012 - 14	-	-	81.7	80.5	79.5	74.7		83.3
Life expectancy at birth (Female)	2012 - 14	-	-	84.6	84.0	83.2	79.8		86.7
Infant mortality	2013 - 15	-	107	2.6	3.2	3.9	7.9		2.0
Killed and seriously injured on roads	2012 - 14	-	1,908	55.2	47.9	39.3	76.3		15.5
Suicide rate	2013 - 15	-	280	9.1	10.2	10.1	17.4		5.6
Deaths from drug misuse	2013 - 15	-	76	2.2	3.6	3.9	-	Insufficient number of values for a spine chart	-
Smoking related deaths	2012 - 14	-	4,228	210.7	241.2	274.8	458.1		184.9
Under 75 mortality rate: cardiovascular	2013 - 15	-	1,612	55.8	62.3	74.6	137.6		45.4
Under 75 mortality rate: cancer	2013 - 15	-	3,447	118.9	129.4	138.8	194.8		105.8
Excess winter deaths	Aug 2012 - Jul 2015	-	1,756	18.8	18.8	19.6	33.0		10.2

Further information can be gained from [www.surreyi.gov.uk](http://www.surreyi.gov.uk)

Urgent care services are an integral part of the unscheduled health care system in Surrey. A collaborative commissioning approach has been undertaken between East Surrey CCG, Guildford & Waverley CCG, North West Surrey CCG and Surrey Downs CCG to meet the current and future unplanned urgent and emergency care needs of the local population, through Integrated Urgent Care (NHS 111, Clinical Assessment Service (CAS) and GP Out of Hours (OOHs).

Surrey has been at the forefront of implementing service changes that improve integration with local services and good practice innovations and many of the initiatives recommended nationally are now in place. This includes:

- Direct booking into GP Out of Hours bases;
- GP/Senior Clinician triage of green ambulance and ED dispositions;
- Use of pharmacist to manage pharmacy and medication queries;
- Close working relationships with mental health, community and primary care services.
- GP registrar training scheme;
- A fully profiled Directory of Services (DoS)
- Mental Health single point of access (go live expected Feb 2018), including Improving Access to Psychological Therapies (IAPT), Community connections, safe haven and other mental health services
- Integration of repeat prescribing with community pharmacists through the nation

## OFFICIAL–SENSITIVE: COMMERCIAL

### PURMS/NUMSAS Schemes.

The aim of this specification will be to commission a service that not only builds on existing successes but also adds value in the context of a fully functional integrated service comprising of the following elements:

- NHS 111
- Multi-Specialty Clinical Advice Service (CAS)
- GP Out of Hours service with the provision of base consultations and home visits
- Profiled and accurate Directory of Services delivering local pathways that are supported and driven through the localities in Surrey.

To support integration and care coordination with local care pathways, the Provider will look to expand the use of special patient notes from primary care and other providers, subject to appropriate Information Governance which will aid patient journey and clinical decision making. These may include the enhanced patient Summary Care Record, the IBIS records that the local ambulance trust manages and other local digital plans. This will assist in helping to access specifically identified and interdependent pathways for the patient. These Special patient notes and interconnected pathways are more fully described in the later sections of this specification.

The commissioner's collective dominant primary care IT system is Emis Web, although there is a pocket of SystmOne users in Dorking. Any system used within the IUC Service will need to be compatible with commonly used provider systems and meet NHS interoperability requirements.

The provider will ensure that there is a system/interoperability in place to access special patient notes held on the various stakeholder systems (e.g ambulance trust), and interoperable. The commissioner is expecting that systems will connect across the life of the contract and will be able to utilise the summary care record, enhanced summary care record and special patient notes. Developments and funding by NHSE and systems such as a Medical Interoperability Gateway (MIG), a secure gateway for exchanging clinical data are becoming available; a MIG already facilitates data sharing for GPs using software systems. It is the Providers responsibility to propose a suitable solution to the Commissioners as part of the procurement process.

Providers, during mobilisation must ensure that their standard operating procedures and staff training ensures a service wide understanding of interdependent pathways and close coordination with the relevant services, including where the patient or carer calling has been connected to this service who is a registered patient in a neighbouring CCG. The provider will also be required to participate in national contingency arrangements and to take calls from other areas as required. These 'overflow' volumes of calls are at present, at circa 12% per month.

## 3. Outcomes

### 3.1. NHS Outcomes Framework Domains & Indicators

The Commissioners utilise the NHS Outcomes domains in ensuring the commissioning of a high quality and patient focused Integrated Urgent Care service. The service must ensure that on-going monitoring is in place to ensure that the desired outcomes are met, including evidence of an entrenched culture of learning and sustainability:

Domain 1	Preventing people from dying prematurely	✓
----------	--	---

## OFFICIAL–SENSITIVE: COMMERCIAL

Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

The IUC Service must deliver against the nine key elements identified by NHSE:

1. A single call to get an appointment during the out-of-hours period
2. Data can be shared between providers
3. The capacity for NHS 111 and urgent multidisciplinary clinical services need to be jointly planned, in conjunction with Commissioners local developments
4. The Summary Care Record (SCR) is available in the CAS and elsewhere
5. Care plans and special patient notes are visible to the Clinicians in the IUC and in any downstream location of care
6. Appointments can be made to in-hours GPs and to GP extended access services, offering services in the evening and at weekends.
7. There is joint governance across Urgent and Emergency Care
8. Suitable calls are transferred to a Clinical Assessment Service containing GPs and other health care and social care professionals
9. The Workforce Blueprint products and guidance are implemented across all providers in the IUC service

As part of local strategy, the effectiveness of the service is expected to contribute to:

- A reduction in minor attendances at A&E – ensuring that high acuity referrals are seen quickly; improving system impact;
- Greater patient convenience and improved professional working environment – increase the opportunity for co-location of services, i.e. Urgent Treatment Centre (UTC), Clinical Assessment Services, GP OOH, GP access hubs offers;
- Reduction in unnecessary ambulance conveyances to A&E
- Offer an alternative out-of-hospital urgent care pathway for ambulance services
- Care delivered in a more convenient setting closer to home.
- Interoperability with emerging locality hubs/ etc
- Improved care for people in mental health crisis

More broadly, the service must be designed to provide enhanced clinical quality leading to improvement in patient outcomes, thereby improving quality of life and decreasing mortality rates for urgent and emergency care conditions.

### 3.2. Locally defined outcomes

The IUC Service will work as an integral part of the local health economy, with clear publicly communicated service level agreements to make it easier and more understandable for the Surrey population to access urgent healthcare, through a number of channels at an appropriate time and location and to receive a consistent and high quality service. Through regular patient, professional internal review, external learning,

## OFFICIAL–SENSITIVE: COMMERCIAL

feedback and assessment to drive improvements in the way in which the NHS delivers Urgent Care in a seamless way across the local system, traversing organisational boundaries to deliver appropriate treatment at the right place, first time.

Within a context of national and local focus on performance and improved outcomes, the aim is to ensure the successful delivery of an Integrated Unplanned Urgent Care service by putting the following objectives / critical success factors in place:

- An integrated urgent care service which contributes to the Surrey health and social care target to reduce avoidable admissions to hospital in a sustainable way
- An integrated urgent care service which supports the system wide achievement of national emergency care targets for the NHS.
- An integrated urgent care service which delivers consistency of response for people and equitable access to NHS services, social care and third sector services, based on individual need and where possible reduces the number of access points from which to receive urgent care.
- An integrated urgent care service which values and contributes to a culture of self-help and personal knowledge. It reduces dependency and avoids paternalistic responses to the public.
- An integrated urgent care service with sufficient capacity and resilience to be able to meet both predictable and unpredictable surges in demand.
- An integrated urgent care service with a robust and demonstrable clinical integration and governance process between the various providers who form part of the service and with key members of the system, especially emergency departments, 999, Primary Care OOHs, and complex care teams.
- An integrated urgent care service which ensures that the best practice in urgent care is provided for patients.
- An integrated urgent care service which must be able to demonstrate that they provide a good service for patients and those patients express satisfaction with the service they receive and can demonstrate an increasing confidence in the offer.
- An integrated urgent care service that is able to stay within its' allocated budget and demonstrate their ability to reduce spend in 999 and emergency department services. The service must be able to demonstrate value for money.
- Put in place appropriate systems and pathways that enable an efficient service delivery model that reduces duplication
- Meeting the urgent care needs of patients and referral back to Primary Care is more clinically appropriate.
- Ensure that specific health needs such as palliative care, mental health and long term conditions are properly met<sup>1</sup>.

---

<sup>1</sup> <http://endoflifecareambitions.org.uk/>  
<http://endoflifecareambitions.org.uk/resources/>  
<https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response>

## OFFICIAL–SENSITIVE: COMMERCIAL

- Coordination of care with:
  - Community pharmacy services for repeat prescriptions and pharmacists 'Hear and Treat', 'See and Treat', for minor illness.
  - Mental Health services providing care for people with mental health conditions.
  - Urgent dental care services.
  - Co-ordination of Specialist Palliative/EOL care including statutory and voluntary sectors.
  - Social care.

Specific outcomes expected from the service are:

### Year One:

- A functionally Integrated Urgent Care service delivering joined up care for users;
- Provision of consistent clinical assessment of patient needs at the first point of contact, including direct clinical consultation in at least 50% of clinically appropriate calls with queue navigation;
- Implementation of IVR lines (where appropriate)
- GP leadership to deliver a robust clinical governance framework with on-going service improvements;
- Pharmacists function for medication queries, repeat prescription requests and minor ailments during defined hours;
- Coordination of care with community pharmacy services for repeat prescriptions and pharmacists;
- Coordination of care for Mental Health conditions with Mental Health services;
- Clinical assessment of non-urgent green ambulance dispositions;
- Clinical assessment of non-life threatening Emergency Department dispositions.
- Co-ordination of Specialist Palliative/EOL Care;
- Access/bypass line for other health care professionals to access advice and coordination regarding further care for their patients. This would include paramedics on scene, registered nurses in care homes, GPs and registered community nurses (Unregistered nursing assistants and health care assistants should go through 111 and be fully risk assessed).

??Benchmark and reduce ED attendances and 999 conveyance?

### Further Years:

- The aim is to develop pathways across the CCGs for increased coordinated care with Community services, Social Care, Mental Health Colleagues, Ambulance services, the Voluntary sector and Emergency Departments as agreed by such bodies including but not limited to the Integrated Care Programme Board and System Resilience Groups.
- NHS On line/use of Apps
- Increased direct booking

**Comment [RL4]:** Add to this once any innovations are agreed/market feedback gained.

<http://www.endoflifecare-intelligence.org.uk/resources/publications/costeffectivecomm>

1 Accessible Information Standard - <https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-upd-july-15.pdf>

## 4. Scope

### 4.1. Aims and objectives of service

The vision for an Integrated Urgent Care Clinical Assessment Service (IUC CAS) is to deliver a 'consult and complete' model of urgent care access that can streamline and improve patient care across the urgent care community.

The introduction of an IUC CAS will remove unnecessary "touch points" for the patient and bring the receiving clinician much closer to the original call.

The Commissioners have identified a number of principles that underpin this service specification:

- An accessible and responsive service that provides patient centered care, delivered by a multi-disciplinary workforce that includes GPs.
- **Equitable** access to the service across the whole of the Surrey territory. To include learning from national pilots such as British Sign Language (BSL) and other patients with impairments.
- A focus on quality and clinical outcomes
- Ability to view patient records, summary care record and advanced summary care record to support provision of the right care.
- Evidence of robust clinical leadership
- Use of local GPs and senior clinicians, who are approved on the performers list whose knowledge of local services spans both in and Out of Hours provision, with appropriate training and validation to ensure that this is the case.
- Robust and tested workforce, escalation plans and business continuity plans to ensure the service meets standards.
- Ability to review ED and green ambulance dispositions from NHS 111 element.
- Integration with the local health and social care system and working constructively with all other providers within the Urgent Emergency Care patient flow/network as appropriate and as agreed.
- A culture of listening and a commitment to respond to suggestions and concerns from within and outside of the service.
- Actively and sustainably markets the service to all local residents, gathers and acts on feedback and manages patient and public expectations.
- Cooperation and communication with neighbouring Providers of Integrated Urgent Care services and (OOH and NHS111) services where an integrated approach has not yet been commissioned.
- Is flexible, adaptable and responsive to the commissioners as the local healthcare system flexes and changes and adapts to new requirements,

**Comment [RL5]:** May need to confirm/review this once GP engagement/extended primary care access is confirmed across the patch

## OFFICIAL–SENSITIVE: COMMERCIAL

legislation and strategic changes.

- Commitment to learn from local and national pilots and committed to the use of technology and digital platforms to achieve outcomes.
- Working with primary, secondary, community, social care, voluntary and mental health care providers.
- Works in partnership with organisations both within and outside of the NHS to systematically promote self-care where appropriate.
- Commitment to developing a workforce with the required skill-mix to deliver optimal patient care
- Commitment to delivering a workforce development plan as described in the NHSE IUC specification

The provider will actively participate via a senior clinician in the development and implementation of the shared strategy, for the integrated delivery of out of hours care in Surrey and will work in partnership with all relevant professionals, teams, organisations and trusts within the local health and social care system.

It is essential that the provider contributes fully to the continuing development of the Surrey Urgent and Emergency Care model. This is by working closely with all local providers including, but not limited to:

- Ambulance Services (SCAmb and SCAS)
- Secondary care providers and A&E Departments
- GPs, Primary Care and Community Services
- Mental Health Trust
- Surrey County Council/Social Care
- Voluntary Sector Bodies
- Other local providers of the Integrated Pathways and other Providers within the Urgent care patient journey.

This needs to include anticipated developments and reforms required to develop a model that is patient centered, responsive, safe, resilient, and fit for purpose to ensure patients receive the right care, in the right place, at the right time.

The commissioners expect the provider to, at a minimum; fully comply with all the relevant NHSE guidance and any revisions to these requirements.

The Service will represent value for money. The provider will be expected to benchmark their GP OOH rates and call handling costs against other urban and large rural counties, at least annually taking into account the demographic profile of the Surrey area and temporary residents in order to provide assurance to the Commissioners that they are getting value for money and the service is working efficiently.

### **4.2. Service Description/Operating Model – 111 Call Handling**

Callers to NHS 111 are routed via the national NHS 111 telephony system to the organisation commissioned to receive NHS 111 calls in the geographic area from which the call originated.

## OFFICIAL–SENSITIVE: COMMERCIAL

The Provider is expected to implement a simple single layer “press1” style Interactive Voice Response (IVR) to stream callers to the most appropriate resource. For example, “*press 1 for a repeat prescription, press 2 for dental enquiries*”. The design of any such IVR menu must adhere to the Telephony Messaging Strategy found in Appendix F.

The provider will utilise appropriately trained staff for the call handling process in accordance to the NHSE Workforce Blueprint.

Calls should be answered either directly by a clinician (not using a CDSS) or by an intermediary member of staff (Administrator/Navigator) whose function is to record demographics and select the appropriate member of staff to conduct the assessment. The staff members will generally be:

- An Administrator/Navigator – only for non-symptomatic callers or the streaming of those with care plans to appropriate clinicians (A/N);
- A Health Advisor;
- Senior Health Advisor (as per the Workforce Blueprint);or
- A Clinician (The clinical advisors now in NHS 111 will be encompassed within the clinical model of the IUC CAS to avoid unnecessary duplication).

In future all Clinicians will be expected to work with a Clinical Decision Support Software (CDSS) tool or an agreed clinical protocol.

The introduction of Clinical Assessment Services (CAS) means that Clinicians can either be locally employed by the NHS 111 call receiving organisation or procured as a service from a third party. Any sub-contracting arrangements will be subject to providing appropriate/adequate processes and technology to facilitate operational requirements outlined in this service specification.

All staff shall adhere to the guidance outlined in this document and any other requirements outlined in the CDSS licence.

The Provider shall ensure that the IUC service is designed in accordance with the operating model principles outlined in the following sub sections.

### **4.2.1. NHS 111 Call Handling Process**

All calls to the NHS 111 service will be recorded.

It is essential when an NHS 111 call is answered that demographic details are accurately recorded. The patient’s NHS number shall be verified using the Patient Demographic Service (PDS).

In all cases, the access to the PDS should identify the patient and subject to express permission to view (PTV) their summary care record, (SCR), summary care record with additional information and any associated special patient note.

All patients must be identified via the PDS service (commonly referred to as the spine) and their NHS number found, the service provider clinical system must have the ability to identify and flag, at the earliest point in the call and have the ability retrieve any Summary Care Record, Special Patient Note (SPN), Electronic Patient Care Co-ordination System (EPaCCS) note that has been created on that patient and with their consent is linked to their NHS number. This can be accessed once the patient has consented verbally that the Integrated Urgent Care (NHS 111) service can have access to that record or where continuous consent is in place.

**Comment [RL6]:** Check MDS

## OFFICIAL–SENSITIVE: COMMERCIAL

It is the provider's responsibility to be a Registration Authority (RA), who administers the process and smart card access services for all staff, in conjunction with appropriate approvals from the commissioner.

The access to SCR/SCRA with additional information/special patient notes is only to be by a clinician but access to a pre note/directions (flags) created by a clinician can be accessed via a health advisor or non-clinician. During mobilisation the commissioner and provider will establish the pre advice/information note that can be accessed by health advisors.

The structure of the SPN and the Clinical Governance of their method of use is the responsibility of the commissioner. The SPNs are created and controlled by the patients GP and other primary care clinicians. The minimum standard is the information held in the patients summary care record SCR – some patients may have a Summary Care Record with additional information also available. The provider will produce a template that will be Emis/primary care compatible.

The maintenance of notes and the updating of records is the responsibility of the commissioner through the local GPs. It is the administrative duty of the provider to ensure that each note can be accessed by the provider's clinical system  
Callers must always be dealt with in a courteous manner. The capture of information either demographic, or for the purpose of assessment, must be carried out in an efficient way in accordance with the relevant CDSS licence and associated training programme. If an Advisor is unsure of how to proceed with a call they must seek advice from either a senior Advisor or a Clinician.

### **4.2.1.1. Demographics and Anonymous Callers**

Demographics shall be recorded in the order and format set out by whatever host IT system is being used, in line with requirements in the IUC Technical Standards pack<sup>2</sup>. As stated above, the NHS number should be matched using the PDS.

Any caller has the right to remain anonymous. If a caller states that they wish to remain anonymous the Advisor shall still record some demographic details, this is necessary in order to carry out a safe assessment using a CDSS. These details include:

- Age (group)
- Gender
- Ethnicity

The Provider shall have policies and procedures to support vulnerable individuals where anonymity could cause problems.

### **4.2.1.2. Out of Area Calls**

There will be occasions where a call is received from a patient who is calling from outside of the geographic area covered by the Provider contract. The Provider shall accept the call and assess the patient in the usual manner.

Depending on the systems used by the Provider there may not be the same level of access to patient records, care plans or service information as would be the case with a patient

---

<sup>2</sup> Integrated Urgent Care Commissioning Standards, Sept 2015  
Integrated Urgent Care Key Performance Indicators, Nov 2016

## OFFICIAL–SENSITIVE: COMMERCIAL

within the Provider's area. In any case the Provider must deal with the patient as fully as possible and utilise the national Directory of Services for onward referral information.

In the event that an out of area caller requires an ambulance, a manual referral to the ambulance service is likely to be required unless a mutual any-to-any arrangement exists. This must take place according to the process detailed in the Provider's operating procedures.

In the unlikely event of receiving a call from another UK country, the Provider shall assess the acuity of the call and if clinically appropriate, transfer the call to the local 111 service in that country using the call transfer process (an established 0300 number that allows advisors to select the required UK country). In the event that an ambulance is required, the Provider shall warm transfer the caller to 999.

In a situation where the NHS 111 provider is supporting other areas with resilience or has contracts with other commissioners there must be no impact on performance in answering Surrey calls due to this activity.

### 4.2.1.3. Confirmation of the patient's registered GP and GP Choice

Traditionally, a patient's registered GP was always local to the patient's residence. However, from January 2015 patients have had the right to register at the practice of their choosing. All GP practices are now able to register new patients who live outside the practice area. These GP Choice registrations are without any obligation to provide urgent home visits, or services out of hours under the GP Choice scheme. The patient pathway differs between 'in hours' and 'out of hours' and whether the patient is at home. Table 1 outlines expected arrangements.

Table 1

Patient at home (away from registered practice)	In Hours Patient shall access the GP Choice service as detailed on the Directory of Services (DoS) via NHS 111. The temporary resident (TR) and immediate and necessary treatment (INT) policies do not apply
	Out of Hours Patient should access routine out of hours service nearest to the patient or other urgent care provision via NHS 111
Patient near registered practice	In Hours Patient able to access registered surgery
	Out of Hours Patient should access routine out of hours services and other urgent care provision via NHS 111

According to GP Choice policy, patients registered under the scheme are NOT able to access care via the 'Temporary Resident' (TR) scheme when they are at their residential address, as these are designed to meet the needs of patients temporarily away from home. In addition, these patients will NOT be able to access care via the 'Immediately Necessary Treatment' (INT) scheme except when the clinical need is owing to an accident or emergency. This is particularly an issue when there is an in- hours urgent primary care need and the patient is not near to their registered practice. For these in-hours urgent needs, local urgent primary medical care services have been commissioned. These are known as GP Choice services. Upon registering with the scheme patients are advised to contact NHS 111 if they require referral to their GP Choice service or OOH service when they need to access services at home.

## OFFICIAL–SENSITIVE: COMMERCIAL

The Provider shall put in place appropriate technical solutions and or operational procedures to handle GP Choice patients in accordance with the requirements set out in Table 1 above.

### **4.2.1.4. Callers Not Located with the Patient.**

If a call is received from a person who is not located in the immediate vicinity of the patient, the Advisor must establish the following:

- Is the patient able to contact the service directly (This is by far the most preferable option)?
- Is the caller in the same building as the patient e.g. residential home? Are they able to move so they can see and talk to the patient whilst undertaking the assessment?
- Is the caller phoning from a remote care line contact centre on behalf of the patient?
- Is the patient contactable? If so, does the caller have the telephone number for the patient?
- Is there any reason the patient should not be contacted?

If the patient is contactable but implied consent to contact them directly cannot be ascertained (i.e. in the instance of the remote care line), the contact details of the original caller shall be recorded and clinical advice sought before the patient is contacted directly, so as not to unwillingly breach data protection principles.

If the patient is not contactable the call handler must gain as much information about the patient's condition as possible in order to decide what action should be taken, for example:

- emergency ambulance dispatch;
- dispatch of another resource be sent (GP visit, community nurse etc.); or
- No action required.

If necessary an Advisor must seek advice from a supervisor on what action is appropriate. In all cases details of the call must be recorded.

### **4.2.1.5. Clinical Assessment**

When conducting a clinical assessment of the patient the safety and appropriate care of the patient must be the primary concern. Clinical assessment can be conducted with the support of a suitable CDSS, from advisor to clinician. The CDSS must be used in accordance with any licensing requirements set out by the CDSS supplier.

It is essential that the clinical assessment is properly recorded for audit purposes. All calls must be recorded along with the primary reason for the call, and the disposition reached at the end of the assessment. If the call is required to be passed to another person (for example, a clinician) for further assessment this should be clearly indicated, including the name of any server referred onto.

Where a patients care plan states that the patients have specific needs, they must be warm transferred to the appropriate clinician/professional or specialist service, where available.

### **4.2.1.6. Non-Symptomatic Calls**

Some callers will not be experiencing symptoms and may be calling to ask advice on a health related matter or will be seeking some form of health information. The advisor must clearly establish that there are no apparent symptoms being experienced. Once this is established the advisor must deal with the call appropriately using tools such as the DoS if the question relates to service information or repeat medication.

### **4.2.1.7. Speaking to a Clinician**

## OFFICIAL–SENSITIVE: COMMERCIAL

If a warm-transfer takes place this must include a hand-over conversation between the advisor and the clinician which must be voice recorded.

### 4.2.1.8. Call Backs from Clinicians

Call backs must be conducted according to the urgency of the call and within any specified time limits, as outlined in published IUC/MDS guidance. Clinicians undertaking telephone assessment must work within any governance requirements set out by the provider and in line with any national NHSE governance standards.

### 4.2.1.9. Assessment Outcomes

Once an assessment is complete the outcome must be clearly recorded. Dependent upon the nature of the outcome further actions may be required (for example, service referral). Any subsequent actions must also be recorded.

If a referral is required this must be done in accordance with the referral criteria/guidelines set out by the service to which the patient is being referred. If the service is listed on the DoS, referral instructions will be indicated in the DoS record.

In the situations where the advice note on the system to the health advisor is a strict instruction that the call should be **early and safe exited and warm transferred to a clinician**, this must be performed and the provider must have appropriate clinical staff in the NHS 111 call centre and/or CAS to accept these warm transfer calls.

The patient will be assessed by the clinician, while remaining in the CDSS system, and the call to be completed normally by the clinician with the following (but not limited to) outcomes:

- Follow DX code
- Amend/alter the DX code/or signposted
- Seek further advice from the clinician/CAS professional via warm transfer call while patient is on hold (conversation to be recorded).
- Appropriately transfer to the clinician/CAS, where clinically appropriate or following a care pathway.
- Book a base visit.
- Book a home visit.
- Upgrade to an ambulance dispatch.
- Close for self-care.
- Signposted/Warm transfer (where possible) to local team in community services via its access number as detailed on the Directory of Services.
- Signpost to or warm transfer (where possible) to the mental health service (Single Point of Access or alternative service). This may also be completed by a tri-partite telephone conference call, where agreed with the commissioner and the local mental health provider.
- Another action agreed in a standard operating procedure at mobilisation.

The service will have in place systems and process to enable it to capture, maintain and respond to any of the Advanced Care Plans for End of Life patients. The Gold Standard Framework for community palliative care is a model for proactively managing palliative care in a primary care setting. Practices are encouraged to identify patients with palliative care needs and issues and to communicate relevant information, including relevant care plans and preferred place of care, to the OOH provider to ensure appropriate clinical care during the out-of-hours periods. The provider shall ensure that where these records exist that they have the ability to receive, store and communicate this information to those who might need it. It also must ensure timely information transfer back to practices following visits to palliative care patients and following deaths, complying with the National Quality

## OFFICIAL–SENSITIVE: COMMERCIAL

Requirements/MDS. These records should be reviewed on a monthly basis for patients who have passed away.

During the life of the contract, specifically around End of Life care plans and use of Electronic Palliative Care Coordination system (EPaCCS), the call should be warm transferred to an appropriate senior clinician, prior to the health advisor taking the call through module zero.

The provider will work with the commissioner to incorporate other future technological access such as on-line connection with view of patient, tele-health, apps (Apple, Microsoft and Android) [www.digitalhealth.net/news/EHI/10050/nhs-111-goes-online](http://www.digitalhealth.net/news/EHI/10050/nhs-111-goes-online). These would likely be via pilots during the life of the contract in line with the developments from the Digital Urgent Care Team at NHSE and will be developed/jointly agreed by both Commissioner and Provider.

**Comment [RL7]:** May need to review this, once innovations/SDIP items are agreed following market pre-engagement.

### 4.2.1.10. Enhanced Dispositions

Where the disposition arrived through the CDSS system, is that of dispatch of a green category 1-4 ambulance or any ED disposition, the required standard is to warm transfer these calls to a senior CAS Clinician (which could be a GP). If a call back is required, the timings of these are referenced in the MDS/LQRs section in schedule 4 of the contract.

The senior CAS Clinician will review this disposition by talking to the patient to ensure that this is the most clinically appropriate decision. The clinician speaking with that patient to either confirm the original disposition from the CDSS, discharge the patient at the end of that call, or once the urgency of the condition (urgent or less urgent) has been determined to direct to the most appropriate service.

For green ambulance dispositions where the call cannot be warm transferred or the patient cannot be called back within the required timeframe, the original disposition is to be followed by the health advisor. This process is to be subject to continued audit for the foreseeable/immediate future and the Provider shall specify a clear operational process regarding how this should take place.

### 4.2.1.11. Discharge processes

Once a call is completed, an outcome reached and any referral made, the patient must be given appropriate safety-netting advice and asked to re-contact the service should symptoms worsen or their condition changes.

The Provider shall send details of all consultations (including appropriate clinical information) to the GP practice where the patient is registered in the form of a Post Event Message (PEM) by 08:00 the following working morning. In time this will be extended to dental practice. Where more than one organisation is involved in the provision of services, there must be clearly agreed responsibilities in respect of the transition of patient data.

If a patient is transferred to a clinician within the IUC CAS only a final PEM need be sent with outcome information. The format of such information will be jointly agreed.

### 4.2.1.12. Specific Caller Groups

The following are specific caller groups for whom particular processes must be followed:

#### 4.2.1.12.1. Unregistered Patients

Callers who are resident in the Provider area and are not registered with a GP must be advised, when appropriate, to register and provided with information to enable registration. For the avoidance of doubt, calls from unregistered patients and patients without a permanent address must be handled, this includes the traveller community who may not be registered with a GP.

#### **4.2.1.12.2. Repeat Callers**

In 2005 the Department of Health issued directions to ensure that any health professional assessing a patient's needs in the OOHs period would have access to the clinical records of any earlier contact that a patient (or their carer) may have recently made with the service.

If a patient (or their carer) calls NHS 111 3 times in 4 days, on the 3rd call the patient must be assessed to determine whether or not an ambulance is required. If an ambulance is not required the call must be transferred to the CAS Senior clinician/GP or registered GP (as availability dictates). The Senior Clinician must complete a thorough re-assessment of the patient's needs and have access to the details of all 3 calls

The Provider shall have agreements in place to feed and query the national Repeat Caller Service (RCS) that has been commissioned by NHSE for this purpose. Providers shall include summary details of the number of records sent, number of queries performed and the number of successful returns to/from the national RCS in their monthly reporting.

#### **4.2.1.12.3. Frequent Callers**

The Repeat Caller requirements detailed in 4.3.1.12.2 do not apply to that small minority of people who regularly make repeated calls (8 times in 1 month) to the same service, where the Provider has made separate arrangements to respond appropriately to those calls. The Repeat Caller protocol does not apply where there is an agreed care plan for the particular patient either (for example, palliative care, long term conditions etc.) a frequent caller protocol will be jointly agreed with the Commissioner.

#### **4.2.1.12.4. Mental Health and Vulnerable Callers**

The Provider shall adhere to the principles of the Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis (18 February 2014) and work with commissioners and patient groups to ensure the most convenient and appropriate access to the service.

In accordance with the Mental Health Concordat, the Provider shall work with local mental health services to ensure the Service intervenes early and identifies appropriate callers to refer to local mental health crisis centres. The Provider shall ensure Advisors manage patients in line with local mental health crisis plans when they are available.

In most IUC CAS it is expected that a patient with primary mental health needs will be put through to a mental health nurse within the IUC CAS or straight through to the mental health provider commissioned within a community without needing to be sorted through the NHS 111 service, for example, via IVRs or through having tagged the callers number for bespoke treatment. When a call is routed directly to a dedicated resource, if the call is not answered in accordance with the KPI, the call must be routed back into the NHS 111 service. Where possible there must also be the ability to reroute a caller who has erroneously chosen the Mental Health option on an IVR to be rerouted quickly back to the NHS 111 service for assessment.

During mobilisation the commissioner and provider will agree a standard operating procedure (SOP) the route for calls that require intervention from a mental health professional and those that require specialist intervention for long term conditions. These specialties may be available in the CAS, supported by other providers or

## OFFICIAL–SENSITIVE: COMMERCIAL

accessible via warm transfer to a single point of access that will be detailed in the Directory of Services.

### 4.2.1.12.5. Health information Callers

In general there are two categories of health information:

- Where the caller may just want to know something about a health related topic or condition
- Where the caller wishes to know about the provision of certain health services within their locality

Where there is a non-symptomatic query relating to a health condition this must be referred to an appropriate Health Advisor or clinician. Service information queries should be dealt with using the DoS.

### 4.2.1.12.6. Health Care Professional Calls

The Service is expected to deal with calls from health care professionals (HCP) and potentially other professionals. This supports the 'No decision in isolation' ethos. Providers shall make arrangements available for HCPs to have direct access to clinical advice (for example, through a direct telephone number or IVR arrangement).

Calls to be answered utilising the same MDS standards and KPIs as for the NHS 111 element of the service. When Healthcare professionals access this line, they will identify themselves as healthcare professionals and will be asked for their professional body registration number, which will be recorded in the notes for the call. The commissioner would expect that these calls where possible are ideally **warm** transferred to a senior clinician during the operational hours of the service.

### 4.2.1.12.7. Self-care

Self-care advice shall be managed by an appropriate clinician (or Senior Health Advisor in the future, if defined in the Workforce Blueprint). Where a warm transfer from an Advisor is not possible the caller should be called back within an agreed timescale.

### 4.2.1.12.8. Ambulance Dispatch

Where the clinical assessment via the health advisor through the CDSS software indicates that the dispatch of a red ambulance is appropriate, the health advisor should be able to dispatch an ambulance without any delay and this call should not be reviewed by the CAS Senior Clinician. During the life of the contract the commissioner expects that based on national and local pilots, that certain Red 2 ambulances could be reviewed prior to dispatch by the CAS Senior Clinician with the agreement of the Commissioner.

Where appropriate, for all ambulance dispatches, the health adviser should stay on the line to provide advice and support prior to the vehicle arriving.

In all cases where the clinical assessment of an NHS 111 caller indicates that the dispatch of an ambulance is appropriate, but the caller's location is unknown, the health advisor should ask the caller to hang up and redial 999 themselves, thereby ensuring that their call reaches the right ambulance service who will have immediate access to their location information, through their superior systems.

The ability to dispatch an ambulance without delay must follow the Integrated Urgent Care inter-operability standards through the CDSS with safe and appropriate clinical intervention.

### 4.3. Clinical Decision Support System (CDSS)/Clinical Triage and Assessment

#### 4.3.1. Operational Principles

Clinical decision support systems (CDSS) offer a critical component of the IUC CAS assessment process. There are three key stages of the patient journey where clinical decision support systems need to be applied:

- Assessing symptoms to initially identify patient need / risk (either over the telephone, by an advisor, or in some cases an interaction that has started with the patient using a digital 111 online service);
- Gathering further information to ensure case streaming to the right clinical care or gathering information to aid the clinical consultation process; and
- Supporting the clinical consultation and delivering the right care (this may be remotely within the clinical assessment service or by connecting to local pathways of care where has been designed locally).

Where a call can only be appropriately assessed or closed with clinical intervention, the patient needs to be transferred to the clinician with a suitable level of competency in an appropriate timescale, and where clinically appropriate, consulted and completed on the phone.

All clinicians undertaking telephone assessment must work within a clearly defined operating model that reflects the different elements of the process within the Integrated Urgent Care service and the OOHs journey. Specifically, this includes:

- Warm transfer and handover from health advisor to clinician – this must be structured and any discussions must take place on recorded telephone lines, which are capable of being recalled easily and used within end to end call reviews.
- Validation by the clinician of the health advisor assessment that has taken place by the health advisor asking the patient questions, following the CDSS software and probing the patient responses where appropriate and according to the CDSS license and provider training.
- Where the clinician has taken over the call within the CDSS system, the clinician must complete the call and end this part of the patient journey through the CDSS system with a valid DX code and appropriate advice and sign posting as detailed in the Integrated Urgent Care Commissioning Standards.
- Where the call is answered by the clinician through a different route, either as result of a transfer or through a disposition following the CDSS assessment then a structured clinical telephone assessment should be undertaken with or without the aid of decision support software.

Where a face –to-face appointment is needed, this must be directly booked (where possible). It is important to provide the patient with confidence that the care they need will be provided and reduced the likelihood that they will defer to a higher acuity service.

#### 4.3.2. Role Based Workflow

The Provider shall ensure that the initial call in to the Advisor fulfils the following functions:

- Asking an initial open question "*what can we do for you today?*" Or "*how can we help you today*" to inform the subsequent consultation with the clinician (Rationale - International studies have shown that patient behaviour after an interaction with a

## OFFICIAL–SENSITIVE: COMMERCIAL

remote clinical assessment service is influenced by what the patient wanted or believed they needed in the first place);

- Initial acuity assessment and elimination of life threatening conditions standard questions;
- Accurate capture of patient demographics;
- Ambulance dispatch where needed; and
- Call streaming via appropriate decision support triage tool to competent registered clinician.

The Provider shall ensure that the Clinician uses clear clinical protocols, guidelines or systems that are supported by training and monitoring to ensure they are understood and applied. It is recognised that from time to time clinical situations will occur in IUC for which there are no clear guidelines or protocols. In such cases, careful application of mature clinical experience must be brought to bear, and training and monitoring must include explicit focus on this area of challenge. This is necessary to support and standardise the clinical consultation (Rationale: Evidence shows that where any clinician uses a CDSS the outcomes are consistently better for patients and that good clinical practice occurs in organisations where there are formal protocols that individuals with agreed competencies are expected to work with).

Combining local protocols with clinical algorithms within CDSS systems will have the following attributes:

- Local Clinical Governance approval with defined processes for monitoring and assuring ongoing clinical safety;
- Commissioners and providers explicitly address how this may affect any licensing agreements with existing CDSS providers and any resultant medical legal liability resides with the local service;
- Direct connection with the Electronic Prescribing Service (EPS) is established and embedded as part of the clinical workflow within the IUC CAS (once available and following roll-out confirmed with Commissioners) (Rationale: For patients needing a prescription following a remote/telephone consultation this can be done without requiring a face-to-face appointment, this approach is widely used across general practice);
- Link to the Directory of Services, this needs to enable the clinician to search for available services based on clinical judgement that maybe broader than the CDSS disposition service set; and
- The clinical workflow enables a patient to be referred to or booked directly (where possible) to a face-to-face service only following clinical assessment.

The Commissioner shall ensure (where possible) that directly bookable services are made available in the DoS and through local commissioning arrangements.

### **4.3.3. The Future of CDSS: Clinical Triage Platform**

The National Informatics Board has commissioned the development of a Clinical Triage Platform to enable modern advancements in technology which will be made available and accessible for deployment by commissioners. These will be supported by a series of safety standards and guidelines as defined in the NHS Five Year Forward Next Steps published in April 2017.

*'CDSS systems are improving exponentially - becoming more personalised and intelligent and able to process more data in real time. From summer 2017 we will be developing and testing new specialist modules of clinical triage for Paediatrics, Mental Health and Frailty and demonstrating the impact of risk stratification. By the end of March 2019 an enhanced triage will be available across Integrated Urgent*

## OFFICIAL–SENSITIVE: COMMERCIAL

*Care, with the potential to also support Urgent Treatment Centres, Care Homes and Ambulance services.'*

### **4.3.4. Commissioning and Procurement of CDSS**

The Provider shall ensure that any procured CDSS meets the following standards:

- It has been robustly tested within the NHS in England;
- It has been demonstrated to be safe, appropriate for each staff / clinical competency level within the IUC CAS;
- It has an assured evidence base that demonstrates clinical safety;
- It is able to electronically dispatch an ambulance as an integral part of the workflow;
- It can be seamlessly connected to the Directory of Service via the defined ITK messaging standards (see Appendix D);
- It has been assessed by MHRA as not being a medical device or be accredited by MHRA as a medical device; and
- It demonstrates compliance with relevant ISO standards.

In line with the deliverables in the Five Year Forward View, CDSS tools that have been identified through previous EU Prior Information Notices (PIN) are being tested across different local providers in partnership with commissioners. Whilst commissioners are at liberty to procure local systems that adhere to the standards set out above and for 111 online products this will need to happen before December 2017. It is important to note that with the delivery of the Clinical Triage Platform in 2019, procurements should be time-limited to ensure that commissioners can take advantage of the benefits of the standards, testing and evidence that will define the Clinical Triage Platform and related products when these become available.

### **4.3.5. Safety Standards**

The Provider shall ensure that the triage products and CDSS meet relevant safety standards in accordance to CQC guidelines.

### **4.3.6. Governance**

Clinical governance arrangements are central to the effective operation of a high quality Integrated NHS111/Urgent care services. The governance arrangements for the CDSS is outlined in the Clinical Governance section 6.3

### **4.3.7 Interdependencies with Other Services/Providers**

The provider will participate in service improvement in any relevant area where a need for service improvement has been identified.

The provider is expected to integrate with the local health and social care system and work constructively with all other providers within the Urgent Emergency Care patient flow/network as appropriate and as agreed in order to contribute to the development of strategic and operational models and urgent and emergency care pathways.

The provider will be required to comply with locally agreed pathways.

The provider will establish cooperation agreements with adjacent authority areas to deploy resources (via tracker knowledge) most efficiently. This should be based on geography, not registered GP practice.

The requirements to update/maintain/use the Directory of Service (DOS) within the 111 call centre and CAS – see section 4.6

### **4.3.8 Risk Management**

## OFFICIAL–SENSITIVE: COMMERCIAL

The provider must undertake risk management activities to ensure that it is able to deliver the service to the standard and specifications as set out in the contract and in order to maintain a resilient service. This should include a risk management information system and a risk management framework which documents the architecture, strategy and procedures relating to risk management. The provider needs to ensure that it maintains a risk register in relation to this contract and that this risk register is reviewed and updated at least 4 times a year. These reviews should include but not limited to the following activities:

- Comprehensive risk identification activities and consideration of new and evolving risks.
- Risk assessment and evaluation, to ensure that risks are prioritised and that an appropriate risk responses are applied.
- Monitoring of existing risks to ensure that the selected risk response actions (e.g. controls) remain effective.
- Review of any logs kept which document service delivery failures, near misses, etc. so that lessons are learnt and incorporated into the risk management process.
- Review of incidents (both clinical and non-clinical) and other sources of information pertinent to effective risk management should be integrated with the risk management process to ensure that
- lessons learnt are embedded in the management of risks.

As appropriate, the provider should provide prompt notification to the commissioner of any serious risk event that has materialised or serious emerging risk. Its procedures should include a clear process supporting escalation of risk within the provider organisation and to the commissioner of the service.

Where appropriate, the provider needs to ensure it has adequate insurance in place to fulfill its contractual obligations and liabilities.

The commissioner may require the provider to support in the risk management of specific risks and these will need to be included on the provider's risk register.

The commissioner retains the right to conduct an annual audit of the effectiveness of risk management activities conducted by the provider.

### **4.4. Operating Model – Clinical Assessment Service**

The Provider shall ensure that the IUC service is designed in accordance with the operating model principles outlined in the following sub sections. All clinicians within the IUC CAS, whether physically co-located or working remotely, shall work to standard professional competencies and must be exposed to regular review and clinically led audit.

#### **4.4.1. Streaming**

Callers will access the service by the following routes:

- NHS 111 Telephony
- On-line
- Ambulance Trust (in the future).

As described in Section 4.2, callers entering through the NHS 111 telephony channel will have undergone an initial assessment before being streamed to the Clinical Assessment Service. This will have included the capture of demographics. A call entering via the on-line channel will have undergone a similar assessment on-line prior to being passed to the

## OFFICIAL–SENSITIVE: COMMERCIAL

Clinical Assessment Service. On receipt of these calls, the Clinical Assessment Service must validate the demographics and if necessary run a PDS match before placing the call in the appropriate clinical queue for assessment.

### **4.4.2. Low acuity Ambulance Validation**

The Provider shall undertake further clinical review of low acuity ambulance calls that originate in NHS 111. Pending the publication of outcomes from the Ambulance Response Programme, commissioners should not at present look to manage those low acuity ambulance calls originating through the 999 service within the CAS. NHSE will offer advice to commissioners on whether there are opportunities for managing some low acuity 999 calls in this way, following a clinically led process. To avoid the need to call patients back this will involve the warm transfer of calls between services.

#### **4.4.2.1. Standard Operating Procedure for low acuity Ambulance Validation and A&E disposition validation in NHS 111 services and IUC CAS**

The Provider shall, in conjunction with NHSE and the Commissioner, develop operating procedures covering the validation of low acuity ambulance and A&E dispositions.

Operating procedures shall include, but not be limited to:

- A joint agreement between the NHS 111, 999 and CAS services with all relevant parties being named;
- A clear diagram showing the flow of calls expected with detail of individual roles at each step;
- A description of the clinical input – who, how, where, when (e.g. floor walker, NHS 111 clinician, GP OOH clinician);
- Clear descriptions of which CDSS disposition codes are expected to be transferred to the clinician (see guidance in Appendix C);
- Prioritisation method - how the call is passed and flagged to receiving clinician;
- Agreement on timelines for call backs;
- Protocol for management of breaches of call back times;
- Documentation on clear lines of accountability at each stage of the process;
- Clear data collection on numbers of calls being handled by a clinician and subsequent outcome;
- Measurement of true outcome (the recording of all clinician advice must occur in a way that identifies the clinician and is accessible / retrievable for subsequent review if required. It was suggested that if the facility to record this advice existed within the host system in a way that shows at what point in the process the advice was given this would be an additional advantage);
- Risk management processes at the sending and receiving end to identify (and if necessary conduct an enhanced handover - e.g. voice not just electronic) for patients felt to be higher risk than usual so that they are flagged within any clinical queue;
- The ability to evaluate outcomes of these systems (see above) and this must be shared to inform future developments;
- Audit practices for staff involved ( e.g. CQI or toolkit);and
- Participation in local IUC clinical governance and participation in call and end-to-end review if necessary.
- Record keeping (see section 5.3.1.5 and 5.3.8)
- Data sharing (see section 5.3.1.2); and
- Access control (see section 4.10).

### **4.4.3. Rapid Access to GP (star-line) – Clinical Support**

Urgent fast track access to a GP via NHS 111 offers a number of benefits:

## OFFICIAL–SENSITIVE: COMMERCIAL

- Evidence suggest that 60-80% of ambulance low acuity and A&E dispositions can be redirected to more clinically appropriate resources in the community;
- Rapid telephone advice (linking to separately commissioned in-hours GP or OOH GP visiting services) for care homes can help keep frail elderly patients in a safe supportive environment reducing the need for conveyance to hospital; and
- Early recognition of sepsis mitigating against the risk of GP surgeries being too busy to respond quickly to these cases (changes have been made to the NHS 111 triage algorithm to help pick up those patients who might have sepsis and the disposition will be speak to GP within 1 hour.

The desired outcome of these interventions is to offer better quality care closer to home by moving toward a “consult and complete” model.

The Provider shall provision 24/7 primary care response offering fast access to a senior CAS clinician for the specific purpose of:

- Validation of low acuity ambulance calls;
- Validation of ED dispositions;
- Rapid telephone advice to care homes (star-line);
- Direct referral for sepsis cases; and
- Other groups such as Ambulance crews and community services, to support the no decision in isolation principle.
- Having the ability to site professionals and/or virtually connect with other organisations e.g. Mental Health Professionals, Community Clinical Staff, specialist Palliative Care Nurses.

### **4.5. Operating Model - Face to Face Consultation and Treatment (Out of Hours Period)**

#### **4.5.1. Clinical Principles**

All calls that have ended the NHS 111 element of the service, either by early exit, patient journey, SOP or that require an out of hours clinician contact, where a home or base visit appointment has not already been booked, ideally will be warm transferred to the CAS for definitive clinical assessment by a senior clinician.

The senior Lead Clinician ideally should be a GP experienced in OOH and all GPs to be used in the service must be registered on the local performers List. Where the senior clinician is not a GP, the other clinicians that the service has decided to use, based on their internal clinical governance must be experienced in the provision of OOH care and have appropriate Health Care Professional clinical registration. Their use will be reviewed by the commissioner with support from the Integrated Urgent Care clinical governance group. At all times, where the senior clinician is not a GP as described above, they must have immediate telephone access to a GP in the service.

On receiving the warm transfer call/message from the NHS 111 element of the service the provider must ensure the clinician on speaking with the patient must record each call in the clinical system and complete a ‘Definitive Clinical Assessment’. This telephone assessment will result in the patient either being discharged from the service after the call with appropriate advice, signposting or referral to another service, recorded as the patient requiring an urgent face to face assessment or less urgent face to face assessment and

## OFFICIAL–SENSITIVE: COMMERCIAL

where this assessment should take place, either at base or at the patients location which will be within the geographical area covered by the CCG.

Patient consultations in a primary care centre or patients' homes must be started within the following timescales (subject to the NQR's), after a clinical assessment has been completed:

- Emergency within 1 hour
- Urgent within 2 hours
- Less urgent within 6 hours

In line with good practice, the Provider must have and adhere to a comprehensive Chaperoning Policy.

The clinician must in all cases record the reason for the decision and this is to be recorded in the clinical system and sent to the patient's registered GP practice following completion of the call.

The definition of an urgent appointment is to ultimately be decided by the senior clinician performing the clinical triage but the commissioner would expect the following to be dealt with urgently. However this list should not be assumed to be exhaustive;

- Severe pain where delay would cause unnecessary suffering.
- Breathing difficulties especially within infants.
- Bleeding minor wounds.
- Acute confusion
- Those at risk to self or others e.g. acutely suicidal
- Urgent requests from fellow colleagues who are with the patient e.g. health care professionals, carers, police, and paramedics.
- On discussion with patient where level of anxiety is such that a 999 call might be made if urgent response is not made.
- End of Life or palliative care patients who are distressed.
- That on review of the special patient note and speaking with the patient that would indicate that the condition of the patient is urgent.

A less urgent appointment should be deemed all other patients, who require a face to face assessment but are not considered to be urgent.

A 'definitive clinical assessment' that will enable the advising or treating clinician to develop an appropriate management plan in conjunction with patient and how this should be undertaken.

The patient or carer should receive telephone advice and where clinically appropriate should be seen by the most appropriate clinician in the most appropriate place i.e. an appointment at their local treatment/base centre or be designated for a visit at the patients' location.

Where any call backs are made from the NHS 111 element of the service or the CAS service under any circumstances the number the service is calling back on must be identified to the patient and must not appear on the receiving individual's handset as a withheld number. The number calling back should be identified to callers when a call back is required. Where the care plan states that the patients have specific needs, they must be warm transferred to the appropriate professional or specialist service, where available.

#### **4.5.2. Patients Requiring Out of Hours Care following a Call from HCP Line/CAS Intervention – Clinical**

The provider must ensure that where a call has been received from a healthcare professional the service will in every instance, through identification access the patient demographics to verify the existence or not of a SCR, SCRA, EPaCCS, Special Patient Note (as defined and operated by the CCG) and the Special Patient Note reviewed when undertaking the definitive clinical assessment.

The provider must ensure that there is a robust system for identifying all immediate life threatening conditions and once identified, those patients must be passed immediately to the ambulance service.

Where clinically appropriate, the Out of Hours clinician may direct the patient to a service and where possible book the patient an appointment for example:

- Emergency care via 999 call where the OOH clinician has not already spoken to the ambulance service on behalf of the patient.
- Visit an OOH base or arrange a home visit.
- Advised to attend their local A&E department or Urgent Care Centre or Minor Injury Unit.
- Attend their GP surgery on next working day.
- Signposting to a safe haven
- Other pathways available on the Directory of Services (DoS).

The provider will need to ensure that each hour or as appropriate, quality assure the urgent call list being for all classes of call or booked visit (base or home) requests, and the length of waiting time to ensure that it is meeting its operating standards and key performance indicators of a call back to patient within the most appropriate timeframes (see LQR section in schedule 4 of the contract) of exiting the CDSS system and a DX code relating to out of hours clinician.

Only in times of extreme pressure on the service, (which should have been reported to the commissioner through the providers escalation policy), if the patient does not receive a definitive assessment within the appropriate timeframe, from the point that the call is passed from NHS 111 element of the service, then a senior clinician must contact the patient or carer by telephone, as a matter of urgency and speak to the patient and decide the next course of action. As stated above this time period should be measured from the time of call exiting the CDSS system and a DX code relating to the requirement to speak with or be seen by an out of hours clinician.

Where face-to-face contact is not deemed necessary by the clinician then patients should be given clear instructions on self-management of their current problem, what to expect in terms of improvement and the timescale. They should also be advised on what to do if and when significant new symptoms develop.

All clinical notes of the patient interaction should be entered within the clinical system and sent to the patients registered GP immediately and no later than by 8am the following morning. An ongoing audit of the risk within this system should be undertaken

#### **4.5.3. Face-to-Face Consultation and Treatment - Clinical**

The provider shall offer a face-to-face consultation (primary care centre, or home visit) conducted by an appropriately trained clinician according to the assessed patient's needs. The use by the provider of a physical pre assessment will not reduce the patient journey time to be seen in any circumstance. In particular:

## OFFICIAL–SENSITIVE: COMMERCIAL

- The provider shall offer final assessment, diagnosis, treatment or treatment plan (in line with minimum clinical standards), or make arrangements for onward referral, follow-up or discharge.
- Prescribing of medicines as required in line with the commissioner prescribing formulary. All dispensed medicines must be analysed by registered practice code and these to be charged back to the patients practice and the provider to provide a list on a monthly basis by patient and by surgery. The provider system is to be tested during the mobilisation period.
- The consultation shall take place at a designated treatment centre/base closest or most accessible to the patient, agreed with the patient at the time of booking.
- Where appropriate the consultation can take place at the patient's location.
- Adequate medical supervision, by at least a registered nurse, must be available to all non-medical staff providing a service to a patient.
- The Provider must ensure that an appropriate chaperone is available.

The time from the patient appointment, to the patient being seen will be measured as stated in the minimum data set released with this specification.

The time from the appointment starting to discharge from the service will be described as the patient journey time from being seen to being discharged.  
Where an appointment at a base/local treatment centre is required this must be started within the total journey times stated.

The primary care centres should ideally be within a 30 minute drive/public transport for the patient. Where this is not the case, the GP/clinician booking the appointment must consider how the patient will access the base and where necessary consider a home visit instead.

Commissioners will review the optimum location for bases on an ongoing basis based on local demand profiles and urgent care commissioning developments.

The Primary Care Centres (PCCs) should ideally be situated in a location(s) accessible for the majority of patients utilising the service. The PCC(s) should have good transport links and local parking facilities for patients. The location(s) of the PCC(s) should fit with the strategic aims of this procurement as stated.

The commissioner and the provider will agree the operational hours of the PCC(s) according to activity flows and demands and decide on the level and type of cover to be provided and once agreed these will be varied into the contract. Staff rotas will be monitored as part of the contract monitoring process to ensure that patients are able to access a suitable level of OOH service. Flexibility and an innovative use of staff will be encouraged.

The Provider is required to have a full contingency plan/escalation procedure in place, to be implemented in the event of a major failure of the infrastructure of the provider's premises (telephony, electricity, fire etc.), as well as the ability to respond to more generalized/unpredicted peaks in demand.

Any PCC(s) shall operate on the following basis:

- The operating hours and location(s) of the PCC(s) may only change in agreement between the Commissioners and the Provider. A formal consultation process may be required if a PCC(s) location(s) were to change during the contract term.
- If NHS site(s) are to be used by the provider, the provider shall use the site(s) only in connection with the provision of the Services and shall ensure that the provider staff use the site(s) only for that purpose and in accordance with any lease agreement.

## OFFICIAL–SENSITIVE: COMMERCIAL

- A formal Heads of Agreement or occupancy license will be entered into between the hosting site(s) and the Provider. It is anticipated that rent and facilities management fees will be payable to the hosting site(s).
- A formal agreed escalation plan will be put in place for situations in which the service is unable to achieve stated quality measures.
- 

See **Appendix XX** for current rota patterns and Section 7 for current locations.

The patient record on the electronic clinical system will be kept up to date as the episode of care progresses.

Once at the base/treatment centre all patients should be seen within the stipulated timeframes outlined in the latest guidance. Where patients arrive late, their condition should be reviewed to see if their condition has worsened and seen in line with above.

The provider will collect and report the “Did Not Attend” per day, per location and report the summary to the commissioner on a monthly basis, excluding patient identifiable data. The commissioner may ask the provider to discuss non-attendance with the patients’ practice(s).

Each primary care centre will also contain appropriately staffed/trained administrative and driving staff (where appropriate/required.)

#### **4.5.4. Home Visits**

The provider shall provide a home visiting service to all patients for whom, following telephone assessment, and in the light of the patient’s medical condition and/or significantly difficult social circumstances (being ‘functionally housebound’), it would not be reasonable to expect them to be able to travel to a local base/treatment centre.

Home visiting must be undertaken by suitably trained, appropriate and experienced staff, who ideally should be a General Medical Practitioner. Use of appropriately qualified and registered healthcare practitioners as ‘mobile’ clinical assessors with direct contact to a supervising GP may be considered where protocols have been agreed in advance with the Commissioner. Nurses working in nursing homes and community hospitals can be used to provide assessments.

The Provider shall offer assessment, diagnosis, treatment or treatment plan and make arrangements for onward referral, follow-up or discharge and medicines as required and in line with the commissioners prescribing formulary/local guidelines which are on the Surrey Prescription Advisory Database PAD.

Where a home visit is required, this consultation must be started within the total journey times as in the NQRs section in schedule 4 of the contract. For reference an urgent home visit total journey time for clinician to start patient consultation at their home should be in accordance to the latest set of published KPIs.

Home visits may include, where appropriate, visits to patients with urgent medical needs in community hospitals, nursing homes and intermediate care centres as well as patients’ homes.

Home visits will occur where the NHS 111 disposition has deemed it clinically appropriate, for example where:

- Patients are at end of life
- Patients are ‘bed bound’
- Patients are ‘housebound’
- Patients are frail or vulnerable

## OFFICIAL–SENSITIVE: COMMERCIAL

- Patients for whom an immediate car journey could lead to an unnecessary deterioration in their condition or unacceptable discomfort or whose condition precludes travelling.

Where a home visit is deemed appropriate and has been agreed with the patient, the prioritisation of such is determined by clinical need. An OOH clinician will make such home visits within the operational periods however, all emergency and urgent cases requiring a 1 or 2 hour response must be seen regardless of the time of receipt even if this means that the consultation takes place outside the defined out-of-hours operating period.

In any event, a call that is deemed urgent in the opinion of the NHS 111 clinician will be undertaken in accordance with the relevant response time set out in the National Quality Standards

The provider will communicate with the patient or carer giving the anticipated time for a visit and will keep the patient/carer informed of any changes to the time (i.e. comfort calling). This will enable any changes to the patient's condition to be established and the response changed accordingly.

The home visiting service must also be available to the GP/clinician accepting calls from paramedics, care homes and to provide remote support to the CAS clinicians where/when required.

The provider will keep patient records and will add additional information as may be relevant following the visit.

Assessment and treatment will be provided at home wherever appropriate. If the visiting health professional requires access to more specialised assessment and/or treatment, emergency patient transport may be arranged to a treatment centre or to another health care facility as may be required.

Visiting health professionals will need to be able to personally administer drugs and / or provide prescriptions according to patient group directions where necessary. The patient record on the clinical system must be updated with details of the home visit, entered on to the clinical system for onward transmission to the patient's registered practice by no later than 8.00am the following morning.

The provider is encouraged to make links with the local team during mobilisation. The current home visiting rota is enclosed within **Appendix XXX**

The Provider must have a lone working policy in order to ensure that staff working in the out of hours service is able to do safely.

### **4.5.5. Prison visits**

The provider shall provide the services to the five HMPs listed in section 1.2. The provider shall agree an access protocol with the prison and adhere to the security requirements of the prison.

The Governing Governor or Duty Governor of each HMP has overriding responsibility for prisoners' welfare and may demand a visit from the provider, who must attend in accordance with and as soon as practicable following such request. NB visits to any one of the HMP's will be subject to NQR monitoring (but dependent on prison security clearance taking place in a timely but secure manner, to enable the visiting GP to have access to the patient). Usually, there are no access issues currently.

## OFFICIAL–SENSITIVE: COMMERCIAL

The provider will work in close liaison with the Prison Healthcare Services Manager and the CCG Lead Pharmacist for the Prison.

Special patient notes /palliative forms or EPaCCS will be used for prisoners who are palliative or have individual requirements.

The provider shall ensure that their staffs visiting the prison are aware that some prisoners will be on the Integrated Drug Treatment System (IDTS).

The provider shall prescribe medication that is clinical indicated according to the Out of Hours prescribing guidelines. There is no requirement to provide/participate in drug rehabilitation.

### 4.5.6. Out of Hours Intermediate Care and Residential Cover

The provider shall provide the service to any patient occupying a bed in a residential/care home, and intermediate care locations as detailed on mobilisation, or mental health/learning disability residential unit in the Commissioner areas, who is appropriately referred to it as requiring urgent clinical attention commensurate with that described in this specification during the out of hours period.

### 4.5.7. Vehicles

The service will ensure the availability of a sufficient number of maintained vehicles for home visits, equipped appropriately including communication equipment, satellite navigation equipment, and Wi-Fi access and suitably marked.

The service will have access to winter tyre equipped/4 wheel drive vehicles for use during winter and extreme weather conditions to ensure business continuity and all drivers should have the appropriate training for driving in adverse weather conditions and be competent to use the equipment on board the vehicle.

The provider will have an appropriate policy in place to avoid breaching timescales in the event of vehicle breakdowns.

### 4.5.8. Medical Equipment and Supplies

The provider shall provide medical and surgical equipment, medical supplies including medicines, drugs, instruments, appliances, and materials necessary for patient care which shall be adequate, functional, safe, fit for purpose and effective.

Both stationary and mobile clinicians will have access to:

- A basic doctor's bag which should include Stethoscope, Sphygmomanometer, Ophthalmoscope, Auriscope (with disposable speculates), Thermometer, Pulse Oximeter (appropriate for children and adults), Blood Glucose Monitor, Tape Measure, Tendon Hammer, Peak Flow Meter, Adult and Children's British National Formulary (BNF) and Catheters (Male/Female with associated items e.g. Local Anaesthetic Gel and Syringe).
- Basic diagnostics including urinalysis. All clinicians should be able to access the local pathology system to check for the results of previous investigations and also have the ability to request and send off microbiology specimens including MSU's, swabs and stool cultures as a minimum. Clinicians should also be able to access a defibrillator (Automated external defibrillator), a nebuliser and have access to oxygen. Clinicians should also be able to access an Electro-Cardiogram (ECG) machine (either at the bases or a portable monitor, with appropriate reading/interpretation service.)

**Comment [PSS]:** Is there also a requirement for some of the cottage hospitals? I am not up to date on their OOH cover. August 2017: Surrey GP OOH do also cover some cottage hospitals but the workload is light. They also accept to cover all CHs where the usual medical cover is unavailable or on holiday.

## OFFICIAL–SENSITIVE: COMMERCIAL

- Materials for management of minor injuries and lacerations should be available and be used by all clinicians at bases and home visits, within the competencies of that clinician in order to reduce the need for a second clinical contact with another professional for simple wound management.
- Medicines and controlled drugs for emergency use (these can only be in a locked cabinet at the OOH base). The transport of Controlled Drugs in cars must meet the Controlled Drug Legislation.

The provider shall establish and maintain a planned preventative programme for its equipment and make adequate contingency arrangements for emergency remedial maintenance.

### **4.5.9. Near Patient Testing**

The service will be expected to have in place the ability for clinical staff to conduct near patient testing to aid in the diagnosis and clinical management of cases. It is expected that these will be available at all Out of Hours bases and in visiting cars where appropriate. The provider will be responsible for developing clinical pathways for their staff and also train the relevant staff in the use and interpretation of these tests.

The provider is expected to establish and agree with the commissioner the various types of testing offered, but will include:

- Blood glucose
- Urinary WBC and protein
- Basic respiratory function tests/Peak flow
- D-Dimer analysis
- Beta HCG

### **4.5.10. Pathology**

The service will be expected to have in place a documented and robust process for receiving any abnormal urgent pathology results in the out of hours period including those reported to GP practices within 15 minutes of GP surgeries contractual closing time. The provider to have communicated with all required stakeholders the process for receiving these pathology results and the provider to accept responsibility for performing the appropriate clinical actions regarding these received results.

The provider is expected to establish, agree with the commissioner and then document and distribute to all required stakeholders specific pathways for certain pathology results reported in the OOH period which may include results such as raised K, low Na, anaemia. Health professionals within the service will be expected to use pathology services in line with local guidance.

Where possible, Health professionals should have access to local pathology systems enabling them to review the results of previous pathology test results of a patient.

Health professionals should also be able to request other tests and investigations in line with locally agreed policies.

### **4.5.11 Medicines Management**

Prescriptions for acute illnesses must adhere to current local or national guidelines for safe prescribing ensuring that a medical history, medication and allergy history have been obtained. A stock of medication will be available for conditions that need immediate

## OFFICIAL–SENSITIVE: COMMERCIAL

treatment and when local pharmacies are closed. The Provider's stock list will be jointly agreed with the Commissioner during mobilisation. All prescribing, whether from stock or on FP10 needs to be in line with local guidance and following advice on the Surrey Prescription Advisory Database (PAD) (<http://pad.res360.net>).

Patients may be advised to obtain over the counter medicines, where this is appropriate.

There is no provision for the supply of drugs for the treatment of addiction from the service.

The provider will ensure that all activities related to the storage, supply and labelling of medicines adhere to current legislation and regulations, including the Human Medicines Regulations 2012 and the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

The provider will only prescribe in line with the NHS standard contract for this service and comply with these provisions and any others outlined in the APMS contract detailed in **schedule 2L** of the contract.

### **4.5.12 Detailed prescribing**

The CCG shall exercise its powers under section 83(2) of the 2006 Act (and where amended) so as to ensure that recipients of out of hours services receive without delay from the provider any necessary drugs, medicines and appliances that the patient requires and for which, in the reasonable opinion of the provider, and in the light of the patient's medical condition, it would not be reasonable in all the circumstances for the patient to wait until such time as they could obtain them during core hours.

The Commissioner will separately fund the stock of drugs and for prescriptions on an FP10. The Provider will invoice the Commissioner on the agreed % share/split. The Provider will be required to meet and review prescribing on a quarterly basis.

### **National Health Service Act 2006**

83 Primary Medical Services

(2) A Primary Care Trust may (in addition to any other power conferred on it)<sup>3</sup>

(a) Provide Primary Medical Services itself (whether within or outside its area),

(b) **Make such arrangements for their provision** (whether within or outside its area) as it considers appropriate, and may in particular make contractual arrangements with any person.

<http://www.legislation.gov.uk/ukpga/2006/41>

### **4.5.13 Regulatory Compliance**

The provider must comply with section 83(2) (b) of the 2006 Act and where amended and implement safe and robust systems to ensure that it:

---

<sup>3</sup> Clinical Commissioning Group since 2013

## OFFICIAL–SENSITIVE: COMMERCIAL

- Provides only necessary drugs, medicines and appliances by out of hours performers and authorised prescribers.
- Provides a complete course of antibiotics when required and prevents the supply by an out of hours performer of drugs, medicines and appliances which that out of hours performer could not lawfully supply; and
- Appliances which are not listed in Part IX of the Drug Tariff.

### **4.5.14 Medication**

In relation to medication the provider must:

Adopt and comply to an agreed out-of-hours formulary based on local and national guidance ([http://www.out-of-hours.info/downloads/short\\_medicines\\_guidance.pdf/guidance](http://www.out-of-hours.info/downloads/short_medicines_guidance.pdf/guidance)) and those elements detailed on the Surrey PAD <http://pad.res360.net> that are designed to meet the majority of out of hours medication needs (including agreed palliative care drugs).

Through access to the Directory of Services, and other accessible sites, such as commissioner websites hold local information regarding out-of-hours pharmacy services where they are available and will direct patients to these services as needed.

Purchase, store, supply, administer, and dispose of medicines in a safe, secure manner and in accordance with current legislation, licensing requirements and best practice.

Operate systems to permit continuity of care with daytime services in relation to prescribing.

### **4.5.15 Preferred Supply of Medicines**

Supply of medicines via pharmacy (or dispensing doctor) remains the preferred approach even during the out-of-hours period. Where this is not practical, the out-of-hours Provider will need to make alternative arrangements. The Provider must agree the service approach with the designated commissioner Medicines Management lead, which may include pre-packs and the inclusion of the electronic prescription service.

### **4.5.16 Medicine Management Policy**

The provider shall have a documented and auditable Medicine Management Policy for medicines, including controlled drugs in line with NHSE Guidance and other national guidance.

### **4.5.17 Out-Of-Hours Formulary and prescribing:**

The provider will ensure that prescribing follows the current policies and guidance of the CCG and ensure the safe and legal storage, dispensing and disposal of medicines and prescriptions. Local decisions on medicines can be found at the Surrey Prescription Advisory Database (PAD). <http://pad.res360.net>. The commissioner will monitor non-formulary prescribing and may challenge this to ensure the appropriateness of prescribing.

The Commissioner will not normally expect the provider to provide repeat prescriptions unless deemed clinically necessary e.g. a patient who has run out of anti-convulsive medication or insulin, or the provision of contraceptive medication where it is deemed unacceptable for the patient to wait to see their GP.

The provider may be advised by the on-call Consultant in Public Health to request prescriptions for the control of communicable diseases, or in a public health emergency. In this instance, the provider will be required to use a PSD for any localised community outbreak of influenza in the out of season period requiring antiviral medicines as advised by the Commissioner/Public Health Consultant.

#### **4.5.18 Antibiotics Formulary**

Prescribing of antibiotics should take account of the need to avoid the development of resistance and the development of healthcare associated infections. The provider must ensure that out-of-hours service takes account of the CCG antibiotic formulary, which is available on the Surrey PAD (<http://pad.res360.net/PAD/Search/DrugCondition/249>) and is in line with the Public Health England antibiotic guidance for primary care 'Management and treatment of common infections' and local resistance patterns when selecting antibiotics. A complete course must be prescribed and full details provided to the patient's GP.

#### **4.5.19 Labelling**

The provider's Medicines Management Policy must include a procedure for the safe supply of medicines out-of-hours in appropriate quantities for the specific condition being treated and comply with relevant legislation on packaging, labelling and patient information leaflets. Manufacturers' original packs should be used wherever possible.

The provider will supply a full course of treatment only where clinically appropriate to the presenting condition. The use of starter packs is not appropriate.

#### **4.5.20 Systems**

The provider must comply with all national standards applicable to out-of-hours services (including the local service quality requirements for this service). These standards include a requirement to put in place mechanisms to purchase, store and supply medicines in line with current legislation, licensing requirements and good practice. The Provider must ensure that these standards are met with robust auditable systems.

The provider must comply with legislative standards including applicable Department of Health and NHSE guidance, policies and procedures.

#### **4.5.21 Pharmaceutical Advice**

The provider should ensure during the hours of operation of the service and when the pharmacist is working in the Integrated Urgent Care service that appropriate patients are able to receive the benefit of the advice of a pharmacist, although this need not be face to face. The Pharmacist will be based in the CAS or have remote working access.

The provider will need to ensure that all health professionals are able to access appropriate levels of pharmaceutical advice in the out-of-hours period and ensure that systems are in place for those rare occasions where it may be necessary to call out a pharmacist.

Where alternative arrangements for supply are used, both patients and the health professionals involved should, where appropriate, be able to receive the benefit of the advice of a pharmacist within the 111 call centre and/or CAS.

#### **4.5.22 Palliative Care**

The palliative care policy must be fit for purpose and ensure:

- Safe medicines management when using palliative care medication.
- Specific reference to Controlled drugs (CD) transportation and continuity of supply.
- Safe access to CDs by clinicians.

## OFFICIAL–SENSITIVE: COMMERCIAL

- Effective working with specialist palliative care nursing and with palliative care patients as described in section 4.2.11.
- Adequate training of clinician and staff is included to comply with palliative care policy.
- Standards are evidenced and audited.
- Ability to access the full range of EoLC medication and syringe drivers

Specific advice from Macmillan nurses and palliative care specialists has been shown to be particularly valuable. Where these do not exist, the provider should seek to develop sources of expertise in palliative care as part of their broader palliative care strategy.

The provider must have in place a policy and procedure to deal with the supply of medicines to palliative care patients in the community, whose condition deteriorates or changes rapidly. The policy must comply with regulations to deliver urgent drug intervention and ensure that the clinician has appropriate training and systems in place to access drugs (including controlled drugs) and a good understanding of the treatment they are administering. Providers should familiarise themselves with the Surrey wide Community Pharmacy scheme for the on demand availability of drugs for palliative care.

As detailed in the patient journey, the provider shall ensure that a GP is available at all times during the Out of Hours Period to visit terminally ill Patients as clinically necessary, based on the SPN and that the service will send a GP for a home visit and will attend the patient immediately in the case of uncontrolled severe symptoms e.g. pain, nausea and vomiting and agitation.

### 4.5.23 Controlled Drugs

Changes and improved governance have been introduced and encompass all healthcare professionals and responsible individuals that handle controlled drugs. The OOH provider must make arrangements to ensure the safe management of controlled drugs in line with the legislation, and be able to demonstrate this. NHSE has a duty to investigate any concerns. However, the provider should have their own controlled drugs standard operating procedures including controlled drugs register and secure cabinet and incident reporting procedures. The provider must liaise with the NHSE (Central Midlands) CD Local Intelligence Network. Any concerns about controlled drugs that they have, or may encounter, must be reported to the NHSE CD team ([England.centralmidlands-cd@nhs.net](mailto:England.centralmidlands-cd@nhs.net)).

“The Controlled Drugs (Supervision of Management and Use Regulations 2006” (last updated in 2015).

The provider's Medicine Management policy must include the quality assurance process for the safe storage, access and administration of controlled drugs. This policy must clearly detail the documents, procedures and audit trail to comply with the nationally recommended practice.

Doctors and pharmacists are legally permitted to possess and supply controlled drugs when acting in their capacity as such. As long as a doctor or a pharmacist undertakes the ordering and handling of such drugs, an organised provider does not require a licence. However, if these duties were to be undertaken by anyone else (e.g. an administrator) a provider(s) (including the out-of-hours Provider) would require a Home Office license. The regulatory framework which governs controlled drugs can be found at:

<http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Prescriptions/ControlledDrugs/index.htm>

The provider must have an appropriately identified officer who is accountable for controlled drugs who should attend their CD Local Intelligence Network.

The provider must ensure that incidents involving controlled drugs must be reported immediately to the NHSE CD Accountable Officer [England.centralmidlands-cd@nhs.net](mailto:England.centralmidlands-cd@nhs.net).

#### **4.5.24 Prescriptions forms**

Where medicines are supplied direct to patients, the Provider should arrange for each supply to be recorded on a standard supply form (FP10PREC), which includes the provider's unique code.

The provider must submit FP10PRECs to the NHS Business Services Authority monthly, allowing the PPD to produce reports for the CCG and the provider, similar to that for other NHS prescriptions.

FP10 usage will only be for those medicines within the approved formulary and the provider is expected to remain within the agreed indicative prescribing budget during the contract period. It is expected that the contract envelope will exclude prescribing. The provider will be able to monitor FP10 prescribing using ePACT (a database held by the NHSBSA <https://www.nhsbsa.nhs.uk/epact>).

#### **4.5.25 Prescription Pad Security**

For guidance on the security of prescription forms and best practice guidance for stock control at the stages of ordering, delivery, receipt, storage and distribution of prescription forms, please click on the following link:

[http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/Security\\_of\\_prescription\\_forms\\_GUIDANCE\\_March\\_2011\\_FINAL.pdf](http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/Security_of_prescription_forms_GUIDANCE_March_2011_FINAL.pdf).

The Provider will meet and maintain this guidance.

#### **4.5.26 Prescription Charges**

The provider must ensure that mechanisms are in place for collection of prescription charges and declaration of exemption status.

The NHS (Charges for Drugs and Appliances) Regulations 2000 were amended by April 2005 to ensure that the normal rules for prescription charges apply to medicines supplied (rather than dispensed) as part of primary medical services.

The charges that should have been collected will be deducted from the payments made to the Provider, where applicable for drug costs.

#### **4.5.27 Drug Costs**

The FP10PREC prescribing costs will be excluded from the contract price; a separate indicative budget will be set by the Commissioner for FP10 prescribing at mobilisation.

Prescriptions should whenever possible be written generically to ensure cost effective prescribing following local guidance.

The provider will be allocated an indicative drugs budget which is excluded from the contract envelope and will be monitored on a quarterly basis to cover the costs of FP10 prescriptions, which will be monitored jointly via regular meetings with CCGs Medicines Management Team and the provider's pharmacy lead. The provider is expected to stay

## OFFICIAL–SENSITIVE: COMMERCIAL

within the allocated agreed amount. The provider will be expected to provide directly purchased and administered drugs from within the allocated sum.

Any variation from this allocation will be reported immediately and necessary action agreed between the Provider and the Commissioners.

### **4.5.28 Patient Safety - Medicines**

In line with advice and escalation plans, the Provider must have set up their own system for the receipt of Chief Medical Officer (CMO) cascade alerts, safety alerts for drugs and devices and for other emergency communications from the CCG and Public Health England. The contact number and e-mail address for the Provider must be made available to those on call for ENH and HV CCGs and the provider.

Any incidents involving medicines must be reported immediately to NHSE and ENH and HV CCGs, following the established policies and procedures.

The Provider must comply and is accountable for ensuring that they receive, risk assess and implement all necessary actions in relation to patient safety information within required timescales e.g. NHSE Central Alerting Systems (CAS); MHRA guidance and alerts; DH patient safety guidance.

### **4.5.29 Use of sub-contract or outsourcing**

The success of the model will be dependent on a transparent working relationship between the parties, particularly around the performance of the provider and any sub-contractors that are used. Whilst commissioners would not wish to enter into any direct relationship with a sub-contractor of the provider, commissioners should be advised of any sub-contracting arrangements and will hold the NHS 111 provider to account for the delivery of the overall contract (including but not limited to enabling access to SPNs by sub-contractors as necessary). Providers will be responsible for ensuring timely and robust reporting from any of their sub-contractors used.

In order to work together collaboratively, the organisations (i.e. the provider, sub-contractors and commissioners) will be expected to:

- Make a sincere effort to understand the other organisations' obligations, goals, expectations, duties and objectives in entering and performing their operational obligations under the contract;
- Be just and open in all dealings relating to this to the contract, and to give a true account of such dealings;
- Work at all times within a spirit of co-operation to ensure the delivery of the service to a high standard;
- Communicate clearly and effectively, and in a timely manner, on all matters relating to the performance and contract;
- Make the most efficient use of resources;
- Make every endeavour to ensure that all people engaged on the contract diligently and faithfully employ themselves to bring about its performance to a high standard;
- Give an early warning to the other organisations of any mistake, discrepancy or omission of which either partner becomes aware, and offer fair and reasonable solutions where practicable; and,
- Give an early warning to the other organisations of any matter that they become aware of, that could affect the achievement of any objective, obligation, or the like contained in the contract.

The performance review will be designed to ensure that all parties, including subcontractors, are fulfilling this specification as well as local and national standards. Any review would then cascade expectations and KPI's from the specification to those subcontractors.

#### 4.6. Directory of Service (DoS) & Capacity Management

A service directory that can provide accurate, real-time information to users is of paramount importance to the success of IUC. It is a key enabler to achieving 'channel-shift' by promoting alternative pathways to acute emergency and primary care services. It should be seen by urgent care commissioners as the cornerstone workflow engine of their IUC provision: driving clinically and financially efficient outcomes for patients; informing commissioners of optimal service design, and; subject to a robust governance process.

The Provider shall link to and use the NHS Directory of Services (DoS) for access to information regarding all commissioned healthcare services across England.

The NHS DoS identifies:

- Where services are situated;
- When those services are open;
- The staff and skill sets they employ;
- The types of clinical presentations they are commissioned to respond to;
- The referral method they accept;
- The patient cohort they accept; and
- Service capacity.

The DoS system (database and search functionality) is commissioned centrally by NHSE and delivered by NHS Digital. However, the responsibility to maintain the data held within it, in accordance with both nationally specified standards and local requirements, resides with the Commissioners working collaboratively with other commissioners such as NHSE, Public Health England and Local Authorities. Full responsibilities are outlined in the DoS Roles and Responsibilities document (see Appendix J).

The DoS is partitioned into local directories, which together form one national database. Thus accurate information about services in any part of England can be accessed from any other area, enabling enquiries to be serviced from anywhere in the country.

There is a requirement for the Provider to also work with the regional DoS lead to develop the local DoS, dispositions and work with GP practices, pharmacists, dentists amongst other services to increase awareness and usage.

The mandated Commissioners requirements listed below will be met by the nominated dedicated DoS Lead for Surrey and will liaise/work in conjunction with the Providers nominated DoS Lead:

- Establish a named role or contact from all NHS services that is responsible for validating their DoS entry with the DoS workforce (in terms of demographics, opening hours, capacity and clinical releases), incorporated within Service contracts.
- Ensure arrangements are in place for all DoS entries to be accurate and up-to-date at all times across the 24/7 period 365 days a year.
- Promote the DoS Provider and Commissioner Helpline number (0300 0200 363) to all stakeholders requiring the ability to request changes to DoS at any time across the 24/7 period 365 days a year.

**Comment [RL9]:** These are effectively all being met at present. However, Surrey has only 1 x part time DOS lead which may need increasing to meet these requirements.

## OFFICIAL–SENSITIVE: COMMERCIAL

- Ensure that an expert and well-trained DoS workforce is available to engage with all providers and service commissioners in order to help them describe their services in DoS-specific terms, and to effectively maintain and update systems providing access to their service information (including but not limited to updating, profiling and ranking changes).
- Ensure that their DoS workforce has undergone a programme of appropriate training for the role and that they partake in regular educational/updating sessions at both regional and national levels (including but not limited to Advisor level CDSS training).
- Ensure the ranking and profiling of service returns on the DoS is in line with national strategies: on providing care closer to home at lower-acuity and lower-cost specialist settings, reserving emergency locations of care for those patients that truly require them.
- Ensure that the DoS workforce employed to maintain service information meet the specific requirements of the DoS Resource Guide and / or produced the desired outputs (Appendix E).
- Make conjoint arrangements with outside agencies (for example, a Local Authority) to enable the addition of services from social care, mental health, public health, community providers and third-sector services so as to improve accessibility for patients to these services.
- Ensure that service information collected from social care, mental health and the third sector is consistent with the quality of data collected from NHS services in terms of accuracy and timeliness.
- Ensure that the access to service information for services within and outside the NHS is completed without duplication across directories.
- Ensure that adequate resource is allocated to testing of service information returns to providers following profiling changes and/or CDSS upgrades (including but not limited to well documented clinical sign off by CCG Clinical Leads and responding to service improvements identified during live operations or as a result of improvement initiatives).
- Work with the local IUC provider and other associated providers to ensure that follow up information is available to the person calling the IUC service by (for example) text message or e-mail confirmation with details of the service.
- Ensure that regularly updated Standard Operating Procedures are in place for managing the day-to-day access to service information, business continuity in the event that service information cannot be accessed, and approaches to handling calls where access to service information does not correctly link to the CDSS. (Where national initiatives provide solutions to continuity of access to service information, work with its providers to support these initiatives).
- Implement operating procedures to enable the capture of feedback from IUC Service staff relating to improvement of access to service information.
- Ensure their DoS entries are configured to respond to specific patient requirements (e.g. frailty, domiciliary services and GP Choice).
- Adhere to the requirements of the nationally agreed DoS Profiling Principles and the DoS Quality Review (see Appendix E), as specified by NHSE (Appendix E).
- Ensure the Provider's clinical systems are in line with the IUC Technical Standards in terms of nationally specified standards on data collection and provision, rejection analysis and DoS display screens.
- Ensure callers requiring public sector services outside the scope of IUC will be signposted to an alternative service or single point of access through the DoS.

### 4.7. Workforce

The provider must prepare and present to the commissioner detailed workforce modelling (including all grades of labour) hour by hour across each 24 hours for

## OFFICIAL–SENSITIVE: COMMERCIAL

weekdays, weekends and bank holidays. This detailed modelling should be tested and flexed to enable the provider to meet the local requirements for access and patient journey and national/local quality and operational requirements of the Integrated Urgent Care service. This workforce modelling is to include all staff in the 111 centres, in the CAS, at GP OOHs bases, in cars and in admiration and floor walking. When modelling and planning these should also be aligned to the statutory responsibilities of Health Education East of England where possible.

### **4.7.1. Introduction and underlying principles**

The IUC CAS / NHS 111 Workforce Blueprint is expected to be published by early 2018, which will set the key guidance and standards for the IUC workforce. NHSE will continue to work with commissioners during the implementation and delivery of the Workforce Blueprint. The Successful Provider will implement the Blueprint requirements to:

- Define the optimal composition, scope of practice, competencies and associated development needs in the NHS 111 environment;
- Develop a career framework for clinical and non-clinical roles;
- Develop standardised competency-based job descriptions for patient-facing roles Skills for Health Levels 2 to 7; and
- Identify core and specialist competences for Skills for Health Levels 7 to 9 roles within the CAS.

These will provide uniformity amongst the workforce, whilst allowing local flexibility across the country.

The provider should use available local historical and planned data, utilising a recognised queuing theory model, staffing levels, skill mix and deployment of staff and non-staff resources across the service and at each OOH base and for telephony and face to face based services. The staffing levels should be sufficiently resourced, with at least 10% increase built in to meet daily demand in all areas of the service, hour by hour and to have resilient plans in place for increasing access to resources in the event of surge in demand.

The Provider will ensure that appropriate staff induction processes are in place. On commencement of employment the employee will:

- Keep up to date and introduce innovation through knowing about, having access to and protected time to take part in a range of learning activities. These will include web based e-learning resources, regular small group learning with peers and in teams, and a programme of large group study sessions. Completion of involvement and necessary actions will be recorded.
- Improve the quality of performance through - reflection, case reviews, audit, and analysis of incidents, adverse incidents and complaints.
- Receive feedback from patients and colleagues about what they think about the individual's performance.
- Undertake an annual appraisal incorporating Professional Development Plan.
- Have opportunities to develop a career as an Integrated Urgent Care worker.
- Have opportunities to teach Integrated Urgent Care (NHS 111, OOH and Multi-disciplinary CAS) colleagues.

## OFFICIAL–SENSITIVE: COMMERCIAL

- Near patient access to local and national protocols, pathways, guidelines and other information resources which can inform clinical decision making.
- Work in a physical environment that supports learning.
- Feel part of a learning organisational culture that aspires to excellence in training and a better educational experience for the entire workforce.

During recruitment and thereafter the Provider must identify and undertake DBS checks on any staff that are eligible in accordance with the National Disclosing and Barring Service Guidance and also CQC standards/guidance in relation to this. In addition if any agency or Locum staff are utilised, for whom annual checks (administered by the agency) may be appropriate, the provider must get written confirmation from the agency that a satisfactory check has been received.

All staff training should include NHS Constitution values and behaviours and these should be incorporated into training, appraisal, recruitment and surveys of staff.

The provider must have a comprehensive health and safety policy for the organisation and up to date risk assessment at all places where staff work that complies with the Health and Safety at Work regulations (1992) and the act 1974. There must be a named Responsible Person for the organisation. The organisation policy and training for staff to cover risks, improvements, occupational health, working time regulations, consultation and counselling, safety audit, accident reporting, fire training, and record keeping as a minimum. The list should not be considered exhaustive.

### **4.7.2. Non-clinical telephone/remote workforce**

Staff should work as part of multi-disciplinary team and must have access to an experienced GP via the CAS at all times. The nominated Clinical Lead must be on a performers list, and would be responsible for organising the work of that team within their geographically defined area. The team across the service should include trained and CDSS licensed Health Advisors, Nurses, Dental Nurses, Administrators, Pharmacists, GPs, GP Registrars, GP Fellowships, Nurse Practitioners, District Nurses, Emergency Care Practitioners/Paramedic Practitioners, Health Care Assistants, Advanced Practice Professionals, including Paramedics and may additionally include Mental Health professionals, Optometrists and other professionals supported by Receptionists, Drivers, Administrators and Management including Floor Walkers, Shift Leaders, and Leads for all functions. The number of staff should be sufficient to deliver the standards set out in this specification and in line with the workforce modelling requirements and appropriate Health Care Professional registration/Professional Body requirements.

All staff must be suitably qualified and experienced to undertake the work they do and a minimum competency required. This will be monitored by the agreed governance processes including audit and call reviews.

### **4.7.3. Clinical telephone/remote workforce**

The Commissioners would like to encourage workforce rotation through the IUC and other providers across urgent and emergency care to maintain and develop their skills and foster knowledge sharing (where possible), acknowledging that working in the remote/telephone environment requires specific competences.

All clinical staff must be trained in line with the CDSS used in the operational service. However, their practice must not be restricted to solely operating within the scope of the CDSS. In addition their practice outside of CDSS must include the necessary specialist

## OFFICIAL–SENSITIVE: COMMERCIAL

competences and capability to work safely and effectively within the remote urgent and emergency care environment.

The IUC CAS/NHS 111 clinical workforce will require specialised skills and competences in remote telephone assessment as defined in the forthcoming Workforce Blueprint.

Where staff work remotely, they must be able to access up-to-date medical records and to record their findings and actions therein.

### **Each GP in the service must:**

- All have been DBS checked in accordance with the National Disclosure and Barring Service Guidance.
- Have performed shifts in England in the last two months (or if not, then work in a supervised capacity) and where applicable be on the local GP Performers List, the Service must confirm this by written confirmation from NHSE regional office that administer and control access to the list.
- Where the GP has not gained their medical qualification in an English speaking country the Service must ensure that an appropriate IELTS level 7.5 language certificate is provided (obtained within the last 2 years) or obtain alternative proof of an equivalent level of language competence. The commissioner is aware that this is a requirement for admittance to the local performers list.
- Have been identity checked by the service provider. The service must ensure that all original documentation, including liability is checked prior to the GP's first shift and that all training is delivered and passed prior to first shift.
- Have been interviewed face to face by the Provider to establish their competencies in providing working within the NHS 111, CAS and/or out of hours elements of the services. These interview notes to be available to the commissioner on request.
- Have completed a detailed induction session with the service on the Directory of Services, use of z-codes, local Surrey policies, pathways and formulary and procedures including all adult and child safeguarding level 3 as a minimum.
- Have completed a minimum of one session of service supported by a GP trained and qualified to supervise in a call centre and in a base during out of hour's services, before being allowed to operate unsupervised. An appropriate further assessment should be carried out and supervision must continue if any concerns are identified.
- Meet the requirements of the latest medical revalidation.
- Hold the appropriate level of indemnity insurance coverage as an individual as detailed by the commissioner and the provider to reflect the work and the number of shifts being undertaken.
- Should any staff be provided by an agency, it is not satisfactory for the provider to rely on or expect an agency to have performed any or all of these checks and therefore the responsibility remain with the provider, prior to work starting. All checks must be suitably documented and auditable by the service.
- Undergo regular audits of work as defined by the providers Medical Director.

### **Other Clinical staff:**

- Have been DBS checked in accordance with the National Disclosure and Barring Service Guidance.
- All health care professionals employed must have a valid registration with their national professional body together with any further specialised training in telephone triage / consultation skills.
- All nurses must meet the NMC revalidation requirements from April 2016.

## OFFICIAL–SENSITIVE: COMMERCIAL

- In addition, all staff should receive a communication competency assessment prior to employment.
- These to be audited by the provider and a report to the Commissioner on a quarterly basis for all staff.
- The provider will operate approved continuing professional training and education for all staff and will be responsible for meeting all statutory and NHS human resources legislation and guidance. (Including Safeguarding to Level 2 and information governance).
- All clinicians should receive quarterly feedback on their performance, including standardized feedback on consultation, compliments and complaints.

All staff must be suitably qualified and experienced to undertake the work they do. Their competency will be monitored by the agreed governance processes including regular audit and call reviews.

### **4.7.4. Staff Mental Health and Wellbeing**

The wellbeing, mental health and career development of the IUC CAS/NHS 111 workforce is very important. The interventions required to support this range from appropriate levels of remuneration; support and development for staff both professionally and in respect of their mental health and wellbeing through the use of the Employee Assistance Programmes. The Provider shall ensure that:

- NICE guidance on promoting healthy workplaces is implemented<sup>4</sup>;
- There are systems and processes in place to manage down staff turnover, maximise retention and encourage staff satisfaction;
- Interventions such as Mental Health First Aid, Mindfulness, Schwartz rounds or accredited equivalent are considered for implementation.

In order to encourage retention of clinical and non-clinical staff, the Provider shall carry out an annual staff survey to assess the wellbeing of the workforce and identify where they need to invest to develop their organisation. This can be through taking part in the NHS annual staff survey as mandated, or through a bespoke annual staff engagement survey. This should include questions that assess:

- Whether staff feel their work is worthwhile
- Whether staff feel happy and proud of their work in the service
- Whether staff feel supported in their work.
- Organisational culture
- Whistleblowing

Employee pulse surveys are also recommended for continually assessing staff engagement. Staff engagement is linked to patient care and therefore measures of overall patient care and quality should be seen as indirect measures of the impact of the staff engagement strategy.<sup>5</sup>

### **4.7.5. IUC Clinical Assessment Service (CAS) workforce**

The IUC CAS workforce will comprise generalist clinicians such as Paramedics, Nurses and GPs as well as specialised clinicians from a range of professions and disciplines, including mental health, dental health, midwifery, pharmacy and paediatrics.

---

<sup>4</sup> NICE: *Mental wellbeing at work*: <https://www.nice.org.uk/Guidance/PH22>

<sup>5</sup> NHS Employers: How to develop a staff engagement strategy <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/staff-engagement/staff-engagement-resource-library/briefings-and-guidance/how-to-develop-a-staff-engagement-strategy>

The competencies that will be required to deliver the service are being identified in response to the needs of service users and the services available for publication as part of the Workforce Blueprint.

IUC CAS clinicians may be based within the IUC CAS physically or virtually. It is feasible, therefore, that some professional groups will be directly employed by providers, others will be contracted in or work from other provider organisations, utilising a range of mechanisms, including secondments or honorary contracts.

All clinicians working within the IUC CAS need to be supported and appraised to provide a consistently high quality service to patients and service users. They will be expected to successfully complete the Providers recruitment, induction and training programmes (where applicable.)

#### **4.7.5.1. Potential Skill Mix**

An IUC CAS will typically comprise of a range of clinicians offering different clinical skills, including: GPs; pharmacists; mental health nurses; dental nurses, allied health professionals and specialist hospital clinicians, which could include Social/Care services, Advanced Nurse Practitioners, Physician Associates etc. Other than for GPs performing the Clinical Navigator role, the skill mix in the IUC CAS will be for the provider to propose and agree with the Commissioner.

The Provider shall develop a workforce strategy, to be agreed by the Commissioner, taking into account the following principles:

- Integrated working across the current workforce deployed within NHS 111 and OOH services;
- The ratio and composition of the workforce in the IUC CAS must be flexible by hours and days, in order to meet the patients' needs and demands on the service;
- 24/7 GP presence is a key requirement of an IUC CAS to enable the Clinical Navigation function;
- Increased closure of calls by clinical consultation, involving assessment and advice to decrease face to face assessments;
- Faster, better access for patients to an appropriate clinician; and
- Medical and non-medical prescribers must have access to the appropriate prescribing capability, e.g. electronic prescription service, to support access to medicines where clinically required (see section 4.13.1: Prescribing).

#### **4.7.5.2. Audit**

The Provider shall develop and utilise a standardised audit system for ALL clinical staff which supports good governance.

All Clinicians must receive regular, at a minimum quarterly feedback on their performance, including standardised feedback on triage, clinical decisions, treatment and complaints. This is in addition to review of incidents, near misses and serious incidents.

Audit forms part of good governance and staff support, and the Provider shall implement the recommendations within the Workforce Blueprint product around governance when published. See section 6.3 for further detail.

#### **4.7.6. IUC CAS / NHS 111 Workforce Blueprint**

The IUC CAS / NHS 111 Workforce Blueprint will be published in early 2018 as a key resource for commissioning the workforce, planning and governance.

## OFFICIAL–SENSITIVE: COMMERCIAL

The Provider shall implement these products as a key element of the IUC service. Where a product does not exist, there is a requirement for Commissioners and Providers to ensure that best practice is implemented.

The Blueprint will include the following products:

1. Career Framework; competency based job descriptions Skills for Health Levels 2-7
2. Core and specialist competencies Skills for Health Levels 7-9
3. Apprenticeship scheme
4. Workforce Governance Guide
5. Workforce Mental Health and Wellbeing
6. Accreditation of education and training
7. Leadership development
8. Workforce modelling
9. Career of choice
10. Workforce Survey Recommendations Report

During the development of the Blueprint products commissioners and providers must remain clearly sighted on the quality, composition and competence of the existing workforce. Specifically, that all staff working within IUC call-centre services, including the CAS, must have an appropriate level of understanding and competence in telephone/remote practice/consultation, the use of the CDSS systems, and knowledge of the wider urgent & emergency care system, to ensure a consistently safe and high quality service for patients.

#### **4.7.7. Recruitment, Retention and Vacancies**

Recruitment and retention remains a key challenge across the current workforce. A number of the workforce products are aimed at creating a sustainable workforce through implementing a clear career structure with the development of competences and access to appropriate education and training, and to supporting a resilient workforce through mental health and wellbeing initiatives. The Commissioner and the Provider shall develop relationships with local HEE teams and LWABs to ensure that system-wide workforce planning is implemented.

The Provider and the Commissioner shall undertake pre-employment checks in accordance with the guidance set out by NHS Employers, which includes relevant criminal records checks. This can be found at: <http://www.nhsemployers.org/case-studies-and-resources/2014/07/eligibility-for-dbs-checks-scenarios>. These checks should be supplemented with robust processes that ensure that the right staff, with the appropriate competences, aptitudes and capabilities are selected.

#### **4.7.8. Medicines and Poisons training**

The Provider shall ensure that where Toxbase is accessed, all clinicians undertake the eToxbase learning module supported by additional medicines and eBNF training in the context of therapeutic overdose.

In addition to the specifics around toxic ingestion, the Provider shall ensure that the clinical workforce has access to appropriate reference resources (i.e. medicines complete and training programmes to allow the appropriate management of polypharmacy issues presented by patients/callers with complex needs).

Further Information can be found at <https://www.toxbase.org/>

#### **4.7.9. Workforce Planning, Support, Education and Training**

The national regulators setting the standards of the support and development promoted and provided for the workforce will include:

## OFFICIAL–SENSITIVE: COMMERCIAL

- CQC, particularly in relation to Fundamental Standard (Regulation 18) regarding “Staffing”
- Health & Care Professions Council (HCPC) (Allied Health Professionals)
- Nursing and Midwifery Council (NMC)
- General Medical Council (GMC) General Dental Council (GDC) for Dental Nurse Registration
- General Pharmaceutical Council (GPhC)
- Health Education England, implementing its Integrated Urgent Care workforce blueprint.

The additional standards of the training in out of hours provided for GP Registrars will meet the expectations provided by the revised position paper 2010 of the Committee of General Practice Education Directors (COGPED), and meet the specific requirements set by the respective local Deanery.

The provider will plan and provide high quality education and training that supports the professional development of individuals and teams and is directly linked to improvements in patients’ outcomes by addressing variation in standards and ensuring excellence in innovation. To achieve this, the provider will measure education and training against the indicators in the five domains of Health Education England’s Strategic Framework.

In line with this Framework, the provider will focus through its workforce planning, resourcing, support and development on building a workforce for now and the future which:

- Includes the informal support that helps people prevent ill health and manage their own care as appropriate;
- Has the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate;
- Has adaptable skills responsive to evidence and innovation to enable “whole person” care, with specialisation driven by patient rather than professional needs;
- Has the skills, values, behaviours and support to provide safe, high-quality care wherever and whenever the patient is, at all times and in all settings; and
- Delivers the NHS constitution: is able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most.

The provider will demonstrate commitment to these principles and to those described in the national IUC workforce development blueprint. In particular the provider will:

- Provide leadership for planning and developing the whole Out of Hours clinical, allied and administrative workforce. In order to fulfil its obligation to deliver the service, the provider will undertake appropriate workforce planning activities. This will include joint working with partners across the wider health system in order to assess system-wide work force requirements. In particular this should be aligned to the statutory responsibilities of Health Education England and the service should additionally respond to requests from Health Education Kent Surrey and Sussex (HEKSS).
- Ensure that every member of the workforce undertakes high quality education and training which is responsive to the changing needs of patients and the service and delivered to standards set by regulators, including HEE’s Quality Framework. The

## OFFICIAL–SENSITIVE: COMMERCIAL

provider should provide supervised on the job training for GP registrars. GP registrars are required as part of their vocational training to undertake a minimum amount of out of hours work which has to be supervised by a vocationally trained GP with current registration on the local performers' list administered by NHSE at a regional level. The provider must also ensure all staff receive mandatory training in an agreed range of areas, including; Health and Safety, Risk Management, Fire Safety, Basic Life Support (BLS), Safeguarding, Information Governance and Infection Prevention and Control Training (Including Hand washing) as agreed with the commissioner. The provider must maintain a record of the dates and training given to all clinicians and staff working within the service. All such records should be immediately available to the commissioner on request for audit purposes. The provider must ensure that training requirements and competencies are monitored through regular assessment, staff appraisal, and an annual training needs analysis. Staff must be enabled to progress through supported learning. The provider must ensure that all practitioners working in the service are checked and deemed competent to deliver a safe service.

- Ensure security of supply of a suitably qualified clinical workforce through role design, recruitment, development and retention-orientated activities.
- Assist the spread of innovation across the Service in order to improve quality of care by sustaining positive organisational culture and leadership in line with NHS expectations.
- Incorporate values in the NHS constitution throughout training, performance management and organisational development activities.
- Allocate and account for the required education and training resources.
- Through the commissioner be accountable to the Local Education and Training Boards.
- Demonstrate how it will comply with all employment legislation, in particular the Working Time Directive.

### **4.7.10. Health Advisor Training, Call Co-ordinator (CAS) and Support (Non-Clinical)**

All staff involved in handling Integrated Urgent Care (NHS 111, Out of Hours, and CAS) service calls must undertake detailed training that covers as a minimum the following areas:

- Full Compliance with the licence requirements of the relevant Clinical Decision Support Software (CDSS), which must be audited internally each 30 days and presented to the clinical governance group on a monthly basis. The provider should look for an external audit at least once every 180 days in conjunction with the commissioner.
- Localisation training for the area that is serviced by the Integrated Urgent Care service including visits to all local services that are available on the Directory of Services and how to interact with urgent care services.
- The use of Directory of Services and the most appropriate way to search and discuss options with the patient.
- Detailed understanding of the booking arrangements to another clinical service where appropriate.
- Basic life support training (annually verified).
- NHS values and NHS constitution.
- Delivering excellent customer service.
- Safeguarding Adults and Children.

## OFFICIAL–SENSITIVE: COMMERCIAL

- Information governance training.
- Local training on the structure of special patient notes, a care plan and an End of Life Care plan.

### **4.7.11. Staff training and support (non-clinical)**

All staff in the list below additional to the requirements detailed above must at all times be in full compliance with the licence requirements of the relevant Clinical Decision Support Software (CDSS), for supervisors, trainers, which must be audited internally each 30 days and presented to the Clinical Governance group. The provider should look for an external audit at least once every 180 days.

- Call Supervisor
- Health Advisor Coaches
- Health Advisor Auditors and Trainers
- Call Centre Managers
- Any clinician whose work involves day to day work with initial NHS 111 access or support to Health Advisors
- Where there are recognised NVQ or call centre specific qualifications for managers, these should be included with the personal development plans of all staff and employer support given.
- When the provider is establishing rotas and schedules they must state the training time in advance for each grade of non-clinical labour, be prepared to show their detailed training course(s) to the commissioner and be prepared to detail their PDP process and structure.

### **4.7.12. Clinical Training and Support**

All clinical staff working in Integrated Urgent Care service must be trained in line with the CDSS licence and the individual pathways (where relevant/stipulated by the respective software used). It is likely that additional training modules will become mandatory for clinical staff, which will increase their knowledge and improve patient outcomes.

### **4.7.13. Other Specialist Training**

The Provider shall ensure that staff undergo specialist training in areas including but not limited to:

- Dementia;
- Mental Health; and
- Suicidal Callers.

## **4.8. Interoperability**

Interoperability within the Integrated Urgent Care environment is detailed in Appendix D. The specification defines the technical standards that must be used for the transfer of data where applicable, to and from Integrated Urgent Care application systems and all the applications that integrate with other service providers.

The following outcomes are required for all Integrated Urgent care services:

- All Integrated Urgent Care applications must connect directly with the SPINE and have followed the CAP Process.
- All Integrated Urgent Care applications must connect with the Summary Care Record to ensure access to patient records is achieved as a minimum.
- NHS Integrated Urgent Care services must submit and retrieve data from the National Repeat Caller Service.

## OFFICIAL–SENSITIVE: COMMERCIAL

- NHS Integrated Urgent Care services must follow the Integrated Urgent Care IM&T assurance toolkit2.
- All Integrated Urgent Care services must have the technical ability and develop the operational or Integrated Urgent Care procedures to book patients into other services in an integrated manner.
- All Integrated Urgent Care services must be able to dispatch ambulances in either an integrated manner locally, or using Interoperability Standards when dispatching to a separate application or out of area 999 service.
- NHS Integrated Urgent Care services must be able to determine where patients are being referred/transferred to and transmit the data for all other services and all 999 services.
- Interoperability with GP Clinical systems – EMIS & SystmOne and Community Services/Hospital

The Integrated Urgent Care services must connect to a single common DoS data layer but may use its own middleware application layer.

The Provider shall use a clinical workflow system that can support the following interoperability requirements, in line with the IUC Technical Standards pack found in Appendix D.

The provider should maintain an awareness of information strategy in the NHS and local health community, and to develop their systems to integrate or interoperate with NHS national systems.

The provider is required to work with the local health community and IT providers to develop and improve interoperability and integration of structured, coded information, so that electronic transfer of and/or access to information is available along the care pathway.

The provider will interoperate with the service and both voice and data systems must be compatible. The interoperability standards must be met where relevant.

The provider will consider ways in which technology such as TeleHealth can be used to improve patient access to the service where the evidence base supports that and by horizon scanning and researching what is happening in other CCGs across England and further afield.

The provider should develop an ICT improvement plan for each year of the contract to meet national and local service improvements and share this with the commissioner together with any funding requirements outside of regular maintenance.

### **4.8.1. Referrals and Transfers (covering Sending, Receiving, Content, and Endpoints)**

All patient encounters that are transferred between IUC services must be enabled using interoperability standards as defined in the Integrated Urgent Care Technical Standards pack ([Appendix D](#)).

### **4.8.2. Transferring/Referring Patients between Services**

All patient transfers and referrals between IUC services must make use of the defined interoperability standards for referrals and transfers (often referred to as ITK Messaging).

The Provider shall identify the interoperability roles that need to be fulfilled, and ensure that the chosen clinical workflow system supports the specific interoperability requirements required for those roles. In the majority of cases, service providers should require their

## OFFICIAL–SENSITIVE: COMMERCIAL

clinical workflow system to support all possible interoperability workflows as this provides the greatest flexibility for introduction of new service models in the future.

The key transfer / referral interoperability roles are:

- Service provider transferring or referring a patient to another IUC service; and
- Service provider receiving a patient from another IUC service.

The architecture must be designed in such a way as to enable end to end reporting (see Section 6.6.2).

Any clinical decision to transfer the care of a patient must be documented in the patient's record and sent to the patients registered GP by 8.00am the following morning.

The provider shall ensure that there is a robust system for the process of the transfer of care or onward referral that satisfies the following conditions:

The patient is able to understand and navigate the system without unnecessary delays or further need for advice.

In all cases the Directory of Service has been reviewed and information on the patient's personal details and clinical assessment is transferred to other services, such as acute, mental health, social and other such services, emergency care teams.

The provider is to make arrangements to inform the receiving service of the patient's attendance to which a referral has been made.

The provider shall ensure that the following information is transferred:

- Patient personal details.
- Time and day of telephone/face to face assessment.
- Clinician and grade assessed by and method of assessment.
- Summary of medical history and where appropriate, examination and investigation.
- Diagnosis (primary and secondary).
- Treatment provided: dose, route, frequency, and amount.

### **4.8.3. Directory of Services**

The Provider shall ensure that the chosen clinical workflow system has technical integration with the National Directory of Services (DoS) allowing the appropriate search and retrieval of service information. Further information on technical integration requirements can be found in the IUC Technical Standards pack – Appendix D.

### **4.8.4. Appointment Booking**

The Provider shall ensure that the chosen clinical workflow system supports the direct booking of appointments into other service provider systems – including dental in the future. For more information, also see Section 4.11 – Appointment Booking.

### **4.8.5. Ambulance Requests**

The Provider shall ensure that the chosen clinical workflow system supports direct ambulance requests using the ambulance interoperability standards (also referred to as ITK Messaging) in line with the IUC Technical Standards.

The chosen clinical workflow system must provide a way of automatically identifying the appropriate ambulance service for a patient – this can make use of either local functionality or a nationally provided directory.

## OFFICIAL–SENSITIVE: COMMERCIAL

The chosen clinical workflow system must ensure that ambulance request functionality can be made available to appropriate users flexibly in order to support both existing and potential service workflows within IUC.

### **4.8.6. Continuation of Triage**

It is important that a patient does not have assessments repeated when moving through IUC.

The Provider shall ensure that it is possible for existing assessments to be continued where possible (e.g. using the NHS Pathways validation functionality) regardless of whether this is being completed in the same system in which the triage was started.

In the event that an assessment is passed to a clinician using a different clinical workflow system, those systems must support the necessary interoperability to transfer the assessment in a structured form to allow validation and continuity. The messaging standards do not officially support the continuation of an NHS Pathways triage across different systems. However, any referrals must include information relating to previous consultations.

### **4.8.7. Repeat Caller Service (RCS)**

The National Repeat Caller Service exists to ensure that any health care professional assessing a patient's needs within IUC will have access to the clinical records of any recent contacts made with IUC by or on behalf of that patient.

The Provider shall ensure that the chosen clinical workflow system has ability to integrate with the National Repeat Caller Service. The Repeat Caller Service must be automatically queried at the beginning of the patient's encounter with Integrated Urgent Care. In the instance that first contact is made directly with a service other than the telephony service (such as, a Clinical Assessment Service), the Repeat Caller Service query shall be performed by whichever clinical workflow system is used at the first contact.

The Provider shall ensure for patients referred to Integrated Urgent Care from an Online Digital Service, a Repeat Caller query is performed after the patient identity has been confirmed. If this has not been completed by the Online Digital Service, it must be performed within the receiving clinical workflow system.

Where a patient is highlighted as a repeat caller by the Repeat Caller Service, the chosen clinical workflow system must enable an alternative workflow in line with the call handling process for repeat callers.

Note: this technical integration is specific to Repeat Callers and the National Repeat Caller Service and does support the identification of frequent callers, or those with designated care plans.

Although the Repeat Caller Service is currently built to meet a specific set of requirements in line with the existing IUC Repeat Caller processes, the Provider shall ensure that the chosen clinical workflow system can be updated to encompass changes to the service in the future.

Further information on the technical integration requirements for the Repeat Caller Service can be found in the IUC Technical Standards (Appendix D) and in Section 4.2.1.12.2.

### **4.8.8. Post Event Messaging**

The Provider shall ensure that the chosen workflow system has the ability to send an electronic Post Event Message to a patient's registered GP surgery by 08:00 the next working day.

For more information see section: “4.14 Post Event Messages (PEM)”.

#### **4.8.9. Online/Digital Services**

As online services are being planned and deployed Providers and commissioners will need to consider how the chosen Clinical Workflow System interoperates with the Online Digital Services. In order for Online Digital Services to complement and enhance IUC, it is essential that they provide an integrated patient journey and are seamlessly embedded into the operational processes of the local IUC.

Online Digital Services will perform an element of triage, once a disposition is complete the emphasis needs to be on connecting a patient to IUC services rather than just signposting to services.

The provider must be prepared to support integration and interoperation with Online Digital Services currently being developed/rolled out nationally.

The Provider shall ensure that patient entered information captured by the Online Digital Service can flow to support the clinical assessment to avoid duplication of effort and repetition for the patient and clinical staff.

For further information on technical interoperability with Online Digital Services, commissioners and providers should refer to the IUC Technical Standards<sup>6</sup>.

### **4.9. Telephony & IT Systems**

#### **4.9.1. The function of the national 111 telephony platform**

##### **4.9.1.1. Hosting and charge reversal**

The 111 number is hosted on the chosen telephone carrier's network (the 111 Carrier) through a contract procured centrally by NHSE. It is free to call 111 from landlines and mobiles, with call charges being automatically reversed in the form of an “inbound-call-charge”, which is levied on the contract holder. For the avoidance of doubt, the cost of hosting the 111 number and reversing the call charge in England is borne by NHSE and not recharged to the Provider.

##### **4.9.1.2. Other users of 111**

The 111 number is available across the whole of the UK national numbering scheme (any country using UK area codes). Devolved Administrations such as Scotland and Wales procure services directly from the 111 Carrier in their locality through side agreements to the main NHSE contract.

In the event of a flu pandemic, the 111 number will also be used by Public Health England (PHE) to access the National Pandemic Flu Service (NPFS). When NPFS is activated, this is achieved by a “press 2 for antivirals” style menu option at the front of 111 which will route calls to dedicated NPFS contact centres.

##### **4.9.1.3. Location based routing**

The underlying principle behind 111 call routing is that the call should where ever possible be delivered to the provider covering the area from which the call originated.

Where available, the location of a caller is identified using information sent to the 111 Carrier by the caller's network operator. In the case of landlines the National Numbering Group

---

<sup>6</sup> These are being updated for online to be published in August 2017.

## OFFICIAL–SENSITIVE: COMMERCIAL

(NNG), formerly known as STD or area code, is used. For mobiles the mast from which the call originated or the emergency zone (a group of masts in a specific area) is used.

If it is not possible to determine the location using information from the caller's network, for example in the case of internet phones, a natural voice recognition system is used. The system asks the caller to state their nearest large town or city (borough, tube or rail station in London) in order to determine the origin of the call. After two attempts, if the caller fails to respond or the response is not recognised, the call is classed as Location Unknown.

In a small number of cases where an NNG, mobile mast or emergency zone straddles a border between providers, a simple "*press 1 if you are in North Essex or 2 if you are in South Essex*" style call steering mechanism should be used.

The Commissioner shall work with the NHSE IUC Team to map postal towns and cities, NNG, mobile masts and emergency zones to the Provider's catchment area. Where necessary the Commissioner shall liaise with bordering commissioners.

### **4.9.1.4. Location Unknown Calls**

Any calls where location could not be determined are distributed amongst all providers based on each provider's normal share of the national call volume.

The Provider shall handle any Location Unknown Calls on a reciprocal basis treating them as if they had originated from the Provider's catchment area and form part of the contracted volume. For the avoidance of doubt, no recharges will be levied on the caller's local commissioner.

### **4.9.1.5. Call Steering - Interactive Voice Response (IVR)**

The 111 Carrier's platform must be capable of providing Interactive Voice Response (IVR) functionality (e.g. "*press 1 if you or the person you are calling about is feeling unwell, press 2 for repeat prescriptions... etc*"). This functionality can be requested by the Commissioner when services are delivered by multiple providers or when the Provider is unable to implement such functionality within the required timescales.

The provider is permitted, in line with commissioner requirements to use a local facility to split off and direct dental, pharmaceutical, repeat callers, healthcare professionals and other groups or type of call – to be agreed. This should be performed by the telephony platform of the provider.

In order to cope with the very high level of demand that occurs on some days (such as bank holidays) there should be at least three times the number of lines available compared to the maximum number of advisers, as detailed in the workforce model .

In addition there must be sufficient "IVR" ports so that calls will go "off hook" (answer acknowledgement) within 5 seconds of the call being presented. This is normally done by playing a message. Calls that do not go "off hook" rapidly are played a message asking the caller to try again. The playing of this message is recorded nationally.

If there is a call to 999 which is not of an emergency nature then the name and number can be sent electronically to the CAS, who will be permitted to call them back. It is currently not supported by law to forward a 999 call from an ambulance service. This operational flow is to be agreed with local ambulance services.

### **4.9.1.6. Resilience**

The 111 Carrier's platform is located across multiple data centres for resilience. In the extremely unlikely event of the primary platform failing, the 111 Carrier's underlying network

## OFFICIAL–SENSITIVE: COMMERCIAL

can continue to route 111 calls using what is known as 'default routing'. This involves distributing 111 calls across providers using the same principles as Location Unknown Routing.

When 'default routing' is active, the Provider shall treat these substitutional calls as if they had originated from the Provider's catchment area and form part of the contracted volume. For the avoidance of doubt, no recharges will be levied on the caller's local commissioner.

### **4.9.1.7. National Contingency**

If a provider suffers a major technical failure or site evacuation, NHSE can re-route calls to the remaining providers based on their normal share of the 111 call volume (adjusted to compensate for the absence of the failing provider).

The Provider shall handle any National Contingency calls on a reciprocal basis treating them as if they had originated from The Provider's catchment area and form part of the contracted volume. For the avoidance of doubt, no recharges will be levied on the caller's local commissioner or failing provider.

In exceptional circumstances, if a provider is deemed to have become clinically unsafe, a percentage of calls can be re-routed away from that provider using National Contingency.

The Commissioner shall monitor the use of National Contingency. If the Provider's use of National Contingency is deemed to constitute a breach of Key Performance Indicators (KPI) or contract, appropriate action shall be taken. This will include but not be limited to invocation of service credits and the contractual remedies process.

### **4.9.1.8. Maintenance of The 111 Carrier's Platform**

Where possible, maintenance work on the 111 Carrier's platform will be carried out during quiet periods (predominantly Tuesday to Thursday 10:00 to 16:00).

### **4.9.1.9. Local Planned Engineering Works (PEW)**

Where possible all local Planned Engineering Works on the Provider's systems should be undertaken in such a way as to avoid downtime.

On a case by case basis NHSE shall consider requests to use National Contingency to cover local Planned Engineering Works.

## **4.9.2. Receiving calls from 111**

To deliver the 111 call to providers, the 111 Carrier's platform simply dials a delivery number. If that delivery number is busy or no front end announcement is detected, secondary or even tertiary numbers can be dialled.

If required, calls can be load balanced across two sets of delivery numbers. This is beneficial when delivering to larger providers operating split architecture. For the avoidance of doubt, this functionality can only be used at data centre level and cannot be used to mimic a virtual system across multiple contact centres.

The Provider shall issue delivery numbers to which 111 calls can be delivered. At a minimum delivery numbers are required for:

- Delivery of calls under normal circumstances
  - Primary
  - Secondary
  - Tertiary (optional)
- Delivery of National Contingency Calls
- Delivery of Unknown Location Calls

## OFFICIAL–SENSITIVE: COMMERCIAL

- Delivery of 'default routed' calls
- Any IVR options

In the event that a call cannot be delivered to the Provider, due to a fault or line congestion, a message stating that "*it has not been possible to connect your call*" is played to the caller (known as the Technical Difficulties message). The Provider shall take appropriate action to ensure that the Technical Difficulties message is not played. This should include but not be limited to requesting that the 111 Carrier change delivery numbers to bypass faulty components and ensuring sufficient line capacity.

The porting of individual telephone numbers between carriers involves call redirection which in turn can result in carrier interconnect congestion. The Provider shall ensure that the chosen carrier has sufficient carrier interconnect capacity and where possible avoid previously ported numbers.

### **4.9.3. Local provider telephony and IT**

#### **4.9.3.1. Lines**

The 111 Carrier's platform does not queue calls, as to do so would create significant reporting challenges. It is therefore essential that there are sufficient lines to support local queueing.

The Provider shall provision a minimum of 3 lines for every equipped agent position. These lines can be conventional ISDN or modern SIP, but where SIP is provisioned, at least one ISDN bearer is recommended as the primary circuit for resilience. Any traffic on SIP bearers should be uncompressed for optimum voice quality.

#### **4.9.3.2. Automatic Call Distribution/PBX**

The Provider shall procure a high availability Automatic Call Distribution system (ACD) to queue calls that cannot be delivered directly to agents.

Voice traffic shall be prioritised in accordance with manufacturer's guidelines and transverse the network in uncompressed format for optimum voice quality.

It is likely that in order to work as part of a CAS it will be necessary for some clinicians to work remotely, in particular those with specialist skills. This may involve individuals working from home or from their substantive place of work.

To facilitate remote working the Provider shall procure a solution to securely extend the contact centre telephony and desktop in such a way as to emulate the contact centre experience. This solution must utilise n3/HSCN circuits where available with any traffic over the public internet being encrypted using appropriate levels of encryption. To achieve this requirement an accredited VPN token authenticated solution, such as the one provided by n3/HSCN must be procured.

Although there are remote telephony solutions that allow both the voice and call control to traverse the public internet, they are reliant on extremely good internet connections. Home working solutions that allow the voice path to be established over the analogue public telephone network are preferable. These solutions keep the telephone line open for the duration of the shift to ensure good audio quality and are less likely to suffer disconnections.<sup>7</sup> They also allow the call to be recorded at source on the Clinical Hub voice recording

---

<sup>7</sup> There are tariffs available to minimise the cost of this call which is established from the hub to the remote telephone for the duration of the shift.

## OFFICIAL–SENSITIVE: COMMERCIAL

platform which is another essential requirement for all hub calls. The provider shall ensure that the procured solution supports home working.<sup>8</sup>

### **4.9.3.3. Desktop IT Systems**

The Provider shall ensure that agent's desktop should be delivered using established virtual desktop technology in such a way as to ensure that there is no "data at rest" on the remote device. A softphone package should also be installed for telephone call control and access to real-time queue information.

### **4.9.3.4. Call Steering - Interactive Voice response (IVR) & Announcements**

The Provider shall procure a solution capable of "press 1 for ..." type functionality to steer callers to the correct resource. Sufficient ports shall be provisioned to ensure that the initial call from the 111 Carrier's platform is answered within 5 seconds and that there is no noticeable inter announcement delay.

The Provider shall adhere to the IUC Telephony Messaging Standards (See Appendix F).

### **4.9.3.5. Voice Recording**

The Provider shall ensure that all calls are voice recorded on extension side and that all conversations, including internal consultation and warm transfer requests, are recorded.

All inbound calls to Integrated Urgent Care and any calls direct from a Health care professional must be recorded. Calls from adults must be retained for 8 years and calls from or about children must be retained until their 26<sup>th</sup> birthday. (This requirement is currently under review by NHSE and the retention time likely to be reduced, but for purposes of this procurement still holds). Providers are also required to ensure that systems are in place to comply with regulations concerning child protection and vulnerable adults. For avoidance of doubt, the Provider shall store voice recordings in accordance with the Records Retention Period and this may involve the need to tag calls with the patient's date of birth to enable records to be purged when the retention period has elapsed.

### **4.9.3.6. Records Management**

The provider shall maintain all records in accordance with an NHS Information Governance compliant Records Management Policy.

### **4.9.3.7. Reporting Systems**

The Provider shall procure reporting systems to satisfy the Commissioner's Minimum Data Set (MDS) requirements. A real-time reporting solution will also be required to service the Provider's intra-day performance management requirements.

### **4.9.3.8. Resilience and Capacity Planning**

At a minimum the Provider's platforms shall employ a geographically separated resilient architecture avoiding single points of failure. All key components shall be powered by generator backed supplies with uninterruptable battery backup. Data and telephone lines shall be diversely routed and where possible sourced from multiple carriers or network providers. Any relevant preferential listings should be sought and all components shall be maintained in accordance with manufacturer's guidelines. For the avoidance of doubt, all maintenance contracts should include priority 24-hour, 365-day, on-site cover.

---

<sup>8</sup> Although the aforementioned solution uses the existing telephone line, for health and safety reasons headsets are essential. In the case of business systems such as those used in GP practices, headsets are readily available. However, it may be necessary to procure new telephones for home based staff in order to ensure they can be used with suitable headsets.

## OFFICIAL–SENSITIVE: COMMERCIAL

The Provider shall undertake regular capacity planning exercises to ensure that networks, platforms and lines are scaled to handle peak demand without degradation. It should not be assumed that roster fulfilment will be achieved; therefore modelling must take into account the impact of excessive queueing on lines, IVR ports and other technical components.

It is often the case that certain positions within the contact centre are only used at peak times. The Provider shall therefore undertake pre-busy period inspections to ensure that all workstations and phones are fully functional.

### **4.9.4. Security**

The Provider shall ensure that appropriate security measures are put in place to protect systems from malicious attack and or loss of data. This shall include but not be limited:

- Penetration testing of any public internet facing components;
- Deployment of Intruder Protection Systems;
- Behavioural monitoring;
- Anti-Virus (AV) with real time updates; and
- Application of all security related patches where there is deemed to be a significant vulnerability.

### **4.9.5. British Sign Language (BSL)**

NHSE has procured a British Sign Language (BSL) interpreting service through the 111 Carrier. BSL callers establish a video link with the interpreter via an app or link on NHS Choices. A voice call is then made by the interpreter into the correct provider after identifying the callers location based on the postcode. In the event that a call-back is required, a dedicated BSL call-back number has been issued (call back only works with the app and requires the app to be running to receive the call).

The Provider shall issue a separate delivery number for BSL interpreted calls. Due to the fact that an interpreted call takes longer than a normal voice call, and interpreters require regular breaks, priority should be given to answering these calls. It is also preferable to warm transfer as opposed to scheduling a call-back.

### **4.9.6. 4.9.6 Front End Message**

The use of front end messaging is not permitted without prior agreement and consent from the Commissioner.

## **4.10. Referral to Other Services**

### **4.10.1. Ambulance Services**

#### **4.10.1.1. Roll out of Ambulance Response Programme (ARP)**

The ARP aims to change the way ambulance services operate in England to release efficiencies and provide a more clinically focused response to all 999 calls. The ARP aims to improve ambulance service efficiency and stability through a new system of call handling and prioritisation. This aims to reduce long waits and improve the speed of response in rural areas.

The ARP is currently being evaluated and a decision will be made on implementation and roll-out in due course. Should the national roll-out of ARP be approved, the Provider shall install an ARP-compliant CDSS version to ensure they are compliant with the roll out of ARP.

The Provider must consider the findings from the ARP pilot and in particular the draft set of measures which better reflect the needs of patients and use of new models of care.

#### **4.10.1.2. Implementing Hear and Treat/See and Treat**

Following the full implementation of the ARP, the Provider shall cooperate with any initiatives that consider how the Clinical Assessment Service can be used for lower acuity ambulance calls, removing the need to have two separate clinical desks/services.

The Provider shall cooperate with any other initiatives or commissioning plans to align services such as Urgent Treatment Centres, NHS 111, Ambulance Services, OOHs and improved GP Access with face to face urgent care.

The Provider shall maximise the use of the Clinical Assessment Service to support opportunities to increase rates of Ambulance Service 'Hear & Treat' and 'See & Treat'.

#### **4.10.1.3. Using the Ambulance Workforce**

The Provider shall consider the implications of the new Band 6 Paramedic Job Description to ensure enhanced clinical autonomy and delivery of 'Hear & Treat' and 'See & Treat'.

#### **4.10.2. Primary Care Response**

The vast majority of urgent care is to continue to be supplied by Primary care Practices during their present opening hours. However if a patient struggles to get access to their own GP at any time or is away from home the Provider shall make a GP available in the IUC CAS according to need.

The "generic" GP in the IUC CAS must be able to consult and complete on relevant cases or refer on to face to face where needed. It is vital that when a local GP practice is open AND it is considered essential that the patient see their own GP for continuity of care that the IUC CAS has access to the practice appointments for direct booking.

At present only c20% of the total call volume for NHS 111 occurs in "in hours" and the requirement for a patient to see their own GP is infrequent. It is anticipated that an individual surgery will only receive a very limited number of direct bookings in a day. The Commissioner shall work with local GP practices, in order that the Provider can (where possible) directly book appointments from the CAS.

#### **Principles**

Urgent Treatment Centres (UTCs) are community and primary care facilities providing access to urgent care for a local population. They encompass current Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as "Type 3 and Type 4 A&E Departments". Urgent Treatment Centres will usually be led by general practitioners, and are ideally co-located with primary care facilities, including GP extended hours /GP Access Hubs or OOHs services.

#### **Co-location with other services**

Co-location with, and strong links to, other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector will also be beneficial in providing an effective and integrated service. There are advantages if they can be co-located alongside hospital A&E departments to allow the most efficient flow of patients to the service that best serves their need but this will be determined by geographic distribution of urgent care sites and patient flows.

#### **Standards for Urgent Treatment Centres**

The Provider shall ensure that Urgent Treatment Centres conform to the Urgent Treatment Centre Standards set out in Appendix G and any local variances as stipulated by the Commissioner.

## OFFICIAL–SENSITIVE: COMMERCIAL

The Provider shall co-ordinate with services (including mental health and social care) to keep patients in the community and avoiding the easier but often more costly option of a hospital admission.

Examples of services include but are not limited to:

- Clinical advice and treatment;
- Home visits by clinicians;
- Community nurse visits;
- Palliative care team access;
- Mental health assessment, help and advice;
- Emergency dental services;
- Social services emergency duty teams;
- Pharmacy services; and
- Elderly care.

### 4.10.3. Dental Services

Management and Referral of callers with dental symptoms:

- Use of IVR to select calls;
- Employment of a specialist dental nurse;
- Triage of cases;
- Navigation of queues;
- Direct booking into services (where available/able);
- Ability to redirect non-dental cases back into the CAS

**Comment [RL10]:** ?? Need to cancel the current dental booking service contract (? Check arrangements for ES) as this will become part of the IUC CAS.

#### 4.10.3.1. General Conditions

The Provider shall make provision for the following general conditions:

- Call streaming through Interactive Voice Recognition or an equivalent system should be utilised for the management of callers with oral symptoms.
- Callers with dental symptoms must be managed using a clinical decision support tool operated by either health advisors or service advisors. Where dental professionals are handling these calls they must operate within their scope of practice and can use a decision support tool to guide them.
- Calls during all hours of the day and night including public holidays will need to be handled by the service.
- The Provider shall refer to services returned in the Directory of Services, considering them (and as long as suitable then offering them to the patient) in the order returned where an end point has been provided to refer to that service through ITK or NHSmail.
- The Provider shall ensure that clinical staff receive suitable training on the management of callers with dental symptoms (including trauma) in order to appropriately refer or manage cases that cannot be referred to another service.
- The Provider shall ensure that all clinical staff working in the service have received training on Toxbase or its equivalent to ensure that analgesia overdose can be identified and managed amongst dental callers.

#### 4.10.3.2. Commissioner Specific Requirements

The provider shall implement a solution capable of streaming calls to a local dental help and advice services where this has been commissioned by NHSE

Where NHSE has made available urgent access dental appointments the Provider shall implement a solution capable of booking patients into these appointments.

#### 4.10.4. Other Services

When referring to other services, the Provider shall implement electronic referral methods with appropriate prioritisation information as part of the agreed referral protocol to ensure callers do not have to repeat themselves other than to validate who they are / any symptom changes. Where a patient is identified as needing to attend another service, the Provider shall, where technically possible and requested by the Commissioner, electronically book an appointment.

Where a patient has been assessed by a clinician in the IUC CAS and a face to face appointment is deemed necessary it must be directly booked according to need where:

- a 'generic' GP or nurse resource can be used in an urgent community provider, it must also be booked; or
- it is more clinically sensible for the patient to be seen by their own registered practice a direct booking should be made.

For the avoidance of doubt, direct booking into a GP practice must only be after a clinical assessment not after call handler input.

The Provider shall implement a solution capable of recording where booking has not been possible as a result of slot unavailability.

In areas where agreement for direct referral to services (for example, acute, community, mental health, sexual health, social care etc.) have been established it must be possible for the advisor to direct callers to services via the DoS. The advisor must consider the services returned (and if suitable then offer them to the patient) in the order displayed. The Providers chosen clinical workflow system shall query the DoS and where possible the NHS 111 assessment information must be sent to the selected service electronically. In all cases the patient must be clear about which service they are being referred to, what the next steps in their care pathway are and in what timescale their next contact will be. Where patients are expected to attend/contact the service they are being referred to, the Provider shall issue contact details to the patient.

?? access to step-up beds at community hospitals?, links to ambulatory care pathways?

#### 4.11. Appointment Booking

The service must have the ability to refer, and where possible, book patients an appointment at the most appropriate urgent or emergency care service, based on the outcome of their CDSS assessment or the outcome of their clinical encounter with the CAS. This process preferably should be undertaken by way of direct technical interoperability between the Provider's chosen clinical workflow system and the clinical system used by the destination service. This desired destination service should be located as close to the patient's location as possible.

The Provider shall implement a solution capable of direct appointment booking with destination services through the chosen clinical workflow system. Direct appointment booking shall be available for both in-hours services (such as, GP Surgeries) and urgent care services (such as, Urgent Treatment Centres, Out of hours GP and in time dental services).

The Commissioner will work with the Provider to ensure that multi-provider commissioning arrangements are designed to enable collaboration for the purposes of Direct Appointment Booking.

## OFFICIAL–SENSITIVE: COMMERCIAL

The chosen clinical workflow system must make use of nationally-defined interoperability for direct appointment booking, where available and appropriate to the workflows.

In the absence of suitable nationally-defined interoperability, the chosen clinical workflow system shall make use of other locally-available technical solutions to facilitate direct appointment booking. Where local technical solutions are available, the Commissioner and the Provider shall ensure that appropriate plans are in place for migration to a nationally-defined solution when it becomes a viable option.

### **4.11.1. Booking Workflow**

The Provider shall ensure that the chosen clinical workflow system provides direct appointment booking as an integrated part of the user workflow, this means that users should be able to complete the booking functions within the same clinical workflow system in use by the Provider wherever possible.

System suppliers shall ensure that workflow design follows a user-led approach to ensure that functionality is provided at the appropriate points within the system. A seamless and supportive user experience is essential to realising the benefits from direct appointment booking interoperability.

### **4.11.2. Technical Interoperability**

The chosen clinical workflow system must provide technical interoperability to allow booking of appointments into other services as an integrated part of the system workflow. The Provider shall ensure that full technical specifications are made available from the chosen System Supplier for any technical interfaces that are implemented for appointment booking.

The Provider shall ensure that the chosen clinical workflow system is committed to implementation of national appointment booking interoperability standards at the earliest opportunity.

Further information on the technical interoperability requirements for Direct Appointment Booking can be found in the IUC Technical Standards.

### **4.11.3. Cancellations and Amendments**

The Provider shall implement a solution that allows the cancellation and amendment of booked appointments which were originally booked via an integrated Urgent Care service. Where a technical solution is not available an operational process should be in place.

### **4.11.4. Notifications and Reminders**

The Provider shall implement a solution capable of sending an optional appointment confirmation and/or reminder messages to patients using SMS or email.

As a minimum, appointment confirmations should provide the time/date of the booked appointment, and details of the service into which the appointment has been booked. Appointment confirmations should avoid containing personally identifiable data (PID) unless specifically necessary.

### **4.11.5. Reporting and Data**

The Provider shall ensure that it is possible to report freely on appointment booking activity from within the chosen clinical workflow system.

Providers must be able to provide activity reporting to Commissioners for appointment booking within Integrated Urgent Care services when requested, and that this reporting information can be usefully aggregated across multiple providers and services where applicable.

## **4.12. Access to Records**

### **4.12.1. Patient Demographic Service (PDS)**

The Personal Demographics Service (PDS) allows the Provider to confirm a patient's demographics including their name, date of birth, sex, the GP surgery at which they are currently registered, and their current home address. This is an essential enabler for interoperability between services, and enables the Provider to send Post Event Messages to the patient's registered GP surgery.

The Provider shall ensure the chosen clinical workflow system has technical integration with PDS, and supports the use of Advanced PDS Tracing. An Advanced PDS trace shall be performed by the Provider for all patients during their encounter with IUC. Performing an advanced PDS trace shall be an integrated part of the workflow within the clinical workflow system and available to all users, subject to appropriate access controls. For the avoidance of doubt, it is not permissible for traces to be performed manually by use of a separate system.

For patient referrals/transfers from another service, the receiving service should first establish if the patient's details have already been traced using PDS by the sending service – in some cases this can be explicitly identified in the referral/transfer message. Where a patient's details have not been traced, the receiving service must perform a PDS trace for that patient. Following successful identification of the patient using PDS, a Repeat Caller query shall be performed where applicable – see Section 4.2.1.12.2 and Section 4.8.7 Repeat Caller Service for more details.

Where a PDS lookup has been performed online, the information must be captured by the provider's workflow system as part of the referral. Where PDS lookup has not been performed by the online service then the PDS lookup must be performed at the point of referral.

### **4.12.2. Summary Care Record (SCR)**

The Provider shall ensure that health care professionals have effective access to the Summary Care Record for all patients, subject to appropriate access controls. To ensure effective access the Provider shall ensure all pre-requisites for access are met.

Access to the Summary Care Record must be embedded within the chosen clinical workflow system as an integrated part of the workflow.

### **4.12.3. Permission to View (PTV)**

Where a patient gives permission to view (consent) during an IUC encounter, this consent can be passed to subsequent providers and services for care provided during that same encounter (where explicit consent covers those agencies).

The Provider will ensure that all staff are trained and understand the importance of information governance, including the requirement for patients to give express permission to view records (PTV) unless a duty of care circumstance arises and therefore implied consent will apply.

### **4.12.4. Patient Flags/Special Patient Notes (SPN)**

The Provider shall ensure the chosen clinical workflow system can provide Patient Flag functionality, allowing advisors and health care professionals to be proactively alerted where important information is available to assist with and direct the specific care that is provided to the patient.

## OFFICIAL–SENSITIVE: COMMERCIAL

The Provider shall ensure that the clinical workflow system supports the necessary interoperability requirements to ensure that important information held in other systems is available and presented in a timely manner to the users.

The Commissioner shall support and enable information sharing between providers, in particular where multiple providers are commissioned. This must include but not be limited to relevant Special Patient Notes.

### **4.12.4.1. GP Choice**

The Provider shall establish the ability to automatically identify patients that are registered under the GP Choice scheme when they access the service.

At the time of publication, a national solution for identification of patients registered under the GP Choice scheme is in development but not available for implementation by System Suppliers. The Provider shall ensure that System Suppliers are committed to implementing the national solution within a reasonable timescale once available.

More information about technical interoperability to support GP Choice will be made available via the IUC Technical Standards.

### **4.12.4.2. Child Protection Information System (CP- IS)**

(<https://digital.nhs.uk/child-protection-information-sharing>) is a national solution (part of the NHS Spine) that connects local authority children's social care systems with those systems used within NHS unscheduled care settings.

The Provider shall ensure that the chosen clinical workflow system has the ability to query the CP-IS and alert users to the presence of a record where appropriate. Queries to the CP-IS are also reported to the responsible social care organisations to make them aware that a child has presented to IUC. The Provider shall work with the CP-IS programme team to establish appropriate use of CP-IS within the context of the service

Further information on CP-IS integration requirements can be found within the IUC Technical Standards.

## **4.12.5. Access to Patient Records**

### **4.12.5.1. Primary Care/GP Records**

The Provider shall ensure that health care professionals are able to access detailed primary care/GP records for all, subject to appropriate access controls. This could be expanded to include other locally held information, such as mental health and discharge information.

The majority of GP practices across the Commissioning area currently use Emis Web, with a small number also using SystemOne. The Provider, in agreement with the Commissioner will implement an electronic platform/approach that enables interoperability, direct booking and sharing of patients records in accordance with IUC Guidance.

### **4.12.5.2. Regional Shared Records**

Where there are close borders and complex telephony routing challenges, patients may be managed by other providers to their home providers; and it is important to ensure that patients receive the same standard of care identified within the plans agreed with the patient.

### **4.12.5.3. National Shared Records**

The Provider shall ensure that the chosen clinical workflow system has the ability to interoperate with Online Digital Services as they become a more prominent piece of the IUC system. In order for Online Digital Services to complement and enhance IUC, it is essential that they provide an integrated patient journey into the rest of IUC.

Many Online Digital Services will perform an element of triage and / or clinical assessment before signposting or referring a patient to IUC services. The Provider shall ensure that best use is made of the information already collected by the Online Digital Service as to avoid duplication of effort and repetition for the patient.

Further information on technical interoperability with Online Digital Services can be found in the IUC Technical Standards.

## **4.13. Medicines Management**

### **4.13.1. Prescribing**

The Provider shall deliver access to medicines and devices through the issuing of NHS prescriptions, where clinically appropriate, to meet urgent need as part of a clinical assessment.

The Provider shall adhere to the following criteria:

- Provision of a competent<sup>9</sup> medical (for example, GP) and/or non-medical prescriber (for example, Pharmacist, Nurse) within the IUC CAS 24 hours a day;
- Access to the Summary Care Record (SCR) and/or local electronic health care record for the patient that provides access to any clinically relevant information to support good prescribing practice e.g. palliative care record<sup>10</sup>;
- Provision of an electronic prescribing system within the IUC CAS to support the issuing of NHS prescriptions;
- Establishment of standard operating procedure to support the process of managing the issuing of prescriptions, directing the prescriptions to the pharmacy of the patient's choice and ensuring secure and timely delivery of the prescription request to the dispensing pharmacy (this may include but not be limited to the ability to print and fax prescriptions following a telephone consultation, the posting of the original prescription form to the dispensing pharmacy and the prescribing of controlled drugs within a remote consultation).
- To the Surrey PAD

The Provider shall work with prescribing system suppliers to prepare for the linking of NHS 111 and GP OOHs to pharmacies via the Electronic Prescription Service (EPS) as and when this becomes available/rolled-out in agreement with Commissioners<sup>11</sup>.

Consideration should be given to the range of medicines that would be prescribed by clinicians within the IUC CAS to ensure medicines optimisation for patients through the application of relevant NICE Guidelines<sup>12</sup> including consideration of antimicrobial resistance and use of antibiotics.

The Commissioners shall identify a prescribing budget for all prescribing undertaken within the service and ensure there are resources in place to monitor and audit prescribing activity.

### **4.13.2. Repeat prescriptions**

The Provider shall prioritise urgent requests for repeat prescriptions according to clinical need. Consideration may be given to how repeat prescription requests could be handled via

---

<sup>9</sup> <https://www.rpharms.com/resources/frameworks/prescribers-competency-framework>

<sup>10</sup> [http://www.gmc-uk.org/guidance/ethical\\_guidance/14316.asp](http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp)

<sup>11</sup> <https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/>

<sup>12</sup> <https://www.nice.org.uk/guidance/ng5>

the use of “Interactive Voice Recognition” at the front end of NHS 111 to stream the calls for a quick assessment by non-clinical staff to identify when the prescription would be required.

The Commissioner must consider the referral of patients to a community pharmacy to make a direct supply of urgent repeat medicines where there is access to a commissioned service, for example, NHS Urgent Medicines Supply Advanced Service (NUMSAS)<sup>13</sup>. A prescription is not required and an electronic referral to a community pharmacy will close the call and enable a more direct access to medicines for the caller.

#### **4.13.3. Electronic Prescription Tracker**

The Electronic Prescription Service (EPS) provides access to a “tracker” that can be viewed via a weblink to find out the status of an NHS prescription issued by a GP practice<sup>14</sup>.

The Provider shall make this tracker available to prescribers and pharmacists working within the IUC Service to support decisions about urgent repeat prescription requests. NHS Digital is working towards implementing the use of the tracker across all NHS 111 providers by March 2018. The Provider will implement such in agreement with the Commissioners.

### **4.14. Post Event Messages (PEM)**

#### **4.14.1. Overview**

A patient's registered GP should always be notified about the clinical outcome of a patient's encounter with an IUC CAS via a Post Event Message (PEM). This should ideally be sent at the end of a patient's whole IUC encounter to avoid multiple messages being sent to the GP and to ensure that the GP is informed of the final outcome for that patient.

Where the telephone service transfers the patient to an IUC CAS, a PEM does not need to be sent from the initial telephone assessment providing that a PEM will be guaranteed once the whole patients IUC encounter is complete.

When an assessment is performed and the resulting outcome is on the Never Send List (see 4.14.6 Never Send List), then a PEM should not be sent regardless of where the call is taken.

#### **4.14.2. Format**

The Provider shall send PEM using the Clinical Document Architecture (CDA) in electronic form (ITK), or whatever may supersede it in the future. A more detailed specification can be found in the IUC Technical Standards. For the avoidance of doubt, fax transmission is only permissible as a last resort backup and must adhere to NHS Information Governance ‘safe haven’ fax guidelines.

#### **4.14.3. Content**

The Provider shall ensure that PEM is clear, concise, and where possible articulates the primary reason for the encounter. The Provider shall ensure that the GP can interpret and possibly take action based the information provided.

The PEM shall at a minimum contain:

- The presenting condition
- The disposition of the encounter (timescale / clinical urgency / clinical need)
- Service Details (where patient is referred or transferred)

<sup>13</sup> <https://www.england.nhs.uk/commissioning/primary-care-comm-pharmacy/urgent-care/>

<sup>14</sup> <https://digital.nhs.uk/electronic-prescription-service/rx-tracker>

## OFFICIAL–SENSITIVE: COMMERCIAL

- A summary of the consultation(s)
- A summary of the triage process (where applicable)
- A summary of any advice provided to the patient

A detailed description of the content and structure of the PEM can be found in the IUC Technical Standards. Clear and concise documentation with clearly defined actions for the registered GP is required if/where appropriate..

### **4.14.4. When to send**

The Provider shall ensure that PEM is sent at the end of a patient's whole IUC encounter to avoid multiple messages being sent to the GP and to ensure that the GP is informed of the final outcome for that patient.

For the avoidance of doubt, where the telephone service transfers the patient to a Clinical Assessment Service, a PEM does not need to be sent from the initial telephone assessment providing that a PEM will be sent at the end of the whole IUC encounter.

### **4.14.5. Recipients**

For all IUC encounters (with the exception of those excluded by other criteria), the Provider shall send a PEM to the patient's registered GP surgery.

In addition to this, the Provider may be required to send a PEM to other recipients where they are directly involved in the patient's care and have a legitimate need to be informed about the encounter.

The Provider shall ensure that appropriate consent has been sought before sending a PEM to any recipient.

If required to do so the Provider shall send PEM to other providers within the local IUC model or to any centrally managed repository as specified by the Commissioner.

### **4.14.6. Never Send Lists**

There are some 'Never Send' situations in which a PEM must not be sent to the patient's registered GP (a list of Never Send situations can be found in Appendix 1 of the IUC Technical Standards).

The Provider shall ensure that the chosen clinical workflow system is configured to honour "Never Send" lists.

## **4.15. Access and Hours of Operation**

### **4.15.1. Access Channels**

The Provider shall make provision to receive contacts from the following channels:

- NHS111 Telephony
- On-line
- Video Relay based British Sign Language Interpreting Services

The Provider shall ensure that procured solutions have multimedia capability, including but not limited to:

- Instant Messaging / Web Chat
- E-mail
- SMS (text)
- MMS (picture)

- High definition picture files
- Video

The Provider will work with the Commissioner to agree any future innovative solutions regarding access methods.

**Comment [RL11]:** These maybe further clarified via the pre-engagement process and any defined/confirmed core and innovations.

#### 4.15.2. Mapping service boundaries

The IUC service boundaries are well established. However, if changes are required, such as the amalgamation or splitting of contract areas the Commissioner shall liaise with neighbouring commissioners to agree any routing changes and instruct NHSE accordingly.

#### 4.15.3. Opening hours

The Provider shall operate:

- the telephony and online elements of IUC Service 24/7 365 days a year(including leap days); and
- the face-to-face service provision elements during periods when GP surgeries in the contract area are not open (including protected learning time when contracted to do so).
- Face to face:
  - Mon – Thursday 18:30 – 08:00
  - Friday – Saturday 20:00 – 08:00
  - Saturday – Sunday & each Bank/public holiday 08:00-08:00
- Home visiting:
  - Mon – Thursday 18:30 – 08:00
  - Friday – Saturday 20:00 – 08:00
  - Saturday – Sunday & each Bank/public holiday 08:00-08:00

**Comment [RL12]:** The development of hours of service will be in line with emerging GP extended hours/CCG strategy and/or innovations during the contract term.

During the period between 18:30 to 08:00, patients will be directed to the local nominated urgent treatment centre – as agreed with the Commissioners.

**Comment [RL13]:** Need to confirm locality/CCG arrangements ?shoulder time 18:15?

## 4.16. Population covered

The Provider shall receive calls and assess patients who:

- Are registered with a GP within the geographic area specified in the contract;
- Are registered outside the geographic area specified in the contract but who call from a telephone National Numbering Group (NNG) allocated by NHSE to the provider;
- Call NHS 111 but cannot be identified geographically and are therefore sent to the provider via the NHS 111 national telephony platform (according to their allocated share); and
- Are unregistered and are calling from the geographic area covered by the contract (including the traveller community).
- Drug & alcohol dependency: people with dependency should always be able to access the services but in relation to specialist help it is recommended that for methadone users a case by case decision is made with background advice, in line with protocols agreed with specialist services. There would be very few circumstances when on-going support is needed, but the provider is expected to have an ongoing relationship with the providers of specialist support to agree and update working protocols.
- Mental health: as above people with mental health needs must be able to access the service but the services should have agreed protocols in place to deal with exacerbations and acute mental health presentations. The use of shared records and special patient messages will be encouraged to provide the optimal care. Again but

## OFFICIAL–SENSITIVE: COMMERCIAL

the provider is expected to have an ongoing relationship with the providers of specialist support to agree and update working protocols.

In the event of National Contingency activation of a failure of the 111 Carrier, the Provider shall receive and assess calls from anywhere in England.

### 4.17. Acceptance and exclusion criteria and thresholds

Exclusion to service delivery:

- Any person in police custody
- Any military personnel on a military base.
- An in-patient in NHS acute hospital care (physical and mental health)
- Women requiring Intrapartum care, where they are already under the care of an acute provider.
- A person requiring treatment for injury at the scene of a road traffic collision.
- Patients who are recorded on the violent patients register, for whom different arrangements are in place for primary care unless there is agreement.
- Clinical conditions where it has been agreed with specialist services that the person needs to be cared for by a specialist service. In these instances the circumstances for groups or individuals need to be jointly agreed and may include agreement with commissioners.
- Dentistry: routine dental care is not provided, and the need for emergency dental treatment is assessed and redirected into the respective community emergency dental service via the DOS.

### 4.18. Interdependencies with other services/providers

The provider will participate in service improvement in any relevant area where a need for service improvement has been identified.

The provider is expected to be a member of the appropriate groups and contributes to the development of strategic and operational models and urgent and emergency care pathways.

The provider will be required to comply with locally agreed pathways. This will include service improvement and pathway development for people with mental health problems and dementia.

Any others that we wish to list here??

Comment [RL14]: Any others?

### 4.19. Intelligent Commissioning

The Provider is required to develop good joint working relationships with the local health and social care system to provide a consistent and coordinated service to patients. This is particularly relevant in relation to the local ambulance service.

The Commissioners have chosen to use the NHS Standard Contract compliant with APMS requirements and will not dictate the commercial arrangements between Providers, but it is expected that the Provider will encourage partnerships/innovations with the key stakeholders.

Comment [RL15]: TBC once commissioning options paper is approved.

#### 4.19.1. Local Pathways

## OFFICIAL–SENSITIVE: COMMERCIAL

The local pathways as listed below require the provider to have a close working relationship with but not limited to ambulance providers, local urgent care providers, community services pathways, social care, palliative care and establish a constructive rapport with other local urgent care, primary care, secondary care and mental health care practitioners. Relationships with GPs, community services and local voluntary groups, especially those that relate to local pathways are absolutely vital. These include, but are not limited to:

- Long Term Conditions
- Mental Health
- Children services
- Palliative Care / End of Life
- Stroke
- Urgent Care
- Community Teams such as Rapid Response Teams
- Community Pharmacists
- Dental services

The provider is expected to evidence its experience/provide commissioners with assurance that it can/has developed clear service standard operating procedures (SOPs) at the ITT stage of this procurement. These will then be implemented through the mobilisation period to provide assurance of a smooth transition/go live. This is also to ensure that the service is clear about the entry points into other pathways, through the CAS, Integrated Urgent Care (NHS 111) and via the Directory of Service (fixed and mobile).

These SOPs need to reflect the ability to make appointments into other services and be able to conference call for additional specialist input where appropriate. Discharge and transfer protocols need to be made clear, noting any system requirement, which would support the patient's journey.

Working in partnership with specific organisations will require the provider to do the following:

### **4.19.2. Integrated Urgent Care Service**

- Delivery of clinically safe, person centred services as required by this specification. The provider is required to operate according to the following core principles:
- The use of a range of interactions with the patient to effectively diagnose and signpost;
- Ability to refer callers to other providers without the caller being re-triaged;
- Ability to transfer clinical assessment data to other providers via ITK where possible and book appointments where appropriate;
- A clinically diverse and experienced workforce model but with effective use of other members of the multidisciplinary team.
- Providing excellent and helpful management information and intelligence to commissioners regarding the demand and usage of urgent care services, enabling evidence-based commissioning and proactive support to be offered to specific client groups;
- Business continuity and disaster recovery for local incidents and national emergencies.
- Improved patient experience because it has access to important health information

## OFFICIAL–SENSITIVE: COMMERCIAL

and preferences such as that held in the NHS Summary Care Record, and End-of-Life care registers;

- Enabling callers that have care plans, special patient notes and other arrangements to be easily identified and managed according to locally agreed pathways;
- Providing services for callers and users of services, whose first language is not English and providing an improved supportive response for callers who may have additional needs;
- Robust clinical governance arrangements to support the services themselves with development, incidents and complaints, but also sufficient capacity to contribute to the community wide processes e.g. membership or urgent clinical networks, 111 assurance processes and primary care audit;
- Close collaborative working relationship with Commissioners and other stakeholders to both develop and promote the use of the right services by patients;
- Data processing, meeting information governance and security standards and ensuring data controllers have the required access;
- Effective communication with other health professionals and services, especially the person's own GP practice.
- Implementation of a 'Lead Governance' Provider whose responsibility will be to integrate governance data produced by partners working within the CAS. This data will be made available on a monthly basis in a format agreed with the Commissioner.

### **In addition:**

The provider will understand the benefit of having a workforce which is not only suitably skilled and experienced but understands the local nature of the urgent care system and providers. This enables the services to benefit additionally from local knowledge & cultural issues, relationships and understanding of the local urgent care services and primary care which create a better service for patients.

### **4.19.3. In-Hours GP, Primary Care Services and Extended Hours**

- Work with the local federations, Local Medical Committee (LMC), Local Pharmaceutical Committee (LPC), GP leads from localities and relevant services to cooperate and coordinate a range of strategies to ensure that patients receive care out of hours when clinically indicated, and that inappropriate use of the GP OOH service by patients who would best be managed by the in-hours service is avoided.
- To specifically work with the GPs who have been awarded non-recurrent funds to increase access and provide additional services across the localities areas and at acute provider premises.
- Work with the other relevant GP individuals and groups to increase the level of involvement by local GPs in the GP OOH service, noting the requirements under the GMS/PMS contract.
- Regularly meet with GP representatives to carry out general case reviews, analyse incidents and professional feedback/complaints in order to improve performance, ideally through the clinical governance meeting.
- Ensure that all clinical information relating to the patient journey, through Urgent Care by the provider, is passed to the patient's registered GP practice by 8am the next working day under the PEM requirements.

#### 4.19.4. Ambulance Services

To work with local Ambulance Service trusts (being predominately SECamb and SCAS) to ensure that patients in the community suffering an emergency or perceived emergency receive the most appropriate response, management and onward care. To include the service being able to accept calls (through a dedicated line, similar to the HCP line currently in existence) from ambulance crews on site and to offer clinical support and advice. To have functionality should it be required to call back patients who have initially contacted 999 services and received a non-emergency response. This cooperation and coordination can reduce inappropriate use of the emergency ambulance service and reduce associated inappropriate secondary care emergency department attendances through reduction of conveyances.

- This cooperation and coordination will increase appropriate use of the provider's service.
- Have a number available for healthcare professionals (paramedics, technicians and clinical support desk staff, community services and others) to contact the CAS and access healthcare professionals (with the same call answering standards as for Integrated Urgent Care (NHS 111 element).
- Work with the local ambulance service trusts and the commissioner to provide an Integrated Out of Hours response to non-emergency patients who need clinical assessment and management in their own home, which may relieve the need to dispatch an ambulance, where the OOH service can visit in an appropriate timescale.
- This Integrated service will apply the appropriate skill mix, teamwork, triage and communication to make the most appropriate use of all clinical skills including but not limited to Community Nurses, OOH Doctors and Emergency Care Practitioners in providing assessment and care to patients in their own home.
- Meet regularly with local stakeholders at Integrated Urgent Care Clinical Governance meetings for the service to carry out case reviews and analyse incidents and complaints in order to improve performance and develop the service. The Commissioner would facilitate these.

#### 4.19.5. Accident and Emergency (A&E) Departments (Secondary Care)

In conjunction with the commissioner the Provider is required to work with all providers of Urgent Care to reduce the number of self-referrals to hospital A&E departments, whose clinical problem does not require an A&E attendance. The provider is required to work with hospital A&E departments to achieve the rapid, safe transfer of patients inappropriately referred or attending A&E through the IUC service, to other appropriate services on the DoS which may include Urgent Care Centres (UCC), Minor Injury Units (MIU) or Urgent Treatment Centres (UTC).

- Provide visible and staffed out of hours treatment centre(s) at the locations identified.
- The out of hours treatment centres will provide patients with appropriate facilities distinct from the A&E department but effective communication and collaboration will allow integrated management of relevant patients as indicated to achieve safe and timely interventions and avoid inappropriate secondary care intervention or admission.
- In conjunction with the commissioner, work with A&E clinicians and managers to develop the care pathways required to achieve the above.
- In conjunction with the commissioner, meet regularly with hospital A&E departments to carry out case reviews and analyse incidents and complaints in order to improve

performance and develop the service.

- Work with the trusts and the commissioner to provide an Integrated Out of Hours primary care response to non-emergency patients who need clinical assessment and management in their own home, post discharge.

#### **4.19.6. 4.19.6 Urgent Treatment Centres – encompassing Urgent Care Centres, Minor Injury Units, Walk-in Centres and other community based urgent care facilities**

- It is anticipated that the Provider/IUC service will work collaboratively alongside the Urgent Treatment Centre (UTC) providers as per patient pathways and the DoS, ensuring that the most appropriate service is recommended to meet the healthcare needs of the user.
- Additionally, there are ambulance conveyance protocols in place in respect of the routing of patients which will remain in place with the new IUC provider to ensure efficient movement of service users across the system. It is expected that both the IUC and UTC providers will work collaboratively with each other and the CCGs to implement efficiencies in the system.
- Work with other providers to establish an integrated approach in conjunction with those existing UTCs which are most appropriate in terms of geography, amenities, services and associated features.
- Provide primary care – treatment/base centre appointments and care through the work of Nurse Practitioners supported by HCAs.
- This integrated service will apply skill mix, teamwork, triage and communication to make the most appropriate use of clinical staff in providing assessment and care to patients in their own home.
- Meet regularly with the commissioner and any other systems established to carry out case reviews and analyse incidents and complaints in order to improve performance and develop the service at the clinical governance meetings.

#### **4.19.7. Local Out of Hours Treatment Centres/Community Nurse Teams/ Mental Health Team Providers**

- Work with other providers to establish an integrated presence of a community nurse team in each of the local OOH treatment centres.
- This presence will give the OOH GPs, nurse practitioners and others regular face to face contact with the community nurse teams.
- This contact will allow effective shared care of patients through discussion, shared consultation and referral between clinicians to achieve the most appropriate skill mix and care.
- Work with other teams and contracts to establish easy access for OOH clinicians to the appropriate local urgent mental health service for advice, shared care or onward referral.
- Work with local mental health trust and managers to develop the care pathways and IT links required to achieve the above.
- Meet regularly with the commissioner through the clinical governance forum and other local mechanisms, to carry out case reviews, analyse incidents and complaints in order to improve performance and develop service at the clinical governance meetings.

#### **4.19.8. Social Care providers**

- Work with the localities and social services departments, including out of hours emergency teams, other bordering county councils as appropriate and other providers of care as appropriate to establish a coordinated, cooperative urgent care service.
- This cooperation will establish a common vision, pathways of shared care, identified referral triggers and enhanced communication.
- This enhanced communication will be enabled by shared information about

## OFFICIAL–SENSITIVE: COMMERCIAL

common service users, their risk factors, support mechanisms and successful management strategies.

- Meet regularly with social care providers to carry out case reviews and analyse incidents and complaints in order to improve performance and develop the service at the clinical governance meetings.

### 4.19.9. Community Hospitals

- Work with the commissioner to establish how the provider will deliver Out of Hours medical advice and care to community hospital in-patients, intermediate care facilities and care home residents and develop a service level agreement that reflects these arrangements.
- This cooperation will establish a common vision and standards, pathways of shared care, identified referral triggers and enhanced communication.
- Assist the professional development, education and training of community hospital staff and reduce inappropriate referrals to the GP OOH Service.
- Through the Directory of Services and other local mechanisms, and where appropriate, the provider will ensure that admission avoidance schemes are used as an alternative to a hospital bed.
- Meet regularly with community hospital leads to carry out case reviews and analyse incidents and complaints in order to improve performance and develop the service at the clinical governance meetings.
- Access to step-up beds??

**Comment [BG16]:** Need to understand what has been specified in the G&W CCG Adult Community contract re: OOH provision, to avoid duplication.

### 4.19.10. Community Pharmacists, Dentists and Optometrists

- Work with the Commissioner, NHSE, The Surrey Local Pharmacy Committee (LPC), Local Dental Committee (LDC) and The Local Optical (LOC) to establish a coordinated and cooperative Urgent Care service which may involve co-location of staff into the call centre/clinical hub.
- This cooperation will establish a common vision and standards, pathways of shared care, identified referral triggers and enhanced patient communication.
- This co-ordinated service will maximise the involvement of community pharmacies and pharmacists, dentists and optometrist's in the management of minor illness, through the sale of pharmacy medicines and self-care and the provision of health care advice and information.
- This coordinated service will reduce the number of calls to the provider from patients wanting prescriptions for routine repeat medication.
- The provider will be required to report on the number of repeat prescriptions issued by practice.
- Regularly meet with pharmacists working in IUC supported by the LPC to carry out case review, analyse incidents, feedback and complaints. This is in order to improve performance and develop the Service at the Clinical Governance meetings.
- Regularly meet with dentists and optometrists to review the service, carry out case reviews and analyse incidents and complaints in order to improve performance and develop the Service at the Clinical Governance meetings.

### 4.19.11. Other Partners, Voluntary Sector and Other Service Providers

- Work with other relevant partners to establish the most appropriate nature, place and timing of Urgent Care for varied patients.
- These partners will include but not limited to, voluntary organisations, neighbouring providers, hospices and other Urgent Care services and the local police forces.
- This cooperation will establish a common vision and standards, pathways of shared care, identified referral triggers and enhanced communication.
- Meet regularly with these other partners to carry out case reviews and analyse

## OFFICIAL–SENSITIVE: COMMERCIAL

incidents and complaints in order to improve performance and develop the service, ideally through the Clinical Governance meetings.

### **4.19.12. System Resilience, Transformation and Urgent Care Networks**

The Provider is expected to attend the appropriate required meetings and contribute to the wider urgent care network and system resilience planning requirements.

## **4.20. Improved patient experience**

Providers must ensure and evidence to the commissioner that it has a systematic process in place to regularly (quarterly as a minimum) seek out, listen to and act on patient feedback (being representative of those using the service) on their experience of using the service, to ensure that they deliver a patient-centred service. This must include:

- Clear, accessible and well-publicised routes for both patients and health professionals to feedback their experience of the service (in line with the Accessible Information Standard).
- Provide prompt and appropriate responses to that feedback
- Regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional insight into the quality of the service.
- Systems in place to collate, aggregate and triangulate feedback from a range of sources such as complaints, surveys, friends and family test, social media, compliments and online resources including NHS Choices, [www.nhs.uk](http://www.nhs.uk), or [patientopinion.org.uk](http://patientopinion.org.uk). This will be used to identify key themes, lessons learnt and actions to be taken.
- Demonstrate via quarterly reports how feedback from these various channels has informed learning, giving examples of changes that have been made to processes and procedures.
- The whole patient feedback process needs to be fully transparent. It is important that an approach that allows users to see the views and experiences of other patients and service users and the responses made by the service and in line with the reporting requirements detailed below.
- Provide analysis quarterly of those areas or population groups that are not accessing NHS 111 element of the service.

The provider will ensure there is a robust process in place for capturing, recording and acting upon feedback (pro-active and reactive) from patients, carers, relatives and any other third party. The provider will have a ratified complaints policy, accessible to staff and public, which details the process for investigating complaints in accordance with the NHS Complaints Regulations (2009) and other good practice guidance, such as the Patient Association Guide for Good Complaints Handling. The provider will also ensure they have a mechanism in place to record and respond to informal enquiries (also known as a PALS Enquiry) and compliments. The provider will ensure that all feedback informs continual improvement of service.

In addition to receiving patient and public feedback, the provider will have a process through which concerns from General Practitioners and other professionals can be

## OFFICIAL–SENSITIVE: COMMERCIAL

recorded and responded to. The provider will ensure that all feedback is triangulated to identify key risks and emerging concerns and to inform quarterly complaints summaries and annual complaints reports.

### 4.21. Communications, engagement and marketing

Patients should be kept informed throughout their patient journey about what they should expect, who will be seeing them and where that will happen. Timescales should be clearly explained at the outset, based on the standards in the service specification and there must be a robust, monitored and auditable system in place that updates the patient about any changes in waiting times and assesses whether there are any changes in the patient's condition that would result in a different course of action to be taken. Where this timescale cannot be achieved, patients should be called back within the time-frame to review their clinical status and update their expectation.

Where applicable, written information should be provided to all patients and carers who visit or who are visited by the Service detailing the episode of care and, where appropriate, to confirm the clinical assessment. Providers should adhere to the Accessible Information Standard (AIS), offer appropriate assistance and make reasonable adjustments for patients and carers who do not speak, read or write English, or have other communication needs (by using Language Line/equivalent where appropriate). The AIS requires providers to identify; record; flag; share and meet communication needs.

The provider will be responsible for monitoring language requirements of patients and ensuring that written materials are accessible for all and are available in different formats and major spoken languages.

Patients unable to communicate effectively in English must be provided with an interpretation service within 15 minutes of initial contact. The provider must also make appropriate provision for patients with impaired hearing or impaired sight using the most up to date techniques available at the commencement of the contract, complying with AIS requirements.

The Provider may also be required to attend the Commissioners Patient, & Carer Advisory group meetings at least twice per annum.

Providers shall comply with the Equality Act 2010 and not discriminate between or against patients or carers on the grounds of gender, age, ethnicity, disability, religion or faith, sexual orientation, pregnancy or maternity, gender reassignment or any other non-medical characteristics. Equality monitoring of service users should be carried out.

The provider must take account of any individual requirements. This includes the following:

- Cultural background
- Learning disability
- Terminal illness- this should link with the End of life care service
- Patients with long term physical illness
- Patients with long term mental illness
- Patients with complex care needs
- Patients with challenging behaviour
- Patients with dementia

## OFFICIAL–SENSITIVE: COMMERCIAL

The provider must ensure that all staff receives Equality and Diversity training in line with the frequency required by their mandatory training programme.

There should be clear flagging of these issues on the notes available to clinicians working in the service where this information is available, either through past contact or information passed from Primary Care and other services. Where this information is not available, the GP Practice should be notified by 08.00 hours.

The service should communicate contact information regarding vulnerable patients to their primary carer. The service must have a comprehensive website which includes the statutory requirements to state Compliance with CQC standards 'Regulation 20A – is the requirement to display performance assessments'. Providers must ensure that their ratings are displayed conspicuously and legibly at each location delivering a regulated service on their website. This must be updated at least quarterly with information about the service and links to other relevant services for use by patients, clinicians and other services.

As detailed below the provider must ensure there is a robust feedback mechanism, with strict KPIs in place to allow patients and carers to comment on aspects of the service (including complaints).

The Provider shall communicate effectively with the Commissioner, local services (including, but not limited to, GP providers, acute trusts, mental health providers and community health providers), the local population and any organisations representing their interests. To support this, The Provider shall:

- Work with Commissioners and local patient groups to jointly establish a strategy to manage any communications relating to IUC Service;
- Co-operate with Health Scrutiny and Overview Committees, Health & Well Being Boards and other stakeholders, as directed by Commissioners; and
- Ensure that Commissioners are made aware of anything that has the potential to impact on service delivery or generate adverse publicity.

Feedback from Healthcare Professionals is imperative with respect to the governance, safety and quality of the service and to enhance patient experience.

In addition to the formal processes for reporting an incident, whistle blowing or making a complaint where there is significant cause for concern, systems to gain feedback from clinicians should be developed.

Existing policies and processes that provide evidence and facilitate raised awareness of issues should be used to inform improved systems for the collection and collation of information that will identify potential gaps, service conflicts, complaints and concerns.

Systems should include:

- Strict KPIs for acknowledging feedback within 3 days and strict KPIs for investigation time and report back.
- Robust data capture in relation to incidents, complaints and concerns to enable full investigation.
- Provision of feedback mechanism to allow healthcare professionals to comment on the quality and safety of the service, secure whistleblowing process.
- Evidence of implementation, with updated procedures presented to the Commissioner of actions to improve the quality of the service and relevant healthcare professionals.

## OFFICIAL–SENSITIVE: COMMERCIAL

For the NHS to improve A&E performance it is important that when someone has an unexpected, unplanned urgent medical need, that is not life threatening, they call 111 instead of attending their local A&E department. That way they can be directed to the best placed local service for their needs.

Public facing marketing of the NHS 111 number is essential to changing the way that people access urgent and emergency care services. This becomes more important as new urgent care services are introduced because it is simpler to change people's behaviour to calling 111 instead of attending A&E than to explain all alternative the services that are available to them.

As a national service all public facing communications and marketing for NHS 111 must be consistent across the country. This is the responsibility of both national and local teams to deliver in partnership. This section sets out the national and local responsibilities for marketing the NHS 111 number.

To deliver nationally consistent public facing communications and marketing it is essential that the NHS 111 brand is properly applied. The Commissioner shall ensure that the NHS 111 brand guidelines are followed. The NHS 111 brand must not be altered. If any issues are encountered with applying the brand it is the Commissioner shall inform the national NHSE IUC team.

NHSE shall manage the NHS 111 brand and guidelines, including updating as necessary. This includes but is not limited to monitoring the application of the NHS 111 brand.

To ensure that marketing activity is nationally consistent all NHS 111 marketing materials will be developed with the national IUC team. National marketing of the NHS 111 number can only be delivered at a national level. The responsibility for delivering national NHS 111 campaigns resides with NHSE; this includes the following aspects of marketing:

- Development of the national marketing strategy for the NHS 111 number and Online;
- Development of marketing campaign creative (campaign assets) to be used both nationally and locally. These will be made available to local teams by the national IUC team, such as digital assets, infographic, posters, flyers etc.;
- Management and implementation of national marketing activity for the NHS 111 number.

The Commissioner shall:

- Ensure that all local communications and marketing activity follows the NHS 111 and Online brand guidelines and where appropriate makes use of nationally developed marketing creative;
- If the nationally marketing creative is not suitable for local marketing requirements, liaise with the national IUC team to develop new creative that is consistent with national NHS 111 campaign materials;
- Liaise with other local NHS commissioners and providers to ensure that any communications and marketing activity does not negatively impact on service delivery; and
- In conjunction with the Provider, deliver local marketing activity that is consistent with the national IUC (including NHS 111) marketing strategy.

### **4.22. Staff and Patient Feedback Surveys**

Patient and staff feedback is a fundamental part of understanding the performance of the IUC service and whether it is meeting patients' needs. Feedback allows the experiences of

## OFFICIAL–SENSITIVE: COMMERCIAL

patients and staff to inform service design and changes. Consistent approaches to surveys between areas are a key requirement of providing information that is comparable between areas.

The provider will ensure they either participate in a national programme of patient survey or implement their own regular survey programme through which patient's experience and feedback can be obtained and monitored. The provider will also ensure they implement other mechanisms to capture patient feedback including national and local initiatives such as participation in the national Friends and Family Test initiative or through local comment cards. Such feedback surveys will be undertaken to ensure that data capture is comparable, providing insight within and across areas for both commissioners and NHSE, as required/in accordance to the Workforce Blueprint requirements.

### 4.23. IUC for Carers

In May 2014, NHSE published *Commitment to Carers* seeking to give the 5.5million carers in England the recognition and support they need to provide invaluable care for loved ones; in December 2014 NHSE and the Royal College of General Practitioners published *Commissioning for carers: Principles and resources to support effective commissioning for adult and young carers* a resource to support CCGs identify and help carers to stay well and deliver the best outcomes for carers. In May 2016 NHSE published an integrated approach to identifying and assessing carer health and wellbeing paper to address changes to the way carer health and wellbeing is identified, assessed and supported.

The Provider shall ensure that the IUC Service is designed around the holistic needs for patients who are carers and carers who are patients – both adult and child carers in accordance to the relevant/latest guidance.

The Provider shall ensure that staff training and systems enable the needs of carers to be considered within the unscheduled urgent & emergency care episodes of care; as cemented within the Equality Act (2010), associated Equality Duty and the NHS Constitution, this means that services must be flexed and reasonable adjustments (include where appropriate, more favourable arrangements) made when dealing with carers.

The Provider and the Commissioner shall work with patient representatives and service users to embed the services needed to meet the needs of carers, which includes ensuring information systems and patient records are able to record relevant information about carers and their dependents.

Based on feedback from services users, two vignettes guiding the types of service considerations that must be made have been included in Appendix H.

### 4.24. Service development and changes

The Commissioner and the Provider shall work as an integral part of local systems and with stakeholders to create improvements in service, embed evidenced based national and local learning into local service provision and plan for changes in strategy, technology and demand, to achieve the aims set out in this specification.

In order to achieve this, the Commissioner and the Provider shall demonstrate how fundamental principles set out below are reflected in their organisational structure and culture:

- Partnership and Integrated Approaches

- Innovative and developmental
- Listening
- Flexible
- Responsive
- Resilient
- Excellent Clinical Governance & Assurance processes
- Robust Policies and Procedures
- Open and Transparent
- Focus on Patient Pathways and outcome
- Delivering appropriate value for money

## 4.25. Future Technology

Three programmes (see Appendix I) have been established by NHSE to deliver the future technology required to support IUC. **The Commissioner must support and enable the implementation of these initiatives.** Where these are emerging products and solutions initial phases will be able building sufficient flexibility into any contracts and commissioning arrangements. Where there are more defined deliverables such as 111 Online it is expected that local decisions will involve STPs as well as considering connections to primary care digital patient access.

**Comment [RL17]:** This is a mandated requirement, may need re-wording but the requirement remains. Suggested wording below:

Through the agreed SDIP, the Provider will work collaboratively with the Commissioner to implement the future technology requirements as outlined by NHS England in Appendix I

### Clinical Triage Platform

The Clinical Triage Platform (CTP) is a programme of transformation to improve the precision, access, and utility of patient triage in the urgent care system.

The objective of the Clinical Triage Platform is to provide NHS 111 services as well as the wider UEC system with the ability to benefit from more advanced triage systems. These systems will be tailored to the needs and risk profiles of the individual patient; enable more responsive improvements and critically will be underpinned by connections to patient and system wide outcomes. Further details are contained in Appendix I.

#### 4.25.1. Access to Service Information

The DoS remains central to ensure providers are able to get the patient to the right service. There are improvements needed to support the transformation of urgent and emergency care. These include the functionality to book appointments, transfer care and understand capacity and real time availability. Further details are contained in Appendix I.

#### 4.25.2. NHS 111 On-line

In 2017 patients' expect to be able to access healthcare via digital channels. As defined in the Five Year Forward View Next Steps published in April 2017, all NHS 111 services are required to have an online service in place by December 2017.

More detailed guidance on expectations and implementation decisions for NHS 111 is set out in Appendix I and regional workshops will be held during the summer to finalise planning and share final evaluations from the pilot projects.

## 4.26. New Services/Helplines

NHS 111 should be the telephone contact for all urgent care services. However, there may be occasions where there is a need for a bespoke helpline using a separate non-geographic freephone number (for example, a service only required by a very small number of people for a limited period). The provider shall provision any such numbers at local level on request.

## 5. Applicable Service Standards

### 5.1. Applicable national standards

The Provider shall deliver the IUC Service in accordance with best practice in health care and shall adhere to the current standards and updated standards and guidance as these are developed and recommendations including those contained in, issued, or referenced as follows:

- Access Information Standards.
- Common law duty of confidentiality (CLDC).
- Code of Confidentiality, Records management;
- Standards issued by the Care Quality Commission, including Essential Standards of Quality and Safety.
- Data Protection Act 1998
- NHS Constitution
- The Vetting and Barring Scheme
- Registration of staff who carry out regulated activity with the Independent Safeguarding Authority (ISA)
- All National Institute for Health and Clinical Excellence (NICE) guidance that is relevant to conditions presenting in an Urgent Care Centre
- National IUC CAS Key Performance Indicators
- NHS Complaints regulations 2009
- National Incident management guidance
- Child and adult safeguarding regulation and guidance
- Central Alerting System (CAS) Safety Alerts
- National outcomes framework
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- National Dementia training requirements

### 5.2. Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The Provider shall adhere to:

- ISO 9001 – Quality Management standards
- ISO 27001 – information Security Standards
- ISO 22301 – Business Continuity Standards

The Provider shall ensure that all Information Standards Notifications issued by NHS Digital are implemented in a timely fashion where applicable to the service.

The Provider shall adhere to other standards issued by a competent body such as the Royal Colleges and Health Education England/committee General Practice Education Directors requirements for GP registrars.

### 5.3. Statutory Duties

### **5.3.1. Information Governance2**

#### **5.3.1.1. Information Governance Compliance**

The Provider will identify an Information Governance Lead and provide assurance to the Commissioner that it:

- will maintain an up to date Data Protection Registration with the Information Commissioners Office (ICO).
- has completed and published an annual information governance assessment using the NHS Information Governance Toolkit and achieved a minimum level 2 performance against all requirements in the relevant Toolkit. Any standard that does not achieve this level must have an improvement plan to be completed within reasonable timeframes and approved by the Commissioner;
- has adopted and implemented the recommendations of the Caldicott Information Governance Review and the Response to Caldicott (or is in the process of doing so);
- has completed the Information Governance Statement of Compliance (IGSoC) process and has in place an IGSoC that has been approved by NHS Digital or its predecessor Health & Social Care Information Centre (HSCIC).

The Provider must ensure that its NHS Information Governance Toolkit submission is audited in accordance with Information Governance Audit Guidance where applicable. The Provider will participate in any additional Information Governance audits agreed with the Commissioner.

The Provider will comply with all relevant national information guidance and best practice including, but not limited to:

- Confidentiality: NHS Code of Practice
- Information Security Management: NHS Code of Practice
- Records Management Code of Practice for Health and Social Care 2016

The provider will supply a detailed plan for taking forward any transfers of patient related records that may be required from current service providers. This plan will fully reflect the information governance requirements relating to records transfers detailed with the Records Management Code of Practice for Health and Social Care 2016 issued by the Information Governance Alliance (IGA).

The commissioner and provider shall carry out an Integrated Impact Assessment (IIA) incorporating a Privacy Impact Assessment (PIA) on selection of the successful bidder.

The provider will be responsible for the secure storage, maintenance, archive and destruction of all records, including paper. At the end of the contract, these will be transferred to the commissioner or a third party nominated by them.

The Provider must report and publish any Information Governance or Cyber Security incidents in accordance with the HSCIC's Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation.

The provider must demonstrate that staff delivering the service are fully indemnified to provide the service and shall maintain in force at its own cost appropriate indemnity arrangements as set out in the NHS Standard Contract General Conditions Clause GC11 Liability and Indemnity.

Intellectual Property Rights (of whatever description) in any material, work, product, process, technique, software, apparatus or equipment (of any nature), or any improvement thereto, including in the Patients Database, which are created by employees of the contractor in the course of the provision of the services (the "Foreground Intellectual

## OFFICIAL–SENSITIVE: COMMERCIAL

Property Rights”) shall belong absolutely to the commissioners from the moment they are created.

The provider will supply a detailed plan for taking forward any transfers of patient related records that may be required from current service providers. This plan will fully reflect the information governance requirements relating to records transfers detailed with the Records Management Code of Practice for Health and Social Care 2016 issued by the Information Governance Alliance (IGA).

### **5.3.1.2. Data Protection and Confidentiality**

The Provider shall adhere to the current UK Data Protection Act 1998 (including the EU Data Protection Directive), the latest NHS Caldicott guidance for information governance and NHS Codes of Practice in regards to Confidentiality, Integrity and Availability (including Information and Cyber security) for all the information processed as part of its service.

The Provider shall have relevant policies and procedures in place to manage Subject Access Requests (SAR) from users or their representatives. The Provider shall report against adherence to the SAR target (80% of requests managed within 21 calendar days of receipt and 100% within 40 calendar days of receipt).

The Provider shall notify the Commissioner of any potential / actual legal claims / court orders for the release of records within 2 working days of notification.

The Provider shall establish a nominated Confidentiality or Information Sharing Lead Officer, policies relating to information governance, security and confidentiality of personal confidential information and robust Data Sharing Agreement procedures.

The Provider shall ensure that all staff (including locum, contractor and temporary) have received regular training and retain records on all aspect of data security and Information Governance.

### **5.3.1.3. Protection and retention of information**

The Provider shall demonstrate adherence to the protection and retention of all information collected and used for the purpose of this contract in line with the Public Records Act<sup>15</sup> and NHS Codes of Practice – Record Management (Part1 and 2<sup>16</sup>), whether electronic or manually held.

Any information required to be held longer than minimum periods outlined in the NHS Code of Practice – Records Management, must be approved by the Commissioner prior to retaining the relevant data. All requests must include details of the extension required and justification for request.

The Provider shall provide a copy of its relevant management policies and procedures upon the Commissioner's request.

The Provider shall ensure that disposal of records and information is in line with minimum retention periods, and make use of appropriate and adequate secure destruction methods. The Provider shall also ensure that any sub-contracted / out sourced services are compliant with these standards.

---

<sup>15</sup> <http://www.legislation.gov.uk/ukpga/Eliz2/6-7/5>

<sup>16</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/02/rec-man-pol.pdf>

## OFFICIAL–SENSITIVE: COMMERCIAL

The Provider shall supply a full list of information (including digital assets) that have been destroyed each year and certificates of destruction to support

The Provider shall not process any Personal Confidential Information outside of the European Economic Area without prior approval from the Commissioner (which will not be unduly withheld).

Where information is scanned and held in digital format, the Provider shall ensure that this is done in line with ISO 15489 – Information and Document standard<sup>17</sup> (or the Code of Practice for Legal Admissibility and evidential weight for information stored electronically).

### **5.3.1.4. Privacy Impact Assessment**

The Provider shall complete a Privacy Impact Assessment (PIA) at commencement of service, and shall provide regular annual reviews throughout the duration of the contract. Privacy Impact Assessments must be carried out for all services and projects identifying potential risks and threats to Personal Confidential Data. Subsequent reviews must confirm previous mitigation is effective and identify that current / new risks are being managed accordingly. The PIAs must be appropriate for the scale of the services and demonstrate adequate robustness in line with ICO and NHS guidelines.

### **5.3.1.5. Record Keeping**

The Provider shall adhere to all legislation and best practice concerning record keeping covering both administrative and clinical records. All calls/contacts with users must be recorded accordingly and retained in line with Department of Health guidance on records retention schedules (NHS Code of Practice – Records Management).

The Provider shall ensure that all records created, held and transferred within its services, and other NHS organisations include a verified NHS number as the unique identifier of any record.

### **5.3.1.6. Freedom of Information**

The Provider shall ensure there are relevant policy and procedures in place to support the Commissioner's roles and functions identified in the Freedom of Information (FOI) Act. The Provider shall:

- notify the Commissioner of all FOI requests received in regards to the Service within 5 working days of receipt; and
- consult with Commissioner on all FOI requests received in relation to this service, including, but not limited to, commercial and operational issues.

### **5.3.1.7. Environmental Information Regulations 2004 (EIR)**

The Provider shall have robust policies and procedures to manage requests made under the EIR and respond in accordance with the regulations.

## **5.3.2. Safeguarding Children and Vulnerable Adults**

The Provider shall ensure:

- Up to date appropriate policies and procedures on safeguarding children and vulnerable adults are in place. These will adhere to all relevant legislation, Care Act 2014, codes of practice, statutory guidance and good practice guidance published by the Department of Health and the local safeguarding boards as appropriate. They

---

<sup>17</sup> <http://www.iso.org/>

## OFFICIAL–SENSITIVE: COMMERCIAL

must also adhere to the requirements in section 11, Children Act 2014 and London Child Protection Procedures 2015.

- Safeguarding policies are effectively communicated to its employees (including volunteers).
- All staff are up to date with appropriate level of safeguarding training (for both children and adults) relevant to their role in the organisation safeguarding children and vulnerable adults at risk—as recommended in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff [Royal College of Paediatrics and Child Health, 2014].
- Compliance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards Accountability and assurance framework for adults at risk, also training and competency framework for Prevent. In line with Bournemouth competencies framework as referenced in Care Act 2014.
- Under the Safeguarding Vulnerable Groups act 2006 the Protection of Children Act (POCA) and Protection of Vulnerable Adults (POVA) lists have been replaced by the Vetting and Barring Scheme administered through the new Independent Safeguarding Authority (ISA). The Provider shall fulfil its legal obligations concerning the gaining of Disclosure and Barring Service checks and checking employees through the ISA and relevant national or local safeguarding authority where applicable and will provide evidence of adherence of this to the Commissioners.

The Provider shall ensure that there are appropriate procedures in place to support:

- The immediate reporting of safeguarding concerns through clear procedures;
- The encouragement of 'whistle blowing' where appropriate, including allegations against staff, through clear procedures for staff;
- Effective working practices and policies to prevent abuse and protect individuals;
- Policies shall highlight the inappropriate nature of private arrangements of any sort between the carer and the patient, including the potential for gross misconduct; and
- Other actions necessary to support relevant policies, including the mandatory participation in safeguarding adults reviews, strategy meetings, serious case reviews and other investigations pertaining to safeguarding of adults at risk or vulnerable children.

The Provider shall not take responsibility for providing care to any other vulnerable adults, or children, in addition to the named service user, such as 'baby-sitting' even for short periods of time.

The Provider shall have in force a written policy of confidentiality that will address the needs of this patient group. This must ensure that personal information disclosed to the Provider or named worker in the course of its work is treated by all employees as confidential. Such information will only be disclosed in adherence with the Data Protection Act (1998) and common law duty of confidentiality. Wherever possible confidential information will only be disclosed with the consent of the patient concerned (except where disclosure is required by law or to safeguard children and vulnerable adults at risk of harm). The Provider shall also ensure that all employees are aware, and understand the importance, of confidentiality.

### **5.3.2.1. Children**

The Provider shall publish a named local lead for Child Protection and Vulnerable Adults, who will undertake a local governance role, attend NHS safeguarding children advisory groups and liaise with local agencies to keep children and vulnerable adults safe.

The Provider shall establish a system for accessing information of children subject to a child protection plan with the local authorities in their area and ensure governance arrangements are in place and that this record system is kept up to date.

#### **5.3.2.2. Vulnerable Adults**

The Provider shall adhere to the Department of Health “No Secrets” guidance (March 2000) on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse and also the Care Act 2014.

The Provider shall adhere to all guidance and legislation and have procedures in place to safeguard and promote the welfare of vulnerable adults.

The Provider shall evidence that it has:

- A named lead for adults at risk who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named lead for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- A named Prevent lead who has undergone the appropriate training and has the knowledge and skills to deliver this role;
- Up to date policies for Adults at Risk, MCA, DoLS and Prevent, which will be shared with the Commissioner on request;
- Systems in place to ensure that all staff have the appropriate level of safeguarding training, including MCA, DoLS and Prevent and evidence figures for training to meet required standards;
- Systems in place to record data relating to referrals, concerns raised and involvement in strategy meetings and Safeguarding Adult Reviews; and
- Met the requirement under Making Safeguarding Personal.

#### **5.3.3. Care Quality Commission**

The Provider shall be registered with the Care Quality Commission and adhere to the requirements of registration and notify commissioners of any statutory and legal requirements, enforcements or improvement notices served upon them.

The Provider shall meet all appropriate recommendations made by the CQC into the IUC Service including the Consultation on the Approach to Regulating NHS 111 Services and Appendices issued February 2015.

The Provider shall meet all appropriate recommendations that were made by the CQC interim report into GP OOHs services published in the autumn of 2009, the Department of Health report into GP OOHs services published in January 2010 and the latest CQC approach to inspect commencing from October 2014.

In the future the Provider(s) will be expected to meet all appropriate recommendations in the CQC guidance for IUC Clinical Assessment Services.

#### **5.3.4. Serious Incidents**

The provider will have a Serious Incident (SI) and Never Event Policy which is in line with NHSE’s Revised Serious Incident Framework (2015) and Never Event Policy (2015). The policy is to detail the process through which the provider will identify and investigate Serious Incidents and Never Events, as well as ensuring the implementation of learning to mitigate future risk. The provider will also implement an Internal Incident policy for those incidents which do not meet the threshold to declare as a Serious Incident but still requires internal investigation and action.

Provider reports of Serious Incidents including Never Events reported in accordance with National Guidance:

- The Provider ensures Serious Incidents are reported on Strategic Executive Information System (StEIS) within 2 working days and will inform the commissioner at the time the serious incident is logged.

## OFFICIAL–SENSITIVE: COMMERCIAL

- The Provider agrees grading with Commissioner as per guidance within 3 working days. This should be linked to NHS standard operating procedure for SI reporting.
- The Provider and the Commissioner will agree who the lead provider is to undertake the investigation, complete the report and shares initial findings with the patient / family in accordance with the duty of candour. This is usually undertaken by the Provider and will adhere to local policies.
- The Provider submits report to the Commissioner for quality assurance review within 45/60 days dependant on grade (100% must be completed in time frame).
- The Commissioner will agree that the report is robust and suitable for closure or the Commissioner may require the Provider to make changes to the investigation report or action plan before closure.
- Provider shares the altered report with patient / family within 10 days.
- The Provider shall submit reports to demonstrate 95% completion of actions within timeframes agreed on the action plan. Commissioner to monitor through quality and safety team.

### **5.3.4.1. Breaches of Confidentiality/Data Security/Cyber Security**

The Provider shall ensure that any actual or potential breaches of confidentiality including loss of data and cyber security incidents are reported in accordance with the NHS Digital and NHSE Guidance. This includes reporting of incidents via the NHS IG Toolkit.

### **5.3.5. Health and Safety**

The Provider shall:

- Adhere to and ensure that its employees adhere to the requirements of the Health and Safety at Work Act 1974 and other relevant legislation, including regulations and codes of practice;
- Maintain a specific health and safety at work policy relating to the employment of its own staff whilst carrying out their duties in relation to the Contract on the Commissioners' or any beneficiary's premises; and
- Ensure all notifiable accidents will immediately be brought to the attention of the Commissioners.

### **5.3.6. Infection control**

The Provider shall ensure that the service is delivered in a suitable environment that meets the NHS and Department of Health (DOH) standard for this type of service.

The Provider shall:

- Provide infection control training for all staff during induction and ensure staff attend annual refresher courses;
- Ensure all staff have copies of an up-to-date infection control manual and Infection Control policies;
- Undertake an infection control audit every year from the commencement date of the contract and produce an action plan for areas where the need for improvement has been identified (the scope of this audit must be submitted to the Commissioner for agreement);
- Allow representatives of the Commissioner to visit the site(s) from where the Provider is delivering the service at any time;
- Notify the Commissioner within 24 hours of confirmation of any outbreaks of infection or if any serious incidents arise;
- Ensure that cleaning arrangements are carried out in accordance with the current NPSA Healthcare Cleaning Manual; and
- Ensure that healthcare waste is disposed of safely and in line with current legislation and DH guidance.

### 5.3.7. Complaints

The Provider shall have a written complaints procedure in line with the NHS Complaints (England) Regulations 2009. This will include informing and involving the Commissioner's Clinical Lead at the earliest possible stage and obtaining sign off of responses before being sent to complainants.

It is recognised that some complaints or dissatisfaction may be raised informally. The Provider shall establish a system for dealing with informal complaints (wherever lodged) and patient expressions of dissatisfaction with the service and will engage with other providers and patient groups to improve processes and pathways.

The Provider shall ensure that all complaints are monitored, audited and appropriate action taken within required timescales in line with national guidance.

The Provider shall publish their complaints procedures in a range of formats such as easy read, different languages and online, to ensure that patients are aware of the complaints procedure.

The Provider shall take reasonable steps to ensure that the complaints procedure is accessible to all patients, including those with specific issues such as hearing impairment, non-English first languages, visual impairment, learning disabilities and other access issues and will ensure that they adhere to the requirements of the Equality Act 2010 at all times.

The Provider shall issue a monthly summary report to the Commissioner of all complaints and recommendations received; a status of the progress to address each, any outcome of any investigations and recommended actions to be taken.

The Provider shall ensure that:

- Complaints regulations are adhered to;
- The Complaints Policy is explicit as to Duty of Candour in respect of complaints handling;
- 100% complaints are acknowledged within 2 working days;
- 85% Complaints responded to in 25 working days. The response must include an action plan (monthly complaints audit results to detail compliance);
- Monthly reports should include but not be limited to:
  - Number of complaints
  - Complaints rates and timeliness of responses
  - Trend analysis of complaints broken down by operational department and division and theme. The report shall contain actions implemented as a result and lessons shared
  - Number of complaints reopened
  - Number of complaints sent to the Health Service Ombudsman and outcome
  - Complainant survey results, detailing 100% complainants surveyed, response rate and survey results

### 5.3.8. Record keeping

The Provider shall ensure that record keeping complies with agreed records retention and keeping policies.

## 6. Applicable quality requirements and CQUIN goals

### 6.1. Applicable Quality Requirements/Standards

## OFFICIAL–SENSITIVE: COMMERCIAL

The strategic direction as set out in the Five Year Forward View, and the Urgent and Emergency Care Review, is that UEC services are configured with the aim of managing patients with urgent care needs closer to home rather than in a hospital (A&E or inpatient) setting.

This CQUIN scheme will help realise that strategic aim for patients triaged through NHS 111, specifically that referrals to 999 and A&E are only made when most appropriate. Two of the three components directly link payment to reductions in such referrals. The third encourages improved data capture of dispositions for service improvement, quality of the Directory of Services (DOS) as well as to inform a basis for payment of the CQUIN.

**Comment [RL18]:** CQUIN is now mandated. This will either reduce core budget available or add a cost pressure as there is no scheme at present.

This CQUIN is designed to incentivise providers to ensure only those patients which need to go to either the ambulance service or A&E are referred, where an alternate service is available it should be used. The Commissioner shall ensure that when applied retrospectively through contract variation the CQUIN incentive does not result in double charging.

### 6.2. Applicable CQUIN Goals

The Provider will be required to undertake a CQUIN scheme that ensures referrals to 999 and A&E are only made when required.

### 6.3. Clinical Governance Quality Requirements

The Provider shall establish a robust internal clinical governance structure with an identified senior clinical lead. The clinical lead is responsible for assuring the clinical quality of the service and that this is supported by a suite of robust policies and procedures. The Provider shall submit the policies and procedures (and any subsequent amendments) to the CCGs Clinical Group during mobilisation and afterwards via the Clinical Quality Review Group (CQRG) for review and approval. A range of metrics will be agreed to monitor service quality and these must be reported to commissioners formally at CQRG and upon request by the Commissioner.

A local clinical governance group, under strong clinical leadership and with clear lines of accountability to Surrey, will work alongside the Provider and contracting teams. This group will bring together the NHS 111 service and out-of-hours GP services clinical leads with clinical representatives from across NHS and social care.

The Surrey Commissioners have appointed a local NHS 111 Clinical Governance Lead (CGL). The CGL role is a clinically credible role responsible for the development of relationships across the whole urgent care network.

The CGL is responsible for holding the Integrated NHS 111/Urgent Care provider to account for achieving and maintaining clinical standards and has clear links to the regional and national NHS 111 clinical governance structures.

The Service Provider must participate in the Surrey, regional and National Clinical Governance arrangements as agreed with the Commissioner.

Through the Clinical Governance Group there will be in place, across the Service provider and all partner providers, as a minimum:

- Clear lines of accountability throughout the whole patient pathway.
- Clear engagement and support by the Service Provider for the clinical governance

## OFFICIAL–SENSITIVE: COMMERCIAL

arrangements in partner provider organisations.

- A robust policy and process setting out the manner, in which all incidents will be identified, reported and managed in line with the NHS Duty of Candour. The policy must adhere to the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and include the principals and process for applying the Being Open Policy. Systems for the reporting of, investigating and learning from such incidents must be clearly described. The clinical leadership of urgent care services must play an appropriate role in understanding, managing and learning from these events, even where they have originated in a partner provider organisation. Where an incident occurs that spans other organisations the service should work with that organisation to undertake a joint investigation process, sharing the learning with the Commissioner and other bodies as relevant;
- Detailed knowledge of the different stages in the patient's journey through the integrated urgent care services, including an understanding of the way in which risks at any stage in that journey will be identified and mitigated ;
- Clear and well-publicised routes for both service users and health professionals to feedback their experience of the Service, ensuring prompt and appropriate response to that feedback with shared learning between organisations, including feedback to the individual who was the source of the comment ;
- Regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional important insight into the quality of the Service. The provider will be encouraged to find innovative technological solutions for rapid feedback;
- Regular staff training and refreshing where required on updated policies and procedures, to ensure quality of service is maintained;
- Regular review by clinical leadership of the quality of the calls and interactions especially where their outcomes have proved problematic, with involvement of partner providers;
- provision of accurate, appropriate, clinically relevant and timely data about the Service demonstrating that it is meeting the quality standards set out in this specification, and;
- Data quality maintenance checking processes and policies within the service, and procedures for acting on feedback.
- The provider will be expected to develop a monthly written report which will aggregate all aspects of the above clinical governance requirements

The Provider shall ensure:

- A named Clinical Lead is appointed to the service to provide clinical leadership and that a substantial part of their role is spent at the service providing clinical leadership to staff;
- The Clinical Lead is an experienced senior medical doctor who has the authority and responsibility to make decisions relating to the clinical direction of the service;
- The Clinical Lead has sufficient time and capacity to effectively undertake his or her duties (part of the role of the Clinical Lead will be to link with local primary care, community based services and local urgent care providers to promote and maintain a whole system integrated response); and
- The Clinical Lead, as part of his or her role, engages with and participates in work to develop ongoing understanding of the health needs of the local population and of local health care services.
- There is a clinical governance audit programme and processes to monitor clinical standards (this must be linked to the Royal College GP audit toolkit or equivalent so there is systemic approach to measuring outcomes).

The Provider's Clinical Lead shall participate in the development of shared governance structures with other urgent care providers in the area and to move towards the

## OFFICIAL–SENSITIVE: COMMERCIAL

implementation of system-wide metrics to fully understand the performance of each component of the urgent care system. This is required to assure quality and ensure there is high quality and seamless integrated care for patients. To achieve this outcome the Provider's Clinical Lead shall work collaboratively with the CCG, primary care networks and other services.

The Provider shall produce a monthly integrated quality report to the Commissioner. This will form the basis of the CQRG meeting. It is recognised that there may be a number of providers involved in the IUC CAS delivery. The Commissioner shall develop and maintain an appropriate reporting structure and ensure that there is close working between all providers to.

The Provider shall submit a monthly report to the Commissioner no later than the third Friday of the following month to which it applies.

The monthly report must include but not be limited to:

- Details of all KPIs within contract;
- Safeguarding issues;
- Incidents;
- Significant incidents - both reported and concluded within period;
- Complaints - divided by theme;
- HCP forms - divided by theme;
- Health advisor, clinical adviser and clinical call and case audits;
- Shift-fill by clinician (including details of agency staff used);
- Ambulance and A&E validation - including details of percentage of those validated and outcomes of validation;
- Clinician involvement in case (as per 5.22 criteria);
- Outcome/disposition - for all cases in IUC CAS (telephone and face to face contacts) and detailed by skill type;
- Friends and family test results;
- Patient survey;
- End to end call reviews; and
- Additional audits as agreed by CQRG (for example, infection control, antibiotic prescribing, ambulance non conveyance reviews or drugs of potential misuse prescribing)

The report must be prefaced with a high level summary detailing:

- Significant incidents
- Complaints
- HCP forms
- Ambulance and A&E validation
- Clinician involvement in case

Additional elements will depend on local variations and developments in the service provided and must be agreed with the Commissioner (examples are available on request).

It is expected that for some areas with multiple providers forming the IUC CAS there will be additional local clinical governance arrangements with host CCGs for some elements. The Commissioner shall ensure that any such arrangements feed into the CQRG to complement the overall IUC CAS Clinical Governance process.

### **6.3.1. Governance Arrangements**

The Commissioner shall publish an organogram describing clinical governance arrangements/included as Appendix XXX.

Comment [RL19]: This is mandated

### **6.3.2. End to End Reviews and Process to Share Learning**

#### **6.3.2.1. Complaints**

See section 5.3.7.

#### **6.3.2.2. Serious Incidents**

See also section 5.3.4.

The Provider shall ensure that all Serious Incidents (SIs) are notified to the CCG Clinical Lead and the Commissioner no later than the day after the incident occurred. SIs must be reported via the Serious Incident Management System (SIMS) where the incident meets SI criteria as defined in the current version of NHSE's Serious Incident Framework or meets criteria for Never Event (NHSE Revised Never Events Policy and Framework). The Provider shall report SIs involving any element of the IUC CAS to the Commissioner irrespective of which IUC provider took the call. The Commissioner may specify additional local processes that the Provider is required to follow.

On production the 72 hour report will be provided to the CCG quality and clinical leads. This will be further reported to the Regional PMO IUC CAS Clinical Lead who will review this and subsequent RCA in order to provide oversight and challenge back to relevant CCG and provider.

The SI reporting to the Regional PMO IUC CAS Clinical Lead will be triangulated against the KPI reporting but this clinical reporting collects the details and RCA from each provider.

The Regional PMO IUC CAS Clinical Leads and the National Medical Advisor for IUC CAS will keep continual oversight on all SIs through this system.

The Provider shall participate in quarterly themed SI "deep dives" to monitor the quality of reporting and RCAs that are sent into the learning log. Following these meetings a brief IUC CAS quality briefing will be shared across all providers in order to share learning and improvement opportunities (see Appendix F).

#### **6.3.2.3. Continuous Audit and Improvement**

The NHS 111 service will be expected to take part in audits and needs assessments to ensure quality assurance and identify any gaps in service provision.

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

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

Audit by clinicians is preferable to reflect the wider assessment role provided by these individuals and must reflect the competences within the Royal College of General Practitioners, Urgent and Emergency Care Out of Hours Clinical Audit Toolkit (2010).

A process will be in place for support and management of staff who are repeatedly non-compliant with audit or are placed repeatedly on action plans.

## OFFICIAL–SENSITIVE: COMMERCIAL

The provider shall participate in a monthly cycle of meetings that include;

- Contract Review Meeting
- Quality Review Meeting
- Clinical Governance/Stakeholder Meeting

### **6.3.2.4. On-going Quality Assurance**

The on-going arrangements for quality assurance will include CCG led Quality Assurance Visits and the commissioner would expect the provider to undertake their own programme of Quality Assurance Visits and report to the commissioner via the Contract Review Meetings.

### **6.3.2.5. Clinical Audit**

The provider is required to develop an annual clinical audit plan to include local audit priorities e.g. medicines management, audit against NICE guidance, themes arising from incidents etc, in addition to applicable national audit requirements. Regular progress reports will be provided to the Quality Review Meeting to include outcomes, risks and action plans to address any shortfalls as per the reporting requirements.

The provider is required to undertake clinical audits of staff as set out in schedule 4 of the

## **6.4. Privacy Impact Assessment (PIA)**

In accordance with NHS Information Governance guidelines, the Provider shall undertake a Privacy Impact Assessment (PIA) for all services. The PIA must include but not be limited to the assessment and treatment of all known risks and be commensurate with the types of services delivered.

## **6.5. Equality Impact Assessment**

The Provider shall meet the full requirements of equality legislation both in relation to the universal service offered to patients but also in how it delivers equality within its organisation and constituent staff. The Provider shall complete an Equality Impact Assessment for the service for the Commissioner's approval.

## **6.6. Performance Management**

Data and metrics about the IUC Service are critical in allowing monitoring, service design and to ensure service resilience. This section outlines the requirements for data provision.

Monitoring will be undertaken through the provision of a range of performance metrics that are reported at regular, specified points. These metrics will provide management information to NHSE and the Commissioner and will allow the Provider to be held to account. Elements of this information will be published by NHSE to provide transparency and visibility.

The Commissioner shall ensure that the procured service is resilient and well-performing. This includes the ability to plan for and respond to peaks in demand, the timing which is usually predictable. The Provider shall plan for, and respond to these changes in demand sharing any information required by the Commissioner to assure the quality and

appropriateness of these plans. This information, along with performance data during the period may be required by NHSE to assure it of the ability of the service to meet the desired levels of performance. On request, the Provider shall release any additional data required by NHSE to undertake this process.

To develop the IUC service to further benefit patients, a robust evidence base is required to inform the service design process. This will require the collection of data items above and beyond those required for the monitoring of performance metrics. The Provider shall share any such data on request establishing connectivity with any centrally provisioned data repositories.

The Provider shall report against all aspects of the MDS within the specified timescales.

The Provider shall integrate with local and or national dashboards rendering real time and historical performance data.

The dashboard will collate (including but not limited to):

- ACD performance data including calls offered, calls answered, abandonment and speed to answer;
- Resource availability and utilisation;
- Clinical queues; and
- Pseudonymised PEM for syndromic surveillance.

#### **6.6.1. Principles**

The Commissioner shall ensure that providers are contractually obliged to share any data required to performance manage and inform the ongoing development of the IUC Service.

The Provider shall ensure that all systems are capable of providing data in accordance with the Commissioner's definitions. These definitions can be found in the NHSE Data Dictionary (Data Dictionary)<sup>18</sup> and other supporting documentation and standards, such as the IUC/NHS 111 Minimum Data Set (MDS)<sup>19</sup>. Where conflicts occur, the IUC MDS definitions take precedence.

The breadth of the IUC service means that data will be required to follow the patient journey through IUC and into the wider health care system. It is important that data is captured and available at each touch point within the IUC service for each patient. This requires that data should be available at the patient level across all IUC services, allowing Commissioners the ability to understand the patient journey through the health care system, starting with IUC. This will afford better understanding of the differential needs of the diverse patient groups. Data should facilitate the ability to link to other health care information, whilst maintaining patient confidentiality.

#### **6.6.2. Reporting and coverage**

Regular reporting of data will be required that covers the entirety of the IUC service for a Commissioner's area. Reporting will involve the provision of data to NHSE and Commissioners. Patient-level aggregate data must be available to NHSE. The Commissioner shall ensure that information is provided to meet the requirements outlined in this Service Specification.

The IUC service is enabled by information sharing and flow. These principles must be continued into the supply of data. A lead supplier of data and information must be specified by the Commissioner who will collate and coordinate requests for data and information that

<sup>18</sup> <http://www.datadictionary.nhs.uk/>

<sup>19</sup> <https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/>

## OFFICIAL–SENSITIVE: COMMERCIAL

covers the commissioned IUC Service. Any sub-contracted providers shall share and provide information about their service to the Provider. This will ensure that, in multi-provider areas, there are clear responsibilities on the collation and supply of data to NHSE, and across services and their commissioners.

Performance reporting will be required at regular intervals, as specified in the IUC MDS. Data to provide assurance of plans at peak periods will be required to ensure a resilient service. The Commissioners shall assure of the quality and appropriateness of these plans. This information, along with performance data during the period may be required by NHSE to assure it of the ability of the service to meet the desired levels of performance. The details of these requirements will be outlined prior to any request for information. The Providers shall support any such information provision in a timely manner.

NHSE will publish a sub set of the information provided, including the MDS, in an aggregate form on the NHS website to provide transparency and visibility. For the avoidance of doubt, this data will be in a form that is non-patient identifiable. The Provider shall ensure that data provided is of adequate quality.

### **6.6.3. IUC Minimum Data Set**

The Commissioner shall ensure the data required to populate the IUC MDS is collected and reported. The IUC MDS is an adaptation of the NHS 111 Minimum Data Set (MDS) and has been specified in close collaboration with providers and commissioners. The IUC MDS forms the minimum level of data provision to NHSE for performance monitoring.

The details of the IUC MDS are published in supplemental document(s). These document(s) may be subject to review and change as the service evolves to meet the needs of patients. The Commissioner shall ensure data complies with the specification outlined in the latest versions of these documents.

Development work will continue to create and set system-wide metrics responsible for tracking patient outcomes as well as service performance. The Provider shall comply with these metrics once agreed.

### **6.6.4. Data Submissions**

The Commissioner shall ensure that data submissions are made using the mechanisms specified and the deadlines outlined in the Service Specification, supplementary document(s) or direct requests. This may be in the form of patient-level data that flows to NHSE, or via aggregate forms. The Commissioner shall ensure a lead Provider is appointed for the IUC Service and that they supply data at the frequency and quality required to comply with local and National requests. The Commissioner shall link the timely provision of data to commensurate service credits within the contract.

### **6.6.5. Disposition and Outcome monitoring**

A key element of understanding the performance of the service and its wider benefit on the health service is the disposition and outcome monitoring. Understanding will be provided through regular performance monitoring and periodic evaluations undertaken by NHSE. This work will be underpinned by information on the call outcome, or disposition and the patient outcome and impact on the wider health service. This information must be captured in line with guidance provided by NHSE, whether that is within the IUC MDS, or evaluation specific guidance.

### **6.6.6. Staff and Patient Feedback and Surveys**

Patient feedback is a fundamental part of understanding the performance of the IUC Service. It allows the Patient's experience of the Service to inform Service design and modification. The Commissioner shall ensure a regular Patient Survey is undertaken for each area to

capture Patients' Feedback. The details of the Survey are contained within the IUC MDS. This outlines the frequency of collection, prescribes question wording and methodology. The Commissioner shall ensure that Services are contracted to meet the requirements outlined in the IUC MDS for Patient Surveys. By following this prescribed information, the Commissioner and NHSE will have comparable data on which to compare performance between areas.

#### **6.6.7. Staff and Financial Metrics**

In order to allow the Commissioner and NHSE to understand the value for money, efficiency and effectiveness of the IUC service, the Provider shall share financial inputs and staff models. Staff and financial information are also required by NHSE for service design purposes. The Commissioner shall ensure that the information available aligns with the requirements outlined in the IUC MDS and is supplied at the frequency to meet these needs. Information supplied to NHSE will be treated as commercially sensitive and will not be publically disclosed.

### **6.7. Syndromic Surveillance**

Syndromic surveillance is the process of collecting, analysing and interpreting health-related data to provide an early warning of human or veterinary public health threats, which require public health action.

The Public Health England (PHE) real-time surveillance team (ReSST) coordinates several syndromic systems collecting and analysing health data from several sources.

The Provider shall ensure that the relevant data feeds are established to support syndromic surveillance in the IUC service and that the relevant data sharing agreements are put in place.

The Provider will ensure that appropriate governance arrangements are in place such that all NHS, voluntary/third sector or commercial organisations participating in the Integrated Urgent Care service are enjoined in the commitment to supply the real-time specified data-set to the PHE (where applicable).

#### **6.7.1. Remote health advice syndromic surveillance system**

Monitoring patterns in phone calls to the NHS 111 service each day across England, to track the spread of infectious diseases like flu and norovirus. This is achieved by linking data held in the Repeat Caller Service (RCS) database.

#### **6.7.2. Integrated Urgent Care surveillance system**

Monitoring the number of visits to GPs during regular surgery hours for known clinical indicators. This data is collected directly from GP systems.

Monitoring the number of unscheduled visits and calls to GPs during evenings, overnight, at weekends and on public bank holidays. This data is collected directly from IUC systems.

### **6.8. Technical Standards**

The provider shall deliver services in accordance with the Integrated Urgent Care Technical Standards (see Appendix D).

## **7. Local Provider Premises**

OFFICIAL-SENSITIVE: COMMERCIAL

The OOH bases/treatment centres will be provided from the locations stipulated below. These are the current base locations and following public engagement feedback are conveniently placed. The provider is expected to keep and maintain these locations for the OOHs face to face provision:

Guildford & Waverley CCG	North West Surrey CCG	Surrey Downs CCG	East Surrey CCG
Royal Surrey Hospital	Ashford Hospital	Epsom Hospital	Surrey & Sussex Hospital (SASH)
Haslemere Hospital*	Woking Community Hospital*	Medwyn Surgery, Dorking*	
Cranleigh Village Hospital*			

\*\* Denotes partial opening times.

In addition to the above, there is access for patients at the community and acute based UTC

CCG	Community	Acute
East Surrey	Caterham Dene	N/A
Guildford & Waverley	Haslemere	Royal Surrey Hospital
North West Surrey	Woking Ashford	St Peters Hospital
Surrey Downs	N/A	Epsom Hospital (facilities also available at Kingston Hospital)

The provider accepts that during the life of the contract that these locations may change and/or additional locations be added which will be agreed with the provider. In all cases where changes and variations to base locations are made, the provider will operate from these bases at cost, with no additional margin and operate open book accounting for all charges. The Provider will also need to seek approval for any future changes to the above locations from the commissioner as public consultation may be required.

The commissioner preference is that the main Integrated Urgent Care call centre / CAS to ideally be situated in Surrey for the duration of this contract, however, the location is not mandated. There are a number of factors to this decision, including that a full complement of Integrated Urgent Care staff are already employed in the county which will assist in mobilisation.

During the Monday- Friday hours of 8.00am to 6.15pm (except on a bank holiday) should the commissioners with other Health and/or Social Care providers wish to locate staff up to 20 staff in the call centre, that this is accommodated at cost.

Commissioner will provide current premises costs available and will provide unwarranted employment related information from current providers with the ITT.

Comment [RL20]: Do we wish to remove this?

Comment [RL21]: Are we?

## OFFICIAL–SENSITIVE: COMMERCIAL

As provided for in the national specification, the provider must have documented and signed business continuity plans in place to receive calls at other call centres (which may not be a call centre that they own).

Where the provider wishes to network calls to other sites, staff at other centres when used, must have received documented localisation training. The commissioner must approve the networking of calls at these other centres and will expect that a certain number of staff ring fenced are maintained where this is supporting the workforce model. This should be agreed as an addendum to the contract signed by both parties.

All facilities should incorporate suitable waiting areas, consultation and examination rooms, furniture, fittings and equipment as required, to provide a safe service. Equipment includes all computer hardware and software required to operate the service.

There must be clear signage in place to ensure easy access for patients, especially where the Service may be co-located with another Provider/service e.g. Accident & Emergency.

As outlined above, any deviation from the current locations, will need prior approval from the Commissioner. There must be reasonable, local access to a treatment centre for patients, across all areas provided for. It is expected that patients should be able to access a base/treatment centre within 30 minutes by public transport/car. In order to deliver this aspiration the service can be provided from either appropriate bases or the patient's home based on the patients discussion with the clinician.

Bases/Treatment Centres should have sufficient parking commensurate with the volume of patients likely to be seen.

All premises should meet statutory requirements and follow best practice guidance. National premises directions define the standards of the above facilities and will be compliant with the latest Disabilities Discrimination Act. Premises must:

- Facilitate the effective and efficient delivery of the GP OOH face to face element of the service to patients.
- Deliver a patient experience and environment that is in line with NHS guidelines.
- Enable the services to be delivered conveniently to patients and NHS standards.
- Take into account the mobility of the local population and the availability of local public transport to maximise access to patients.

All parts of the premises in which Service operates must be suitable for the purpose, kept clean and maintained in good physical repair and condition. In particular the physical environment must comply with Infection Prevention and Control in the Built Environment (NHS Estates: 2002). The document specifically includes (but is not limited to) the following aspects to reduce risks of infection:

- Sizing/space
- Clinical sinks
- Ancillary areas
- Engineering services which incorporates advice on ventilation, lighting, water supply
- Storage
- Finishes, floors, walls, ceilings, doors, windows, fixtures and fittings
- Decontamination
- Laundry and linen
- Waste – segregation, storage and disposal
- Workflow

## 8. Business Continuity/Resilience

### 8.1. Business Continuity

All NHS-funded organisations must meet the requirements of the Civil Contingencies Act 2004, the NHS Act 2006 as amended by the Health and Social Care Act 2012, the NHS standard contract, the NHS England Core Standards for EPRR and NHS England business continuity management framework. The Provider shall ensure that there are arrangements in place to invoke contingency and maintain acceptable service levels in the event of fluctuations in demand, technical failures or staff shortages, fulfilling any obligations outlined in the above named documents alongside the IG Toolkit and the NHS111 National Business Continuity Escalation Policy (Feb 2014), in relation to disaster recovery, business continuity and national resilience requirements.

It is vital that the service remains safe for patients at all times. It is suggested that a collaborative provider-to-provider relationship, where possible geographically separated, would be a pragmatic approach to this. If providers are looking at implementing this approach then this must be undertaken in conjunction with NHSE and the Commissioner, so any changes that may be required to the telephone call routing can be implemented. Any arrangement of this sort must have clear agreement regarding how much activity could be potentially transferred to the support provider.

Commissioners and providers should be aware of their responsibilities to support national disaster recovery in the event that another service provider is unable to take calls due to some catastrophic event. In these circumstances, the NHS 111 National Contingency will be invoked and the Provider shall accept an appropriate proportion of calls in order to maintain national patient safety. The proportion of calls will be determined by the amount of activity each provider routinely experiences. Neither funding nor performance penalties shall be applied to the receiving call handling service in this situation. The Commissioner shall seek to establish retrospectively whether the catastrophic event was within the failing party's control and constituted a breach, or whether it should be classed as "force majeure".

The Provider shall ensure that Planned Engineering Works (PEW) are scheduled to minimise disruption and wherever possible undertaken in such a way as to avoid the need for invocation of National Contingency (in a staged manner or using local contingency arrangements). However, on a case by case basis NHSE will consider the use of National Contingency to cover PEW where there is a high risk of severe disruption to services.

The capacity of the Service should be sufficient to meet call volume and fluctuations in demand, in line with the National Quality Requirements. Providers shall plan their resources in relation to historical demand and ensure that any current trends in demand are also taken into account. Providers shall ensure that their capacity planning is conducted in liaison with other healthcare providers who may be affected by their outputs (for example, urgent face to face service providers, ambulance services, A&E departments).

### 8.2. Response to a Major Incident

The Service has a number of possible roles in response to a major incident. The Provider shall be engaged in planning and preparedness for these roles and must take part in the

## OFFICIAL–SENSITIVE: COMMERCIAL

response if required to do so by NHSE, Public Health England (PHE) or a multi-agency gold command structure.

In certain major incident situations, such as a major chemical explosion, individuals may contact NHS 111 with concerns or symptoms. The Provider shall have mechanisms to identify this type of situation and must link with the appropriate commissioner and provider organisations to ensure appropriate business and service continuity arrangements are put into action.

The Provider shall have mechanisms in place to be informed of a major incident by the NHS and other agencies and to give out the appropriate public health advice as directed by Public Health England or the gold command arrangements which may be in place.

If a major outbreak of a serious infectious disease occurs then the Provider will be an essential component of the response and may experience very high levels of demand. It is likely that the Provider will be part of the NHS command arrangements and will be expected to respond as directed by NHSE.

Therefore, the Provider shall have:

- Staff trained to respond to a major incident at strategic level;
- Major incident plans in place;
- A programme of exercising and testing plans; and
- A plan for implementation of changes to systems to immediately meet the needs of the incident.

The Provider shall include, as part of its Major Incident Plan and Business Continuity Plan, mechanisms, procedures and policies on how to identify any external forces that may affect services and how they plan to handle the matter. These external forces may include, but are not limited to, cyber-attacks, ambulance service strikes, acute hospital declarations of “black” status, resilience groups deciding issues that may affect service and other issues.

Any notification made to the Provider must immediately be notified to the Commissioner within 24 hours along with the plan to tackle these issues.

## Appendix A – Evidence Base

### IUC Evaluation Interim Findings (August 2017)

1. There is evidence that NHS 111 currently directs more people to A&E than need to go because the NHS Pathways algorithm by itself lacks flexibility. The hypothesis is that if more NHS 111 callers received clinical advice, fewer people would be directed to A&E.
2. This view was supported in a North of England Commissioning Support (NECS) study which showed that for a sub-set of callers recommended to attend A&E by the Pathways algorithm, 83% were recommended not to attend after clinical input was provided.
3. Pilots were set up to test this finding across other NHS 111 sites in the North East (NE), Staffordshire, and Outer North West London (ONWL), to understand the impact on Type 1 A & E attendances of providing clinical consultation to NHS 111 calls through a Clinical Assessment Service (CAS) .

### Key Findings

4. A clinical advice service can reduce the number of callers being advised to attend A&E. Of NHS 111 callers in the NE who would have been advised to attend A&E and who were subsequently referred to a CAS, 82% were not then advised to attend A&E.
5. However, the overall effect on the proportion of callers advised to attend A&E is more modest. This is because only around a fifth of callers who would have been advised to attend A&E were deemed appropriate clinically to refer to a CAS. In the NE, the overall proportion of NHS 111 callers advised to attend A&E reduced from 8.0% to 6.4% as a result of this intervention, i.e. a reduction of around 20%.
6. Figure 1 shows that people who attend A&E after calling NHS 111 are comprised of both those who are advised to attend and those who were referred to other services but still choose to attend A&E.
7. The proportion of NE NHS 111 callers actually attending A&E reduced from 21.8% to 21.2%. This is a 3% reduction in A&E attendances by NHS 111 callers. In the NE, 20% of A&E attendances were preceded by a call to NHS 111, therefore the effect on all A&E attendances would be a reduction of 0.6%.

## OFFICIAL-SENSITIVE: COMMERCIAL

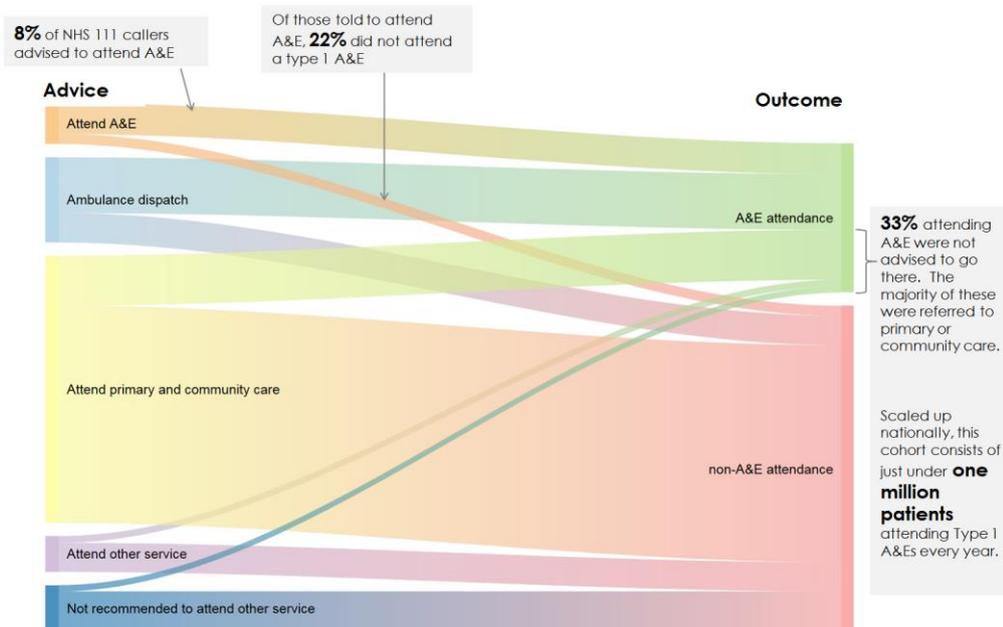


Fig 1

8. These results are consistent with results from Staffordshire. In Staffordshire the proportion of callers advised to attend A&E fell from 7.8% to 6.8% as a result of the CAS. However, there was no statistically significant impact on type 1 A&E attendances from NHS 111.

In ONWL, the model piloted was different. It targeted patients with a pathways disposition of attend ED or contact GP and then compared those who received clinical input to those who did not. There was no statistically significant reduction on type 1 A&E attendances as a result of clinical input.

10. Further evaluation work will focus on understanding why people not advised to go to A&E adhere (or don't adhere) to advice; and the extent to which these related A&E attendances are inappropriate. Key lines of enquiry include:

- Would increased clinical input to this group improve adherence to advice?
- Would immediately bookable GP appointments for these patients improve adherence?
- Would immediately bookable appointments in a UTC help?
- NHS 111 able to issue repeat and new prescriptions?
- Are there other behavioural factors we can target (e.g. how the advice is phrased)?

11. Full phase 1 evaluation findings are available upon request.

## Appendix B - Clinical Governance Tool Kit

<http://webarchive.nationalarchives.gov.uk/20161103214538/https://www.england.nhs.uk/wp-content/uploads/2015/03/nhs111-clincl-govrnce-tool-kit.pdf>



nhs111-clincl-govrnce-tool-kit.pdf

[https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/clinical-governance-in-iuc-guidance-for-commissioners/file\\_popview](https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/clinical-governance-in-iuc-guidance-for-commissioners/file_popview)

DRAFT

## Appendix C – Low Acuity Ambulance and ED Disposition Validation

Candidate dispositions including but are not limited to:

111 Clinical Assessment:

Warm transfer: DX32; DX106; DX321 - 328

Normal transfer: DX36; DX35; DX38; DX58; DX59

A&E Calls:

DX89; DX92; DX03; DX118; DX02; DX0

The timelines required for call back are as follows:

The following pathway disposition codes and call back times are being used in an operational IUC CAS and have been approved by the National Clinical Governance meeting on 22<sup>nd</sup> February 2017.

This is guidance that may be adopted locally but only after local clinical agreement is reached.

**Comment [RL22]:** Do we wish to stipulate our required times?

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
DX05	To contact the GP practice or other local service within 2 hours.	Appointment booking required	Urgent	20 min	Less Urgent	60 min	111 to book appointments directly onto Lincolnshire Urgent Care Rota
DX06	To contact the GP practice or other local service within 6 hours.	Appointment booking required	Less Urgent	2 hrs	Less Urgent	4 hrs	111 to book appointments directly onto Lincolnshire Urgent Care Rota
DX07	To contact the GP practice or other local service within	Appointment booking required	Less Urgent	2 hrs	Less Urgent	4 Hrs	111 to book appointments directly onto Lincolnshire Urgent Care Rota

OFFICIAL-SENSITIVE: COMMERCIAL

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
	12 hours.						
DX08	To contact the GP practice or other local service within 24 hours	Appointment booking required	Less Urgent	2 hrs	Less Urgent	4 Hrs	111 to book appointments directly onto Lincolnshire Urgent Care Rota
DX11	Speak to GP practice within 1 hour.	Clinician call back required	Less Urgent	60 min	Less Urgent	60 min	To go directly to CAS if this is technically possible
DX32	Speak to a clinician within our service immediately	Clinician call back required	Immediate	Warm transfer	Urgent	15min	To go directly to CAS if this is technically possible
DX34	Speak to a clinician within our service within 30 mins	Clinician call back required	Urgent	30 min	Urgent	30 min	To go directly to CAS if this is technically possible
DX35	Speak to a clinician within 2 hours	Clinician call back required	Less Urgent	2 hours	Less Urgent	2 hrs	To go directly to CAS if this is technically possible
DX38	Speak to a clinician for home management	Clinician call back required	Less Urgent	4 hours	Less Urgent	4 hrs	To go directly to CAS if this is technically possible
DX39	Symptom management advice (colds & flu)	Clinician call back required	Less Urgent	4 hours	Less Urgent	4 hrs	To go directly to CAS if this is technically possible
DX46,96	Refer to Health Information	Clinician call back required	Less Urgent	12 – 24 hours	Less Urgent	4 hrs	To go directly to CAS if this is technically possible

OFFICIAL-SENSITIVE: COMMERCIAL

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
DX58,59	No 111 CA available. Refer for urgent Primary Care assessment	Clinician call back required	Less Urgent	20 min (G3) 60 min (G4)	Urgent	20 min 60 min	To go directly to CAS if this is technically possible
DX82	Medication enquiries	Clinician call back required	Immediate	Warm transfer	Less Urgent	1 hr	To go directly to CAS if this is technically possible
DX321	Refused ambulance disposition	Clinician call back required	Immediate	Warm transfer	Urgent	15min	To go directly to CAS if this is technically possible
DX322	Refused ED disposition	Clinician call back required	Immediate	Warm transfer	Urgent	30min	To go directly to CAS if this is technically possible
DX323	Refused Primary Care disposition	Clinician call back required	Immediate	Warm transfer	Less Urgent	2 hrs	To go directly to CAS if this is technically possible
DX324	Refused disposition	Clinician call back required	Immediate	Warm transfer	Urgent	30min	To go directly to CAS if this is technically possible
DX325	Toxic ingestion/inhalation	Clinician call back required	Immediate	Warm transfer	Urgent	15min	To go directly to CAS if this is technically possible
DX326	Frequent caller	Clinician call back required	Immediate	Warm transfer	Less Urgent	2 hr	To go directly to CAS if this is technically possible
DX327	Chemical eye splash	Clinician call back required	Immediate	Warm transfer	Urgent	15 min	To go directly to CAS if this is technically possible

OFFICIAL-SENSITIVE: COMMERCIAL

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
DX110	Community nurse within 4 hours.	Clinician call back required	Less Urgent	60 min	Less Urgent	2 hrs	Contact centre to deal with this request
DX111	Community nurse within 24 hours.	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	Contact centre to deal with this request
DX1111	Speak to primary care service within 1 hour possible viral haemorrhagic fever.	Clinician call back required	Urgent	?	Less Urgent	60 min	
DX112	Community nurse next working day.	Clinician call back required	Less Urgent	4 hrs	Less Urgent	4 hrs	Contact centre to deal with this request
DX113	Health visitor next working day.	Clinician call back required	Less Urgent	4 hrs	Less Urgent	4 hrs	Should not be coming to Urgent care.
DX114	Community midwife next working day	Clinician call back required	Less Urgent	4 hrs	Less Urgent	4 hrs	Should not be coming to Urgent care
DX115	Contact own GP practice next working day for appointment.	Clinician call back required	Less Urgent	4 hrs	Less Urgent	4 hrs	Should not be coming to Urgent care
DX116	Speak to GP practice within 2 hours	Clinician call back required	Urgent	60 min	Less Urgent	60 min	To go directly to CAS if this is technically possible
DX117	To contact GP practice or other	Clinician call back	Urgent	20 min	Less Urgent	60 min	To go directly to CAS if this is technically possible

OFFICIAL-SENSITIVE: COMMERCIAL

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
	local service within 1 hour	required					
DX12	Speak to GP practice within 2 hours	Clinician call back required	Less Urgent	60 min	Less Urgent	2 hrs	To go directly to CAS if this is technically possible
DX13	Speak to GP practice within 6 hours	Clinician call back required	Less Urgent	60 min	Less Urgent	4 hrs	To go directly to CAS if this is technically possible
DX14	Speak to GP practice within 12 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	To go directly to CAS if this is technically possible
DX15	Speak to GP practice within 24 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	6 hrs	To go directly to CAS if this is technically possible
DX76	call-back by healthcare professional within 20 minutes	Clinician call back required	Less Urgent	20 min	Urgent	20 min	To go directly to CAS if this is technically possible
DX77	call-back by healthcare professional within 60 minutes	Clinician call back required	Less Urgent	20 min	Less Urgent	60 min	To go directly to CAS if this is technically possible
DX79	Failed contraception	Clinician call back required	Less Urgent	2 hrs			DX code no longer in use
DX80	Repeat prescription required within 6 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	Can these be managed differently without the need for urgent care input?

OFFICIAL-SENSITIVE: COMMERCIAL

DX Code	Disposition	Status Event	Current Urgency		Proposed Urgency		Comments
DX85	Repeat prescription required within 2 hours	Clinician call back required	Urgent	2 hrs	Less Urgent	4 hrs	Can these be managed differently without the need for urgent care input?
DX86	Repeat prescription required within 12 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	Can these be managed differently without the need for urgent care input?
DX87	Repeat prescription required within 24 hours	Clinician call back required	Less Urgent	2 hrs	Less Urgent	4 hrs	Can these be managed differently without the need for urgent care input?
DX93	Speak to GP practice within 1 hour (3 calls within 4 days)	Clinician call back required	Urgent	20 min	Less Urgent	60 min	To go Directly to CAS if this is technically possible

Indicates NHS 111 CA dispositions

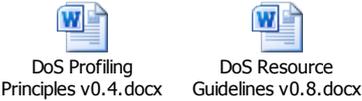
## Appendix D – IT Standards



IUC Technical  
Standards v0.3 - DRA

DRAFT

**Appendix E – DoS Standards [hypertext link](#)**



DRAFT

## Appendix F – Telephony Messaging Strategy



20160601\_IUC\_  
Telephony Messaging

DRAFT

## Appendix G – Urgent Treatment Centre Standards [hyper-text link](#)

Urgent treatment centres must conform to the following minimum standards. Standards are taken from the NHS England Urgent Treatment Centres – Principles and Standards, published July 2017.

1. Urgent Treatment Centres should be open for at least 12 hours a day seven days a week, including bank holidays, to maximise their ability to receive streamed patients who would otherwise attend an A&E department. Typically this will be an 8-8 service, but commissioners will wish to tailor to local requirements based on locally determined demand.
2. Urgent Treatment Centres should provide both pre-booked same day and “walk-in” appointments, however patients and the public should be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.
3. Urgent Treatment Centres, and NHS 111, should support patients to self-care and use community pharmacy whenever it is appropriate to do so. Urgent Treatment Centres should promote and record the numbers of patients offered self-care management and patient education.
4. The Urgent Treatment Centre should ensure that there is an effective and consistent approach to primary prioritisation of “walk-in” and pre-booked appointments, and the allocation of pre-booked routine and same day appointment slots.
5. For patients who require an appointment in the Urgent Treatment Centre this should be booked by a single phone call to NHS 111; locally patients should be encouraged to use NHS 111 as the primary route to access an appointment at an Urgent Treatment Centre.
6. Patients who “walk-in” to an Urgent Treatment Centre should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary.
7. Following clinical assessment, patients will be given an appointment slot, which will not be more than two hours after the time of arrival.
8. Patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time.
9. Protocols should be in place to manage critically ill and injured adults and children who arrive at an Urgent Treatment Centre unexpectedly. These will usually rely on support from the ambulance service for transport to the correct facility. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance ‘*Quality standards for cardiopulmonary resuscitation practice and training*’ should be

immediately available. At least one member of staff training in adult and paediatric resuscitation present in the urgent treatment centre at all times. This should all be part of an approach of 'design for the usual, and plan for the unusual'.

10. An appropriately trained multidisciplinary clinical workforce will be deployed whenever the Urgent Treatment Centre is open. The Urgent Treatment Centre will usually be a GP-led service, which is under the clinical leadership of a GP. There will be an option for bookable appointments with a GP or other members of the multidisciplinary team. Where the centre is co-located with an emergency department there may be justification for joint clinical leadership from an ED consultant.
11. The scope of practice in Urgent Treatment Centres must include minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries.
12. All Urgent Treatment Centres should have access to investigations including swabs, pregnancy tests and urine dipstick and culture. Near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes should be available. Electrocardiograms (ECG) should be available, and in some Urgent Treatment Centres near-patient troponin testing could also be considered.
13. Bedside diagnostics and plain x-ray facilities, particularly of the chest and limbs, are desirable and considerably increase the assessment capability of an Urgent Treatment Centre, particularly where not co-located with A&E. Where facilities are not available on site, clear access protocols should be in place. Commissioners will need to consider patients throughput in their cost benefit analysis where capital investment will be required.
14. All Urgent Treatment Centres should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (e-prescribing should be in place in all sites by June 2019).
15. All Urgent Treatment Centres should be able to provide emergency contraception, where requested.
16. All Urgent Treatment Centres must have direct access to local mental health advice and services, such as through the on-site provision of 'core' liaison mental health services where services are co-located with acute trusts or links to community-based crisis services.
17. All Urgent Treatment Centres should have arrangements in place for staff to access an up-to-date electronic patient care record; this may be a summary care record or local equivalent. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient's best interests in an emergency situation where the patient lacks capacity to consent.
18. There must be the ability for other services (such as NHS 111) to electronically book appointments at the urgent treatment centre directly, and relevant flays or crisis data should be made available for patients.
19. A patient's registered GP should always be notified about the clinical outcome of a patient's encounter with an Urgent Treatment Centre via a Post Event Message

(PEM), accompanied by a real-time update of the electronic patient care record locally. For children the episode of care should also be communicated to their health visitor or school nurse, where known, within two working days.

20. Where available, systems interoperability should make use of nationally-defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMED-CT) and nationally-defined record structures.
21. Urgent treatment centres should make capacity and waiting times data available to the local health economy in as close to real-time as is possible for the purposes of system-wide capacity management; relevant real-time capacity information should also be made available for use across Integrated Urgent Care nationally.
22. Urgent treatment centres should refer to and align with the Integrated Urgent Care Technical Standards to ensure effective service and technical interoperability.
23. Urgent treatment centres should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.
24. Where appropriate, patients attending an urgent treatment centre should be provided with health and wellbeing advice and sign-posting to local community and social care service where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).
25. All urgent treatment centre should collect contemporaneous quantitative and qualitative data, including patient experience. From October 2018 all urgent treatment centres must return the data item specified in the Emergency Care Data Set (ECDS). Locally collective data should be used in a process of continuous quality improvement and ongoing refinement of the service.
26. All healthcare practitioners working in urgent treatment centres should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.
27. All urgent treatment centres to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.

DRAFT

## Appendix H – IUC for Carers

Based on feedback from services users, the following vignettes guide the types of service considerations that must be made:

1. In the early evening at the weekend, a carer in her 60's calls NHS111 for herself, she has a long history of asthma and has developed a chest infection – she knows from many years of experience that she must seek early oral steroid and antibiotics to avoid hospital admission. This is very important for her as she is the only carer for her husband with advanced Alzheimer's disease. He is suffering with Sundowning and is unable to leave the house and there are no carers due until the Tuesday, after the bank holiday weekend. She appropriately receives a primary care disposition to see a GP at an urgent treatment centre, however is unable to attend due to her needs as a Carer for her husband without securing emergency carers. After trying to get emergency carers for nearly two hours, this proves impossible and she calls NHS 111 to ask to have a home visit but this takes many hours to arrange. Eventually she is seen at home at 02:30am by a GP, which disturbed her husband who could not sleep again all night. She was unable to get the prescription until the following day.

In this case the service should have taken into account the fact that the caller was a Carer and sought to understand how best to meet her needs and that of her husband – in this case a telephone conversation with a clinician may have ameliorated the need to see the patient, or alternatively a home visit should have been made available earlier, supported by appropriate prescribing and dispensing capabilities.

2. A 14 year old calls NHS111 about his mother who has a learning disability at midday on Saturday – she has been suffering with depression over the previous 4 weeks and the caller has taken time off of school to look after her as they live alone. The triage identifies no immediate clinical need and suggests that he contacts the GP on Monday morning; the Health Advisor speaks to a clinician and they talk to the caller to identify any safeguarding requirements – however there are no immediate priorities identified and it is considered that whilst a safeguarding referral was appropriate in the circumstances as this has happened quite a lot of times and the school were aware, that no immediate action should be taken. However, what was not disclosed during the telephone call was that the caller had been self-harming for a significant period of time, as a result of social isolation from school and worries about exams. In fact he had been self-harming that morning and was very capable at hiding his distress. Unfortunately, the service was not aware of this as they did not have access to the records around the Carer associated with the patient's records.

In this case the service the safeguarding issues were considered well, but the holistic needs of the Carer were not well address – instead a system should have been available to ensure a fast track referral to a visiting primary care team was undertaken over the weekend, who have links with the social care teams, to undertake a holistic assessment of the needs of the Carer and patient. This should have been supported by a patient record and a Carer's record to enable the most appropriate and well-informed decision to be made.

DRAFT

## Appendix I – Future Technology

### Clinical Triage Platform (CTP)

The Clinical Triage Platform (CTP) is a programme of transformation to improve the precision, access, and utility of patient triage in the urgent care system.

The Clinical Triage Platform will be tailored to the needs of the individual; with continual improvements in accuracy and timeliness being underpinned by both individual patient data and evidence of outcomes. Through accurate and personalised triage the CTP will contribute to intelligent demand management, promoting and supporting a sustainable, clinically effective, and financially affordable NHS. The CTP will include improvement of the current NHS Pathways service but is also exploring commercial and partnership options to optimise value for money and provide the best fit with the requirements of the future design of the service.

There are a number of objectives that the CTP programme anticipates delivering:

- The CTP will enable **alternative access routes** to triage that are appropriate to the channel they are accessed by (for example, online), these alternative routes will need to be able to integrate with all other channels providing a seamless journey for patients, and provide consistent and replicable outcomes across the system.
- The CTP will enable triaging in a consistent and replicable manner while being deployed in a variety of situations, with users of differing needs and skill levels. The programme acknowledges that providers may procure a variety of systems locally and are asked to ensure that there are provisions within any service contract to provide detailed outcome data (including NHS Number) to a central repository under Legal Direction, to ensure consistency and replicability of triage across systems can be assured.
- The provision of this data will be **linked with clinical outcomes** from national and local data sets to enable evidence-based decision making for triage and patient care, referring users to the **most appropriate care** for them based on their needs assessment and all available evidence.
- The CTP will be a responsive system that can utilise data and technology for **continuous triage improvement**, delivering updates into the live environment in the shortest time possible whilst maintaining clinical safety. Providers are asked to factor regular releases and associated training into their operational plans.
- The future CTP will also utilise patient specific data to provide a more **personalised triage**. Providers are asked to ensure their technology roadmaps include the ability to connect with and integrate GP and other patient data via APIs (Application Programming Interfaces) into the CDSS, to enable a personalised, improved and streamlined triage.
- To enable a **seamless user journey** and facilitate transfer of a patients care, the CTP will interoperate by providing integration of data flowing in, through, and out of the whole system.
- Providers are advised to ensure technology procurements and roadmaps factor this interoperability in.

### Access to Service Information (A2Si)

The Access to Service Information (A2Si) programme has been created to ensure the existing DoS is both sustained in its current form and is developed to support a wider set of use cases across and in support of Urgent and Emergency Care.

It will be possible for IUC Providers and their system suppliers to access and query the DoS irrespective of the triage/CDSS in use. The existing DoS service is primarily designed around the use of NHS Pathways; however it is acknowledged that clinical professionals operating in IUC also require access to the DoS (including searching for service by service type and/or symptom group) as a necessary part of their day to day operations. Accordingly, standalone applications and integrated access to the DoS via APIs will be developed in order to support the wide range of IUC models and systems planned or in use.

Providers are advised to ensure technology procurements and roadmaps factor this future development.

In order for the above initiative to be successful it is essential that upon completion the clinical triage of a patient there are common standards relating to the resulting clinical disposition. The A2Si programme will be working to develop these standards and encourage all providers to contribute to the development of and ensure the adoption of these standards.

There are a number of emerging themes and anticipated technology deliverables that will become applicable to IUC providers in future:

- The programme acknowledges the existence and ongoing development of other directories of service. Providers are encouraged to ensure that existing and future directories are developed consistently with the national DoS in order to ensure integration across technical and regional boundaries to improve service information accuracy.
- The programme will also look to develop a common approach to collection, storage and presentation of urgent and emergency care capacity and demand data such as waiting times, service availability and bed management to support IUC providers in the way they recommend or refer patients to an onward service. Providers are encouraged to ensure their existing systems are able to both store, send, receive and display such capacity and demand data to their users and to downstream systems and services. Similarly, the programme is exploring how users can seamlessly use this information and their local systems in order to fully transfer the care of patients from their care to an appropriate onward service. This potentially includes the ability to refer a patient and directly book an appointment.
- Finally, the programme will ensure any urgent and emergency care activity data is maximised in terms of its ability to provide intelligence on how patients and professionals require access to and interact with urgent and emergency care services. By applying open data principles and data science methodology NHS Digital will research how this can potentially inform future urgent and emergency care commissioning and service design. Providers must ensure all activity data they collect is available for publication and research subject to appropriate stakeholder agreement and privacy impact assessments etc.

### **111 On-line**

Patients increasingly expect to be able to access healthcare via digital channels. But as well as better meeting patient needs, digital access to care provides the potential for channel shift to mitigate costs of rising call volumes. They can be quicker than telephone triage; and demonstrate strengths in dealing with pre-primary, low acuity conditions. They can also help support unmet patient needs for specific conditions and needs such

## OFFICIAL–SENSITIVE: COMMERCIAL

as sexual health concerns, dental complaints, or repeat prescriptions. As defined in the Five Year Forward View Next Steps published in April 2017, all NHS 111 services are required to have an online service in place by December 2017.

To ensure that these new digital services are implemented appropriately and based on tested technologies, and that there is evidence of the impact of opening a new digital channel a series of tests have been undertaken in each of the four regions.

A pragmatic evaluation of the 111 online pilots was undertaken in 2017. Its findings were:

- While the numbers through the service are small, the online channel does not appear to stimulate additional demand.
- Uptake is moderately low; between 4 and 15% of callers opt for an online journey, but with development and additional marketing is likely to increase.
- Utilisation generally tends to be for relatively lower complexity conditions but with greater awareness this could also change.
- There has been positive clinical validation of the streaming of patients from the digital services, i.e. the cases sent to a clinician was appropriate.
- There has not been a single product that has stood out as the best. There are local preferences that have influenced the successful implementation.

Commissioners will have the option to choose the service they believe will best meet their needs and are encouraged to contact the test sites to discuss experiences before making a procurement decision. There will be a series of standards and products made available during the summer to provide more detailed guidance to commissioners.

An internal NHS product was commissioned, developed and tested as part of this discovery work. The NHS 111 online product is based on NHS Pathways algorithms. This product will be made available to commissioners.

This service will be hosted on the NHS.UK web domain and will be fully interoperable with the Directory of Services and local services via ITK messaging. This will form an addendum to the NHS Pathways licence.

Where commissioners opt for one of the private sector tested services the responsibility for clinical governance and assurance will sit outside of the NHS Pathways agreements and rest with local services. Commissioners must consider the following in the decision making process for their NHS 111 online product:

- **Commissioning and procurement.** Where possible procurement of digital systems locally should adhere to best practice approaches set out in the government's Technology Code of Practice. In particular given the pace of change in this market NHSE recommends that any contract length with providers of digital triage technology should not exceed 2 years. Given the fast moving nature of these products commissioners are advised to ensure that supplier switch and transition arrangements are included in any contracts and that the chosen supplier can comply with strategy of becoming part of a central platform for all clinical triage tools. A more detailed set of key procurement standards for NHS 111 online will be produced by August 2017
- **Safety standards.** NHSE will expect triage products on the market to meet relevant safety standards; and be developed in accordance with MHRA or CQC guidelines

## OFFICIAL–SENSITIVE: COMMERCIAL

- **Directory of Service.** Where relevant commissioners should be mindful of the work that may be required to the DoS to render it suitable for exposure to the public
- **Workforce issues.** Commissioners should consider downstream effects on workforces of increased access to clinicians via digital routes at particular times of the year
- **Testing.** Commissioners must extensively test and assure themselves of the quality and safety of products available in an area. . Plans must be in place for what to do if the digital service goes offline.
- **Governance.** CCGs must establish appropriate clinical and information governance models to govern the use of online channels. This should include consideration of the minimum data set and other mandatory reporting.
- **Service design.** CCGs should consider overall service design in their delivery of online services. For instance, by looking at digital access to primary care and how this might link to digital services in urgent care. Suppliers will be required to adhere to a national brand for the NHS 111 online service
- **Implementation.** Commissioners should plan resources necessary to implement 111 online services by December 2017; and consider any downstream impacts on call volumes.

Commissioners are not advised to procure untested products at this time however where new technologies become available there will be a further series of testing and evaluation.

To support a mixed economy of suppliers in this market, a central project team will be available to provide advice and standards on governance (both clinical and information), support interoperability activity, and providing advice to commissioners on products on the market covering the following areas:

- Setting central standards for triage technologies
- Providing advice on implementing interoperability solutions
- Providing access to key infrastructure such as the DoS via APIs

## Appendix J – Roles and Responsibilities

Clinical Commissioning Groups (CCGs) are responsible for:

- Commissioning IUC as an integral part of the urgent care system according to national requirements and standards.
- Providing NHSE with evidence that they have undertaken a robust procurement with an appropriate assurance process.
- Assuring NHSE that they have a contingency strategy in place should the chosen provider fail to deliver the IUC service as contracted.
- Monitoring the impact of IUC on local services so that over/under utilised services are identified and improvements to the urgent care system are made.
- Ensuring the effective mobilisation and operational delivery of an IUC service that serves the CCG population, either directly or via joint commissioning arrangements.
- Performance managing the contract against agreed metrics and KPIs.
- Reporting on the quality, benefits and performance of IUC services.
- Ensuring that Access to Service Information (formerly DoS) is fully up to date with the availability of local services and the agreed referral protocols with service providers.
- Ensuring that the summary care record, local care records, care plans, special patient notes and end of life care records are up to date and available to IUC services.
- Ensuring clinical governance of IUC as an integral part of the urgent care system. This will ensure the quality, safety and effectiveness of the service, leading to people experiencing continuity of service.
- Publicising IUC locally.
- Local stakeholder communications and media handling.
- Ensuring that business continuity and disaster recovery procedures are in place in the event of disruptions to the provision of the IUC service locally.
- Meeting the public sector Equality Duty
- Reporting on the quality, benefits and performance of IUC services and coordinate the collection of data from different organisations where this may be required.

Networks are responsible for:

- Creating and agreeing an overarching, medium to long term plan to deliver IUC aligned to the objectives of the Urgent and Emergency Care Review.
- Designating urgent care facilities within the network, setting and monitoring standards, and defining consistent pathways of care and equitable access to diagnostics and services for both physical and mental health.
- Making arrangements to ensure effective patient flow through the whole urgent care system (including access to specialist facilities and repatriation to local hospitals).
- Maintaining oversight and enabling benchmarking of outcomes across the whole urgent care system, including primary, community, social, mental health and hospital services, the interfaces between these services and at network boundaries.

## OFFICIAL–SENSITIVE: COMMERCIAL

- Achieving resilience and efficiency in the urgent care system through coordination, consistency and economies of scale (e.g. agreeing common pathways and services across SRG boundaries).
- Coordinating workforce and training needs: establishing adequate workforce provision and sharing of resources across the network.
- Ensuring the building of trust and collaboration throughout the network, spreading good and best practice and demonstrating positive impact and value, with a focus on relationships rather than structures.

STPs are responsible for:

- Developing a plan to deliver IUC to support the 'high impact interventions' as agreed by the national tripartite.
- The translation and delivery of network service designations and standards to match the local provision of services. This will usually be achieved through the development of written plans and protocols for patient care, agreed with all 3 stakeholders, and adapted from national templates. High priority plans will relate to high-volume and undifferentiated conditions, where there are strong precedents for ambulatory and community-based patient management.
- Ensuring a high level of clinical assessment for the patient, in or close to their home, and ready access to diagnostics where required. This will be particularly important in more remote and rural communities, in which the role of smaller hospitals will be developed and strengthened.
- The development and utilisation of “clinical decision-support hubs” to support the timely and effective delivery of community-based care.
- Establishing effective communication, information technology and data sharing systems, including real-time access to an electronic patient record containing information relevant to the patient’s urgent care needs.
- The delivery of local mental health crisis care action plans to ensure early and effective intervention to prevent crisis and support people who experience mental health crisis.
- Ensuring the effective development and configuration of primary and community care to underpin the provision of urgent care outside hospital settings 24/7.
- Achieving accurate data capture and performance monitoring.

NHSE is responsible for:

- Monitoring the performance of IUC and compliance with national requirements, quality and performance standards.
- Monitoring the impact of IUC with the urgent care system.
- Assuring that CCGs are managing their responsibility for quality and safety.
- Commissioning and management of IUC national telephony infrastructure and IT systems including repeat caller service, NHS Pathways and Access to Service Information (formerly DoS).
- Liaison with Ofcom over the use of the 111 number.
- Accreditation of IUC Clinical Decision Support System(s)
- National communications and media handling.
- Ownership of and development of the IUC (111) brand, core values and guidelines for usage.
- Ownership of the IUC Commissioning Standards and governance of any changes.
- Identifying and sharing lessons learned and good practice across local areas.
- Meeting its legal duties on equality and on health inequalities

OFFICIAL–SENSITIVE: COMMERCIAL

- Assuring national business continuity and CCG's contingency arrangements for managing unforeseen surges in demand.
- Approving key decisions, plans, deliverables and any changes to the IUC service design.
- Overseeing interdependencies with related initiatives and programmes outside the scope of IUC.
- Assuring that the interests of key stakeholder groups are represented.
- Providing a formal escalation point for the NHS and other stakeholders for issues and concerns relating to IUC.
- Periodically providing assurance to the NHSE Board.
- Supporting CCGs' re-procurements of IUC contracts and the transition of services from their current state to any new provider.

DRAFT

## Glossary

Initialisation /Term	Definition/Use
111	Free to call telephone number for non-emergency care (Easy to remember three digit telephone number, used for single point of entry access IUC services)
0300	An 11 digit non-geographic Freephone number for government, healthcare, charities and non-profit use.
999	Free to call telephone number for emergency service (i.e. Ambulance Service)
24/7	24 hours a day, 7 days a week.
'No decision in isolation'	Clinical process by which colleagues are always available to support decision making.
24/7/365	Every hour of the day, day of the week and day of the year (including leap years)
A&E	Accident and Emergency (also known as ED)
A2Si	Access to Service Information
ACD	Automatic Call Distribution (the telephone system that distributes calls to agents and produced management information).
Administrator/Navigator	A person within the contact-centre environment that may manages queues, takes demographics but does not carry out any clinical assessment.
Algorithm	A process or set of rules to be followed in problem solving.
Any-to-any	A process by which a system has the ability to communication with any other similar system, in the IUC context it is the ability for providers to electronically despatch ambulances from any ambulance trust.
App	Application (Software used on either a PC or mobile phone)
ARP	Ambulance Response Programme
AST	Ambulance Service Trust
Average Handling Time	The average time taken to complete a telephone assessment.
BSL	British Sign Language – communication used by the deaf community.
Call Volumes	The number of calls received by a specific contact-centre over a define period of time
CAS	Clinical Assessment Service
Case Mix	The different types of presented symptoms received within the contact-centre
CCGs	Clinical Commissioning Groups
CDSS	Clinical Decision Support System (Computer based tool for gathering patient demographics and providing clinical assessment workflow)
CG	Clinical Governance
Clinician	A medically qualified person.
Consult and Complete	A consultation where no further intervention is required.
Contact-centre	Location where patient contact is made, primarily via telephone but may include other media
CQC	Care Quality Commission

OFFICIAL–SENSITIVE: COMMERCIAL

Initialisation /Term	Definition/Use
CQI	Clinical Quality Indicator
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CTP	Clinical Triage Platform
CWS	Clinical Workflow System
DAB	Direct Appointment Booking
DAs	Devolved Administrations
Data Dictionary	A set of information describing the contents and format of a database.
Disposition	End point in a consultation
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DoS	Directory of Service - containing information pertaining to locations of care.
Dos Profiling Principles	Document detailing the process for ensuring that the DoS outcome provides the most appropriate range of dispositions.
DPA	Data Protection Act
ED	Emergency Department (also known as A&E)
EDSSS	Emergency Department Syndromic Surveillance System
EIA	Equality Impact Assessment
EIR	Environmental Information Regulations
EoL	End of Life
EPS	Electronic Prescribing Service
Erlang C	A formula used to predict the number resources needed to service a given demand (i.e. number of agents)
Face to Face	Consultation in person
FOI	Freedom of Information
force majeure	Occurrences beyond the reasonable control of a party, generally in reference to contractual obligations.
Freephone number	Telephone number free for use by the caller
GP	General Practitioner
GP Choice	An NHS initiative which allows a patient to choose the GP and GP practice of their choice.
HCP	Health Care Professional
Health Advisor	A non-clinician trained in the use of a CDSS.
Hear and Treat	Ambulance Response Principle (ARP) where the telephony consultation offers completion on the phone where possible.
HEE	Health Education England
HSCN	Health & Social Care Network – a data network for health and care organisations which will replace N3
HSOCs	Health Scrutiny and Overview Committees
hypertext	Hypertext Transfer Protocol (HTTP) an embedded link within a document that allows direct access to a different web-based resource.

OFFICIAL–SENSITIVE: COMMERCIAL

Initialisation /Term	Definition/Use
ICO	Information Commissioners Office
IG	Information Governance
INT	Immediate and Necessary Treatment
Intraday call profiling	Variation of calls received at different times of the day used to calculate staffing requirements.
ISA	Independent Safeguarding Authority
ISDN	Integrated Services Digital Network – conventional digital telephone lines.
ISO	International Organisation for Standardisation
IT	Information Technology
ITK	Interoperability tool kit
IUC	Integrated Urgent Care
IVR	Interactive Voice Response - A process which allows callers to choose options during the telephone call by using the telephone keypad or by speech recognition (Natural Voice IVR).
KPI	Key Performance Indicator (Metric used to measure the performance of a system or service)
Locations of Care	Also known as 'Service of Care', the point of patient referral.
Low Acuity Ambulance	Lower acuity Ambulance disposition formally known as Green Ambulance.
LWABs	Local Workforce Action Boards
MCA	Mental Capacity Act
MDS	Minimum Data Set (as specified by NHS England)
MHRA	Medicines and Healthcare products Regulatory Agency
Mindfulness	A complete/meditative process for reducing stress by bringing one's attention to the internal experiences occurring in the present moment.
Minor Injuries unit	A walk in centre for non-emergency treatment.
MMS	Multimedia Messaging Service, a standard protocol to send multimedia content to and from mobile phones.
n3	The national high-speed IP-based virtual private network used by NHS (superseded by HSCN).
NHS	National Health Service
NHS 111 Workforce Blueprint	Workforce Strategy document due for publication in 2018
NHS Digital	Formally the Health and Social Care Information Centre (HSCIC)
NHS Five Year Forward View	NHS future planning strategy document issued in October 2014
NHSmail	Email system used within NHS, the only system designate safe for the transmission of PID.
NICE	National Institute for Health and Care Excellence
NNG	National Numbering Group (Area code), Formerly known as STD codes.
Non-symptomatic call	A caller requiring information on a pre-diagnosed condition or information on local services.
NPFS	National Pandemic Flu Service

OFFICIAL–SENSITIVE: COMMERCIAL

Initialisation /Term	Definition/Use
NPSA	National Patient Safety Agency
NQRs	Natioanal Quality Requirements for Out of hours services 2004
NUMSAS	NHS Urgent Medicines Supply Advanced Service
Online	Web based service (delivered either via a web browser or as a mobile app)
OOH	Out of Hours (Historically covering services the period outside of normal GP consulting hours)
Pathways	NHS owned algorithmic clinical assessment tool
PBX	Private Branch Exchange
PC	Personal Computer
PDS	Patient Demographic Service (System for referencing patients NHS number based of demographics)
PEM	Post Event Messages (Message sent to GP to provide information on patient interaction with IUC)
PEW	Planned Engineering Works
PHE	Public Health England
PIA	Privacy Impact Assessment
PID	Personal Identifiable Data
PIN	Prior Information Notice
PMO	Programme Management Office
POCA	Protection of Children Act
POVA	Protection of Vulnerable Adults
Primary Care	Day to day health care given by health care providers, typically as the first contact point for
PSTN	Public Switched Telephone Network
PTV	Permission to View (a flag within the CDSS that says that the patient has given consent for the patients record to be viewed during this encounter)
RCA	Root Cause Analysis
RCS	Repeat Caller Service
Repeat Caller	Identifies repeat caller that calls the 111 service on multiple occasions over a short period of time (in response to the section 28 of the coroners ruling in the Penny Campbell case).
ReST	real-time surveillance team
Royal Colleges	The organisations that provide oversight and governance to the medical professions.
Schwartz rounds	A process developed by Kenneth B Schwartz designed to offer healthcare providers a regularly scheduled time to discuss the social and emotional issues they face in caring for patients and families.
SCR	Summary Care Record (High level patient clinical history)
See and Treat	Ambulance Response Principle (ARP) where treatment is completed on the scene with no need for conveyance.
SI	Serious Incident
SIMS	Serious Incident Management System

OFFICIAL–SENSITIVE: COMMERCIAL

Initialisation /Term	Definition/Use
SIP	Session Initiated Protocol. A protocol that allows voice to be transmitted as packets of data across a data network. SIP trunks use this technology to deliver telephone lines.
Smart Phone	Mobile phone with enhanced features, such as the ability to run applications (Apps).
SMS	Short Message Service (text messaging)
SP-IS	Child Protection Information System
SPN	Special Patient Notes (Specific Information on a given patient, their history, any special requirements or factors that need to be taken into account during an encounter)
Star line	Telephony menu option for providing rapid access to additional clinical support for Care Homes and paramedics
STD	Subscriber Trunk Dialling (now superseded term for telephone area code, i.e. NNG)
StEIS	Strategic Executive Information System
STP(s)	Sustainability and transformation plans
Toxbase	Toxic substance reference database
TR	Temporary Resident
Triage	Process for Assessing Clinical Acuity
UCT	Urgent Treatment Centre
UECDP	Urgent and Emergency Care Delivery Programme
Use Case	A methodology used in system analysis to identify, clarify, and organise system requirements.
Walk-in centre	Non-emergency treatment centre that does not require appointment booking

## Document Reference

Document
Urgent and Emergency Care Review - Sir Bruce Keogh (13 November 2013) - <a href="https://www.england.nhs.uk/2013/11/keogh-urgent-emergency/">https://www.england.nhs.uk/2013/11/keogh-urgent-emergency/</a>
NHS Five Year Forward View - <a href="https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf">https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf</a>
NHS Outcomes Framework - <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/513157/NHSOF_at_a_glance.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/513157/NHSOF_at_a_glance.pdf</a>
CCG Improvement and Assessment Framework - <a href="https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iaf-mar16.pdf">https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iaf-mar16.pdf</a>
GP Choice scheme - <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216504/dh_133411.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216504/dh_133411.pdf</a>
Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis (18 February 2014) - <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf</a>
National Quality Requirements
NHS Five Year Forward Next Steps (April 2017) - <a href="https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/the-nhs-in-2017/">https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/the-nhs-in-2017/</a>
NHS 111 Workforce Development Programme
NHS 111 Workforce Blueprint (will be published by early 2018)
IUC Technical Standards pack
IUC Telephony Messaging Standards
NICE Guidelines - <a href="https://www.nice.org.uk/guidance/published?type=csq.cg.mpg.ph.sg.sc">https://www.nice.org.uk/guidance/published?type=csq.cg.mpg.ph.sg.sc</a>
Interoperability Tool Kit (ITK) - <a href="https://digital.nhs.uk/interoperability-toolkit">https://digital.nhs.uk/interoperability-toolkit</a>
NHS England, Commitment to Carers (May 2014) - <a href="https://www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf">https://www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf</a>
Equality Act (2010) - <a href="http://www.legislation.gov.uk/ukpga/2010/15/contents">http://www.legislation.gov.uk/ukpga/2010/15/contents</a>
Standards issued by the Care Quality Commission, including Essential Standards of Quality and Safety - <a href="https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf">https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf</a>
Data Protection Act (1998) - <a href="http://www.legislation.gov.uk/ukpga/1998/29/contents">http://www.legislation.gov.uk/ukpga/1998/29/contents</a>
NHS Complaints regulations (2009) - <a href="http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf">http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf</a>
Freedom of Information – FOI Act (2000) - <a href="http://www.legislation.gov.uk/ukpga/2000/36/contents">http://www.legislation.gov.uk/ukpga/2000/36/contents</a>
Environmental Information Regulations (2004) - <a href="http://www.legislation.gov.uk/uksi/2004/3391/contents/made">http://www.legislation.gov.uk/uksi/2004/3391/contents/made</a>
National Dementia training requirements - <a href="http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf">http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf</a>
National outcomes framework - <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/513157/NHSOF_at_a_glance.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/513157/NHSOF_at_a_glance.pdf</a>
National Incident management guidance

OFFICIAL–SENSITIVE: COMMERCIAL

Child and adult safeguarding regulation and guidance - <a href="https://www.gov.uk/topic/schools-colleges-childrens-services/safeguarding-children">https://www.gov.uk/topic/schools-colleges-childrens-services/safeguarding-children</a>
ISO 9001 – Quality Management standards
ISO 27001 – information Security Standards
ISO 22301 – Business Continuity Standards
NHS Caldicott guidance - <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/581213/cgmanual.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/581213/cgmanual.pdf</a>
Public Records Act 1958 - <a href="http://www.legislation.gov.uk/ukpga/Eliz2/6-7/51">http://www.legislation.gov.uk/ukpga/Eliz2/6-7/51</a>
NHS Codes of Practice – Record Management (Part1 and 2) - <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/547055/Records_Management_-_NHS_Code_of_Practice_Part_1.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/547055/Records_Management_-_NHS_Code_of_Practice_Part_1.pdf</a> and <a href="http://www.nhsgrampian.org/grampianfoi/files/English_RM_code_of_practice_2.pdf">http://www.nhsgrampian.org/grampianfoi/files/English_RM_code_of_practice_2.pdf</a>
ISO 15489 – Information and Document standard
Care Act 2014 - <a href="http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted">http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted</a>
Children Act 2014 - <a href="http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf">http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf</a>
London Child Protection Procedures 2015 - <a href="http://www.londoncp.co.uk/">http://www.londoncp.co.uk/</a>
Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Royal College of Paediatrics and Child Health, 2014) - <a href="http://www.rcpch.ac.uk/system/files/protected/education/Safeguarding%20children%20and%20young%20people%20-%20%20roles%20and%20competencies%20for%20health%20care%20staff%20-%20Intercollegiate%20document%20March%202014.pdf">http://www.rcpch.ac.uk/system/files/protected/education/Safeguarding%20children%20and%20young%20people%20-%20%20roles%20and%20competencies%20for%20health%20care%20staff%20-%20Intercollegiate%20document%20March%202014.pdf</a>
Mental Capacity Act 2005 - <a href="http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf">http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf</a>
Deprivation of Liberty Safeguards Accountability and assurance framework for adults at risk - <a href="https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance">https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance</a>
Safeguarding Vulnerable Groups Act 2006 - <a href="http://www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf">http://www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf</a>
Mental Capacity Act 2005 - <a href="http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf">http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf</a>
CQC guidance for IUC Clinical Assessment Services - <a href="https://www.cqc.org.uk/guidance-providers/nhs-111">https://www.cqc.org.uk/guidance-providers/nhs-111</a>
NHS IG Toolkit - <a href="https://igtoolkit.net/">https://igtoolkit.net/</a>
Health and Safety at Work Act 1974 - <a href="http://www.legislation.gov.uk/ukpga/1974/37">http://www.legislation.gov.uk/ukpga/1974/37</a>
NPSA Healthcare Cleaning Manual - <a href="http://nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61814">http://nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61814</a>
NHS Complaints (England) Regulations 2009 - <a href="http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf">http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf</a>
NHS England Revised Never Events Policy and Framework (27 March 2015) - <a href="https://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf">https://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf</a>
NHS Information Governance guidelines - <a href="https://www.england.nhs.uk/ourwork/tsd/ig/">https://www.england.nhs.uk/ourwork/tsd/ig/</a>
NHS England Data Dictionary - <a href="http://www.datadictionary.nhs.uk/">http://www.datadictionary.nhs.uk/</a>
NHS 111 Minimum Data Set - <a href="https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/">https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/</a>

---

DRAFT