**SWL Integrated Urgent Care Services Specification**

**July 2021**

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# Background/Context

## National and Local Context and Evidence Base

The Urgent and Emergency Care (UEC) Review[[1]](#footnote-1) proposed a fundamental shift in the way UEC services are provided. The intention was to:

* Increase capacity to provide care closer to home;
* Reduce unnecessary hospital attendances and admissions;
* Improve the experience for patients.

This need to redesign UEC services in England was originally set out in the Five Year Forward View (FYFV) and was reviewed in early 2020 to consider how it should support the longer-term sustainability and, crucially, ensure a resilient provider market. This could affect future models and we need to be able to react to the emerging IUC landscape and adapt accordingly.

The Integrated Urgent Care (IUC) Service Specification[[2]](#footnote-2) proposes a 111 Call Centre, with pathways assessment, a Clinical Assessment Service (CAS) and Treatment services outside General Practice hours, to fundamentally change the way patients access health services. It will mean patients will still access unscheduled care through the NHS 111 telephony service, or NHS 111 Online, and, following appropriate clinician support over the telephone delivered by the pathways’ clinicians or senior clinicians within the CAS, they receive a complete episode of care concluding with either: advice, a prescription, treatment or an appointment for further assessment or treatment.

The vision is to deliver a functionally integrated 24/7 urgent care service for patients that is the ‘front door’ of the NHS and which provides the public with access to both treatment and clinical advice. This will include:

* NHS 111 IUC Providers;
* GP services;
* Community services;
* Ambulance services;
* Emergency departments;
* Social care.

This system, through IT interoperability and robust joint governance processes, will deliver high-quality clinical assessment, advice and treatment to shared standards and processes with clear accountability and leadership. We expect organisations to collaborate to deliver this, particularly through high quality clinical assessment, advice and treatment to shared standards and processes, with clear accountability and leadership. Central to this is access to a wide range of clinicians; both experienced generalists and specialists. The service also offers advice to health professionals in the community, such as general practitioners, pharmacists, dentists, paramedics and emergency technicians, so that no decision is taken in isolation.



Figure 1 – Patient Flow

At a high level, the Long-Term Plan[[3]](#footnote-3) (LTP) creates a backdrop for the future development of IUC. It sets out a commitment to a ‘new service model for the 21st century’ whereby:

* ’Out-of-hospital’ care will be strengthened and the historic divide between primary and community health services dissolved;
* Pressure on emergency hospital services will be reduced;
* People will get more control over their own health and more personalised care when they need it;
* Digitally-enabled primary and outpatient care will become mainstream across the NHS;
* A comprehensive new workforce plan will be implemented.

The Long-Term Plan explicitly outlines the requirement that, by 2023, the CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.

The GP contract reform[[4]](#footnote-4) is joining up with IUC to ensure that only patients who genuinely need to attend ED or use the ambulance service are advised to do so, directing patients to healthcare settings which are clinically appropriate. This includes a small number of cases directly booked into a patient’s own practice for continuity. NHS England and the GP Committee (GPC) England have agreed that, for 2019/20, this will be at the level of one practice appointment per day, per 3,000 patients, with a minimum of one appointment per practice per day. The number of appointments will rise in increments of 3,000 patients. For example, a list size of 7,500 would provide a minimum of two appointments per day and so on. Under COVID regulations, it is 1 worklist slot available per 500. This may go back to 1:3000 in time, and will become a core GP contract requirement.

The core vision for an IUC Service builds upon the success of NHS 111 in simplifying access for patients and increasing the confidence that patients, local commissioners, health professionals and, most importantly, the public have in services. The offer is easy access to urgent health care services that is fully integrated with all aspects of the system - through NHS 111. This integration sees urgent care services collaborating to deliver high-quality clinical assessment, advice and treatment, with shared standards, processes and clear accountability and leadership. The 111 number must become the single telephony access point. For the avoidance of doubt, the use of other non-geographic numbers for access to out-of-hours services is no longer permitted.

Sustainability for IUC depends on maximising opportunities for economies of scale including achieving greater efficiency, effectiveness, productivity and resilience, for example, through delivering telephony at greater scale (as supported by the Erlang methodology). The benefits of scale need to be balanced with the ability to work effectively with local Clinical Assessment Services (CAS) at both a local and ‘at scale’ level.

Following the advent of Th111nk First in April 2020, the UEC response to COVID-19 refocussed the UEC system to provide a unique opportunity to test clinically-led service improvements and workforce integration. This approach is delivering change at a much faster rate than has previously been possible. Its legacy should be retained.

This approach is also highlighted in the *‘2021/22 priorities and operational planning guidance’[[5]](#footnote-5),* ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments:

* promote the use of NHS 111 as a primary route into all urgent care services
* maximise the use of booked time slots in ED with an expectation that at least 70% of all patients referred to an emergency department by NHS 111 receive a booked time slot to attend
* maximise the utilisation of direct referral from NHS 111 to other hospital services (including SDEC and specialty hot clinics) and implement referral pathways from NHS 111 to urgent community and mental health services
* adopt a consistent, expanded, model of SDEC provision, including associated acute frailty services, within all providers with a type 1 emergency department to avoid unnecessary hospital admissions
* change data collection and reporting to meet the Integrated Urgent Care Aggregate Data Collection (IUC ADC) specification[[6]](#footnote-6).

The impact of COVID has resulted in the public avoiding ED and UTCs, notably Type 3 attendances (minor injuries and illnesses such as sprains). A plan to support patients’ ability to **access the most appropriate service is required;** there is an opportunity to influence public decision making when **needing same-day, urgent care**, **post-COVID**. A plan that will keep patients safe, minimise waiting areas to reduce nosocomial infection risk; provide advice re self-care or referral to booked appointments in direct access clinics or services.

**Intelligent Patient Flow for Th111nk First:**

Principles:

* Implement initial changes at pace, safely with clinical oversight - whilst planning for more extensive system change
* Considering learning gained through COVID-19 response
* Integrated delivery team across system
* Agile and responsive approach to implementation; continuously iterating and optimising pathways

Consider:

* Speak, decision, respond message
* Different ways of working, i.e. virtual clinics; digital assessment pods
* Opportunities to capture observations to enhance remote assessment
* **Demographics in London** and importance of targeted communications and messaging. To mitigate any inequalities of access to services, patient online registration could be one approach

Implementation programmes at pace:

**Decision Support:**

* **Enhanced Star Line response,** including access to **specialist clinicians** for HCPs and Care Home staff
* **Same Day Emergency Care**

**Hot Clinics**

* **Access to existing services** in secondary care that **accept direct referrals**.
* Paediatrics / Maternity / Surgery / Medicine / Frailty.

**Same day Referrals into Primary Care:**

* Utilising GP Connect / **direct booking** functionality from 111/IUC to ED,SDEC, hot clinics, urgent community services and additional services as developments are agreed
* **Access to GP records** with the ability to include free text through platforms such as GP Connect.
* **Consistent access** to GP Extended Access and COVID Hot Hubs

**Urgent Community Response (2 hours):**

* **Support to care homes** / those in their own home.
* **Direct referrals, from 999 and 111** to rapid response services utilising available technology.
* Implement a **consistent referral approach** across London.

**Mental Health Crisis:**

* Direct IVR to mental health provider

Th111nk 111 Flow:



*Figure 2: Think 111 First Patient Flow (2020)*

***1.1.1 Clinical Assessment Service (CAS)***

The vision for an IUC physical and virtual CAS offers a transformational opportunity to deliver a model of urgent care access that will streamline and improve patient care across the urgent care community, through the implementation of the ‘Consult and Complete’ model.

The IUC CAS will contain a multidisciplinary clinical team, contain/include at least one senior responsible GP available 24/7 with additional GPs rostered according to demand. Working with them and rostered according to demand and local need, will be specialist clinicians such as advanced nurse practitioners, pharmacists, dental nurses, mental health nurses, and palliative care nurses.

The CAS should be designed to offer the optimum service to patients so that they reach their service end point as seamlessly as possible with the minimum number of clinical touch points required to meet their clinical need.

Providers must ensure:

* There is direct access to clinical advice for HCPs working in the community (e.g. through a direct telephone number or IVR arrangements)
* They cooperate with any initiatives that consider how the CAS can be used for lower acuity ambulance calls
* Clinicians are able to access patient records (including the Summary Care Record), special patient notes, and local records such as crisis plans where available and subject to appropriate access controls
* Clinicians have the ability to prescribe medications and access the Electronic Prescribing Service (EPS) as appropriate
* Video consultation facilities are available
* Demographics are captured where these are not already completed
* Local Clinical Governance approval with defined processes for monitoring and assuring ongoing clinical safety is in place
* Once the disposition is reached, agree with the patient about suitable onward service selection (where possible selecting the first option on the DoS)
* Clinicians have the ability to search the DoS using appropriate tools
* Clinicians have the ability to directly book into points of care
* Details of the patient assessment are captured on the system

### Face-to-Face Services (outside General Practice hours)

Face-to-Face (F2F) services will be compliant with all key service levels and requirements. The provision of IUC services is defined by primary care contract as 6.30pm to 8am. However, SWL will also need to consider the extended primary care requirements defined in the new 2022/23 Enhanced Access Service Specification.

### Technology

The delivery of IUC services is reliant on harnessing the latest technology and applying it in an operational setting. We must be alert to new developments in technology and consider how they can be best used to enhance the patient pathway and outcomes. We will work with the national IUC team to maximise use of technology and work with our providers and system suppliers to ensure that updates and implementation of technology is done in a timely way.

The IUC Service is underpinned by technology. This IUC Service specification sets out the standards against which technology must be procured and emphasises the importance of robust resilient solutions. These include the following:

* **Telephony**: The function of the national and regional Patient RelationshipManager (PRM), 111 platforms and how Providers receive 111 calls;
* **Directory of Services (DoS):** The importance of maintainingan accurate service directory, how to access and use it, and the Provider reporting challenges and gaps in service;
* **Interoperability**: The referral of encounters into and out of the IUC Service, access to records and appointment booking, with appropriate information sharing agreements across all of the healthcare domains;
* **Future Technology**: The usage of current and emerging alternative access channels such asNHS 111 Online, development of new NHS Digital National Standards, and the replacement / onwards development of existing technologies such as service directories and triage tools;
* **Consultation Options**: The service needs to be flexible and develop to include the ability to consult with the patient face to face via SWL-approved electronic means (online / video consultation) or other options as they become available/prescribed;
* **Direct Booking**: GP in-hours / Extended Access Hubs / Urgent Treatment Centres –Provider tocarry out weekly testing to check functionality is working;
* **Appointment Confirmation / Follow-up Advice via Text Message**: Toensure ‘Do Not Attends’ (DNAs) are minimised, and clinical risk is mitigated by supplying robust follow-up advice.

## About South West London

The South West London Health and Care Partnership has formally been designated as an Integrated Care System (ICS), since April 2020.

In awarding ICS status, NHS England has recognised the strength of the South West London partnership and the shared ambitions for the six boroughs – Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

The significant progress made together over the past three years to deliver better outcomes for local people so that in their lives they can start well, live well and age well, has also been recognised.

South West London has a diverse and mobile population with extremes of deprivation and wealth. A high proportion of the population lives in areas that are among the most deprived in England, while a smaller proportion lives in the most affluent areas. Commissioners recognise the frequency of multiple co-morbidities in deprived populations and have ensured that a range of support services are listed in the Directory of Services to best manage more frequent occurrences of ill health and higher mortality from chronic conditions, as well as higher frequency of mental health needs resulting from deprivation.

South West London’s current registered population is approximately 1.68 million; this is expected to grow to about 1.73 million by 2023[[7]](#footnote-7).

In addition, South West London has a large transient population, both in those moving in and out of the area in a short space of time, and the large working population derived from all areas of South East England. Within the SWL boundary, there is a number of large sporting and recreational attractions, including Wimbledon tennis, Chessington World of Adventures, Hampton Court and Twickenham Rugby. Other temporary events include Epsom Races and the Oxford-Cambridge boat race.

The Provider must be able to deliver services to this population range and flex to support those periods of higher demand; e.g. during the Wimbledon tennis tournaments.

# Outcomes

## NHS Outcomes Framework Domains & Indicators[[8]](#footnote-8)

Indicators in the NHS Outcomes Framework[[9]](#footnote-9) (NHSOF) are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. It has an emphasis on outcomes for patients rather than the process. It is included as standard in NHS service specifications to provide context for Providers on how individual services should align with national policy.

| **Domain** | **Description** |
| --- | --- |
| Domain 1 | Preventing people from dying prematurelyThis domain captures how successful the NHS is in reducing the number of avoidable deaths. |
| Domain 2 | Enhancing quality of life for people with long-term conditionsThis domain captures how successful the NHS is in supporting people with long-term conditions to live as normal a life as possible. |
| Domain 3 | Helping people to recover from episodes of ill health or following injuryThis domain captures how people recover from ill health or injury and, wherever possible, how it can be prevented. |
| Domain 4 | Ensuring that people have a positive experience of careThis domain looks at the importance of providing a positive experience of care for patients, service users and carers. |
| Domain 5 | Treating and caring for people in a safe environment and protecting them from avoidable harmThis domain explores patients’ safety and its importance in terms of quality of care to deliver better health outcomes. |

Table 1 - NHS Outcomes Framework Domain Descriptions

The provision of a high-performing, safe and effective IUC Consult and Complete service can be mapped to the domains within the NHS Outcomes Framework. In addition, CCGs are required to commission a service based on the Consult and Complete model that delivers against the key elements of an IUC Service:

* A single call to get an appointment outside core general practice hours;
* Data and Information can be shared between Providers;
* The capacity for NHS 111 and urgent multidisciplinary clinical services needs to be jointly planned;
* The Summary Care Record (SCR) is available in the service (e.g., the Clinical Assessment Service);
* Care plans, Primary care records, Co-ordinate my Care (CMC) records, special patient notes, etc. are visible to the clinicians in the IUC and in any downstream location of care;
* Appointments can be made to in-hours GPs and to GP extended access services, offering services in the evenings and at weekends;
* Appointments can be made to Emergency Departments (EDs) and Urgent Treatment Centres (UTCs) 24/7.

These also include joint governance across Urgent and Emergency Care:

* Suitable calls are transferred to a Clinical Assessment Service comprising GPs and other health care and social care professionals;
* providers must ensure crisis response care is available to all people within their own homes or usual place of residence, including care homes, within two hours, who have a health or social care need.

These key elements will be measured against the CCG Improvement and Assessment Framework[[10]](#footnote-10) (Indicator 127a).

## Locally Defined Outcomes

The new Provider of the SWL IUC will deliver the following outcomes through their service model:

| **Outcome No** | **Outcome the Provider is Expected to Deliver** |
| --- | --- |
| 1 | Build confidence and trust to encourage our local community to access health care through 111 as a single-entry point into the IUC model, instead of through 999 or direct attendance at Emergency Departments or Urgent Treatment Centres, reducing demand on emergency services.111 becomes the trusted, single point of contact for advice or clinical input. |
| 2 | Manage patients through the IUC service with as few touchpoints as possible. |
| 3 | Effective use of CAS clinicians to support patients being directed to the most suitable outcome and reduce both low-acuity calls to 999 and conveyances to ED by LAS ambulance crews.The CAS will review low-acuity 999 outcomes and provide support to LAS ambulance crews and other community healthcare professionals, providing advice and co-ordination of onward referral, enabling the patient to remain at home or in their place of residence, where appropriate. |
| 4 | Effective use of CAS clinicians to support patients being directed to the most suitable outcome by reviewing referrals into ED. |
| 5 | Increase the number of patients booked into appropriate face-to-face and virtual appointments by working with all key stakeholders in urgent, emergency and primary care, in SWL and pan-London, and by implementing the digital interoperability agenda. |
| 6 | Develop and implement innovative ways to deliver closer integration of Face-to-Face and virtual services, working with Urgent Treatment Centres, Extended Access Hubs, London Ambulance Service and the Primary Care Networks. |
| 7 | Work as an active partner with Commissioners and Patients to innovate and shape the IUC landscape in SWL and London, including delivering change alongside the Five Year Forward View, Long Term Plan and digital innovation. |
| 8 | Improved access and staff training for supporting and managing patients with specific issues such as:* Hearing impairment;
* Non-English first languages;
* Visual impairment;
* Physical disabilities;
* Mental health and learning disabilities;
* Elderly and confused patients;
* Palliative Care patients;
* Unregistered and out of area registered patients.
 |

Table 2 - Local Outcomes

# Scope

The Vision

Patients will receive a complete episode of care with an outcome: advice and self-care, a prescription, a face-to-face or virtual appointment for further assessment or treatment in a primary, urgent or emergency care setting.

The IUC Clinical Service in SWL will consist of a single service with one specification and one contract for the whole of SWL CCG/ICS (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth CCGs). The service will comprise of five parts:

1. LAS Call Service (not in scope, covering \* lines, dental, pharmacy, \*5 call-back and Cat 3 & 4 validation);
2. NHS 111 Call Centre (with exclusions above);
3. Clinical Assessment Service;
4. Face to Face site visits; and
5. Home visits (outside General Practice hours).

The following outlines the Commissioners’ expectation of the service. Additional requirements for the service are included in the enclosed document:

## Aims and Objectives of Service

The aim of the SWL IUC Service is to provide the entry point for patients needing urgent care support. It will mean patients will access unscheduled care through the NHS 111 telephony service, or NHS 111 Online, and, following appropriate clinical support over the telephone delivered by the CAS, they receive a complete episode of care concluding with either: advice, a prescription or an appointment for further assessment or treatment.

Where a patient needs face-to-face services outside of General Practice hours, the IUC Clinical Service will book an appointment for the patient or schedule a visit to their home in line with agreed protocols and patient need.

Wherever possible, patients, who need further care not offered by the IUC Clinical Service, should have appointments made for them in services appropriate to their need.

## Service Scope Summary

### National Requirements

For all IUC call handling and CAS services the provider must ensure:

* They are available to accept calls and digital referral from the NHS 111 telephony and NHS 111 Online platforms and to provide any subsequent face-to-face treatment, or make onward referral for face-to-face treatment 24/7, 365 days a year (including leap year days).
* A responsible GP is available 24/7 to allow for generalist clinical consultation at all times, with other professionals employed according to times of local need.
* CDSS systems are used within the licencing requirements of that system.
* The ability to link to ambulance systems is in place in order to facilitate activating an emergency response where required.
* Call streaming through Interactive Voice Recognition (IVR) or an equivalent system may be beneficial for the management of callers with dental symptoms.
* 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.
* Clinical staff working in the service have received training on Toxbase or its equivalent to ensure that substance overdose can be identified and managed amongst callers and analgesia overdose specific to dental callers. Referral to services returned in the Directory of Services, considering them (and if 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 (migrating to the FHIR standards as they become available) or NHSmail.
* As many episodes of care as possible receive clinical assessment as part of the telephony journey, including specialist clinicians where appropriate, in order to achieve the best assessment of the patient. This is linked to the desire to complete the episode of care as fully as possible, resulting in provision of self-care, booking into onward services or prescribing of appropriate medications (e.g. the ‘consult and complete’ model).
* Implementation of a solution capable of direct appointment booking with destination services through the chosen clinical workflow system.
* Connection to GP Connect to facilitate booking and access to records.
* That the chosen workflow system has the ability to send an electronic Post Event Message (PEM), which is timely, contemporaneous and synchronised.
* Consideration is given to how the chosen workflow system interoperates with NHS 111 Online.
* The chosen workflow system has technical integration with the Personal Demographics Service (PDS).
* The chosen workflow system can provide Patient Flag functionality, allowing Health 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.
* The chosen workflow system has ability to integrate with the National Repeat Caller Service.
* The chosen workflow system has the ability to query the Child Protection Information System (CP-IS).
* The chosen workflow system has the ability to book slots in ETCs via the EDDI system and any future booking systems.
* An equitable service is provided, whether or not a caller is registered on the GP Choice scheme.
* A systematic process is in place to regularly seek out, listen to, and act on patient feedback on their experience of using the service.
* Electronic referral methods are utilised where possible.
* A ‘RED FLAG’ system to ensure patients can be referred directly to the CAS for immediate clinical assessment.
* 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 (at least annually).
* Consideration has been given to the NHS 111 Workforce Blueprint in relation to service delivery.
* Call handling and clinical advice staff are enabled to work remotely with access to the appropriate technology, that is fit for purpose, robust and sustainable.
* The provider are contributing as necessary to the data requirements for the provision of national metrics (e.g. as nominated lead data provider where appropriate or suppliers of relevant data to the lead data provider). The provider has an obligation to work with other local providers to ensure the provision of national data as specified by NHS England and the commissioner. This relationship will be underpinned by the commissioner.
* They are involved in planning and preparedness for response to a major incident, including any pandemic response.
* Where they have responsibility for premises (e.g. call centres and/or IUC Treatment Centres) they should meet the required standards as outlined in Appendix A.
* Following assessment, the service must agree with the caller the appropriate next step to meet the patients’ needs and the caller should be provided with the most appropriate safety-netting advice and asked to re-contact the service should symptoms worsen or the patient condition changes.

### Local Requirements

#### General

The Provider **must** ensure that:

* The Call Centre is located within the boundary of England or Wales;
* The Call Centre provides service primarily for the SWL contract. For the avoidance of doubt, this should be for greater than 70% of the weekly operational hours;
* The CAS is based within South West London with **at least 90%** of the clinical assessment staff based within the geographical boundaries of South West London;
* The CAS is delivered by a dedicated SWL workforce a **minimum of 90%** of the time. For the avoidance of doubt, this should be for the hours of 07:00 - 23:59 daily;
* The CAS maximises use of clinicians working virtually wherever possible, especially where this can add additional, specialist expertise to the service in line with specific patient need;
* There is a robust information system available to all clinicians, regardless of location, (virtual or centre-based) providing up-to-date information on pathways available in each of the SWL CCG areas, both clinical and non-clinical, such as Social Prescribing, acute redesign pathways or planned care pathways;
* They follow specific pathways agreed for local requirements. These will be agreed during the transition and mobilisation period and will be reviewed during the life of the contract in line with changing local needs. Example pathways are:
* Under 5s;
* 80 and over;
* Red flag;
* Patients presenting with CMC, SPN records etc.;
* They have and adhere to a comprehensive Chaperoning Policy;
* When a chaperone is offered, accepted or declined, 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.
* Deliver the principles of NHS 111 First[[11]](#footnote-11); offering people a different way of accessing and receiving healthcare, including a new way to access Emergency Departments. Standards of delivery include:
* NHS 111 or a GP practice is the first place a patient should contact when they experience a health issue that is not immediately life-threatening;
* reducing the need for a patient to go to a physical location when accessing healthcare;
* embracing remote assessment and the technology that supports it preventing nosocomial (hospital-acquired) infection by ensuring patients do not need to congregate in ED waiting rooms;
* ensuring patients get clear direction on what they need to do and where they need to go to resolve their health issue;
* protecting those most at risk (e.g. people who are extremely clinically vulnerable from COVID-19) by giving them an enhanced service.
* Deliver the commissioning guidance of the Integrated Urgent Care Mental Health Access for Adults; with a direct interactive voice response (IVR) to mental health providers and mental health assessments via NHS 111, utilising the new *‘Select 2’* process.

Providers **should** ensure that:

* Non-symptomatic calls are closed without clinical consultation.

Providers **may** implement the following:

* The Call Centre may be located inside or outside of the London boundary.

#### Access Channels

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

* NHS 111 Telephony including patient Interactive Voice Response (IVR) options;
* *NOT IN SCOPE - NHS 111 Telephony for healthcare professionals to access clinical support through a star (\*) line process. These calls will be managed by LAS*;
* Direct referral for sepsis and other more urgent symptoms;
* Laboratory tests results when the patient’s own GP is not available;
* NHS 111 Online;
* Video Relay based British Sign Language Interpreting Services;
* ‘Type Talk’ friendly access and non-verbal translator facilities;
* Ambulance Trusts;
* Any NHS digital applications as they become available and are interconnected;
* *NOT IN SCOPE - 999 crew electronic message request for Health Care Professional call backs;* and/or
* Any future specified access points as dictated by NHS England or agreed with Commissioners such as referrals from EDs after unheralded patients attend with lower acuity.

#### Communication Channels

The provider must ensure that procured software solutions have multimedia capability, including but not limited to:

* Instant Messaging / Web Chat;
* E-mail;
* SMS (text);
* E-assessment;
* MMS (picture);
* E-consultation;
* High definition picture files; and
* Video.

#### Opening Hours

The Provider **must** operate:

* The telephony, CAS and online elements of IUC Service 24/7, 365 days a year (including leap days); and
* Face-to-face and virtual services Monday to Friday (18:30 to 08:00), Saturdays, Sundays and Bank Holidays (08:00 to 08:00).

#### Clinical Staffing

The Provider **must** ensure that:

* The service has a Clinical Director accountable for all elements of the clinical service (ref: Workforce Blueprint);
* The seniority of the clinical staffing in the CAS meets the needs of the patient demand (ref: Workforce Blueprint);
* Clinicians working in the face-to-face service have:
* Clinical prescribing qualifications;
* Experience in delivering care and prescribing in an urgent care setting or, where training is being given through the service, appropriate mentoring and support;
* Appropriate training to see patients with specialist need, e.g. End of Life (EoL) care;
* Where non-GP clinicians are working in the face-to-face service, they always have access to a GP for support.

The Provider **should** ensure that:

* The CAS is staffed by at least 90% of clinicians based in SWL, the wider London area or in CCGs that abut to the London CCG areas;
* At least 50% of the CAS is staffed by GPs;
* ED validations, in line with national and London requirements, are completed by non-CDSS clinicians.

#### Clinical Assessment Service

Providers **must** ensure that the CAS:

* Offers patients clinical consultations where appropriate, with the aim of completing the consultation on the telephone (‘Consult and Complete’ model). Where onward referrals for F2F or virtual consultation is necessary, the clinician shall have access, either directly or via a specialist resource, to book appointments for patients where these are available;
* Provides senior clinicians with access to a clinical support tool which enables them to call ambulances for patients through the automated system, to book appointments in Extended Access Hubs (EAHs), UTCs, GP in-hours and other downstream services within the designated area;
* Issues a prescription for a repeat item if appropriate and sends to a convenient pharmacy or arranges supply through CPCS;
* Ensures crisis response care is available to all people within their own homes or usual place of residence, including care homes, within two hours, who have a health or social care need which requires urgent treatment or support that can be safely delivered in the home setting (Community Services 2-hour crisis response).

#### Clinical Staff Expectations

A 'definitive clinical assessment’ is one that will enable the advising or treating clinician to develop an appropriate management plan in conjunction with the 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 patient’s location.

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. The Provider must offer a face-to-face or virtual consultation (at a centre or in the patient’s home) conducted by an appropriately trained clinician, according to the assessed patient’s needs. A virtual (video) consultation can also be an alternative solution if appropriate.

In addition, the provider **must** ensure that:

* The service Lead Clinician is a GP experienced in telephone triage and urgent care assessment and treatment (outside of core general practice hours);
* All GPs used in the service, regardless of location or role, are registered on the performers’ list;
* All clinicians working in the service, regardless of location or role, have:
* Appropriate and current registration with their relevant professional body;
* Current and appropriate immunisations, including Hepatitis B, Covid-19;
* Indemnity insurance in place appropriate to their role;
* Statutory and mandatory training in line with the need of the role;

For the avoidance of doubt, the minimum requirements for clinicians working in the service will be as currently defined by the Care Quality Commission (CQC) standards, unless specified by any appropriate national body, e.g. NHS England, GMC, NMC,;

* All clinicians, whether physically co-located or working remotely, work to standard professional competencies and are exposed to regular review and clinically led audit, especially where this is mandated for compliance with the CDSS system expectations and to support re-accreditation with registration authorities;
* All clinicians undertake annual appraisal and revalidation;
* All clinicians engaged directly by the Provider, regardless of employment status, e.g. employed, sessional, agency, etc., work a minimum of one session per month to support continuity of service and maintenance of familiarity with SWL local services and pathways;
* All clinicians engaged directly by the Provider at a Provider location to support audit, monitoring and review purposes;
* All clinicians engaged through an agency are also reviewed to ensure that they meet, and continue to meet, all their professional competencies and any CDSS accreditation requirements.
* All Clinicians mandated to use the ‘Senior Clinician Module’ (SCM) and/or ‘Pathways Clinical Consultation Support’ tool (PaCCS).

#### Patient Engagement

Patient engagement is essential to ensuring that the IUC service, spanning the Call Centre and the Clinical Services for SWL, meets and reflects the needs of patients and the diversity of our populations in SWL. The local Clinical Services providers must work with the 111 Call Centre provider, under an Alliance or sub-Contracting Agreement to ensure that there is robust patient engagement across the full pathway for IUC.

Commissioners expect the following to be delivered as an integrated service across all alliance providers, ensuring that patients are at the heart of the service by:

* Establishing, managing and evolving an effective patient engagement strategy;
* Establishing, managing, supporting, and providing effective administration for a patient engagement group (or groups) which meet/s at least quarterly. Reports from these meetings must be provided for inclusion in the overarching service contract management process;
* Ensuring that patient engagement is representative of the CCGs in SWL and of any hard-to-reach groups relevant to SWL;
* Delivering evidence-based service planning which has robust patient involvement alongside the ongoing Commissioner engagement;
* Holding regular review meetings with local patient engagement groups and demonstrating how they are able to act as a ’critical friend‘to the Provider;
* Providing evidence of the impact of patient engagement in the Provider’s service improvement planning and implementation;
* Providing the patient engagement group with timely and relevant quality reports and data to ensure patient advice and participation is based on current and anticipated future conditions; and
* Meeting all national requirements with respect to patient surveys of all elements of their service.

#### Stakeholder Engagement

Stakeholder engagement is pivotal to supporting both best patient care and integration with the wider health system, including not only other urgent care providers, but also emergency care, primary and community care providers. The Provider **must**:

* Be an active member of local ED Delivery Boards (AEDBs) and any associated sub-groups;
* Be an active member of pan-London IUC meetings, both operational and clinical;
* Contribute to the initiation and development of strategic and operational models and UEC pathways;
* Support and initiate development of alternative local pathways.

#### Registrar Training

The Provider **must** ensure that:

* They offer support to and comply with the requirement to provide training for GP Speciality Registrars in line with the Health Education England guidance for the GP Vocational Training Scheme[[12]](#footnote-12);
* There are sufficient appropriately trained GPs engaged in both the face-to-face service and within the CAS to support the training scheme.
* They are involved in Pan-London multi-agency complaints where relevant.

#### Physical Face to Face (F2F) Sites

Centres Expectations

* Centres/F2F sites will be open in line with agreed hours and clinical sessions;
* There must the flexibility to use centre clinicians to support the CAS;
* Centres can be opened overnight by the visiting service when it is more appropriate/efficient to see patients who can travel, maximising the utilisation of this key resource.

| **Days of Cover** | **Opening Hours** |
| --- | --- |
| Monday-Friday excl. BH | 19:00-08:00 |
| Saturday, Sunday and Bank Holidays | 08:00-08:00 |

Table 3 – OOH’ F2F Site Coverage Hours

Providers will identify IUC Centres/F2F sites through local ED Delivery Boards and local Primary Care Committees, facilitated by commissioners. This will ensure that SWL can co-locate services where possible to maximise local workforce. The Provider **must** ensure that:

* All centres are open in line with the contractually agreed hours and clinical sessions. For avoidance of doubt, this must be a minimum of 98% of the contracted hours;
* Clinicians working in centres are able to contribute to the CAS whenever they have capacity;
* Centres can be opened outside of the prescribed opening hours to support flex in demand, especially during the overnight period.

The Provider **should** ensure that:

* The centres can provide resource to support local escalation issues i.e. transfers from ED where there is capacity in OOHs;
* Infection control training for all staff is provided during induction and ensure staff attend annual refresher courses;
* All staff have copies of an up-to-date infection control manual and Infection Control policies;
* An infection control audit is undertaken 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);
* Representatives of the commissioner are allowed to visit the site(s) from where the provider is delivering the service at any time;
* The commissioner is notified within 24 hours of confirmation of any outbreaks of infection, or if any serious incidents arise;
* Cleaning arrangements are carried out in accordance with the current NPSA Healthcare Cleaning Manual; and
* Healthcare waste is disposed of safely and in line with current legislation and DH guidance.

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

#### Home Visiting

Home Visiting Expectations

* The Provider uses a GP in the CAS to act as the gatekeeper for home visits to maximise their appropriateness and reduce unnecessary visits. It is noted that GPs are more experienced in managing this form of risk management;
* A home visit will encompass a visit to any location where a patient is currently

residing. This may include places other than a patient’s home address.

* The face-to-face visiting service must have the flexibility to be able to open clinics overnight when it is more appropriate/efficient to see patients who can travel, maximising the utilisation of this key resource.

| **Days of Cover** | **Opening Hours** |
| --- | --- |
| Monday-Friday excl. BH | 19:00-08:00 |
| Saturday, Sunday and Bank Holidays | 08:00-08:00 |

Table 4 – OOH’ Vehicle Coverage Hours

The Provider **must** implement vehicle rotas on the following criteria:

* They are a minimum of four hours, in line with standard GP expectations;
* All vehicles are staffed and available in line with the contractually agreed hours and clinical sessions. For avoidance of doubt, this must be a minimum of 98% of the contracted hours;
* They provide sufficient coverage so that urgent and routine visits can be achieved at least within the associated Key Performance Indicators (KPIs);
* Consultations are with an appropriate clinician;
* Home visits are completed by an appropriate member of a multidisciplinary team with direct access to clinical support - this can be achieved either through connectivity with the wider CAS or direct with the patient’s GP;
* Home visits are undertaken according to local protocols and pathways developed by the provider and agreed with the commissioner to avoid unnecessary re-triage. Patients must be left with a written plan of care and the provider must ensure the patient’s GP is informed of the visit;
* The mode of transport, medicines management arrangements, availability and suitability of vehicles, the bases, the drivers and associated infrastructure and management controls are able to meet requirements
* Vehicles must be suitable for reaching remote homes in adverse weather conditions so except in the most urban areas should have 4-wheel drive capability; and
* Access to the home visiting service is also available to the GP accepting calls from paramedics and care homes, via a rapid access (e.g. IVR) telephony route.

## Location of Service

The Provider **must** ensure that:

* **At least 90%** of calls, both clinical and non-clinical, are managed by a core team delivering services to SWL;
* There is flexibility for staff to work virtually to meet variable demand, and this support should be extendable to incorporate clinicians into the CAS for less well utilised specialisms;
* All staff delivering the IUC Service are fully conversant with:
* The SWL geographic area;
* Local services for patient onward referral, including any specifics regarding service opening hours, and referral processes or protocols;
* Local transport routes and options.
* All Information Governance (IG) and Clinical Governance requirements are met for all staff, regardless of location, including clinical staff forming part of the greater ‘virtual’ CAS. Staff working remotely must have access to the same level of support as staff located physically in the Call Centre environment and all calls must be recorded;
* The ‘virtual’ CAS should include the ability for GPs and clinicians from other parts of the IUC Service (e.g. Face to Face and Home Visiting) to take calls from the clinical queue.

In support of this, the Provider **should** ensure that:

* Their service is able to accommodate other clinicians from other providers, either virtually or on site in order to support true integration. Provider-to-Provider agreements must be in place to ensure appropriate governance.
* They develop a robust contingency and surge plan, to include creating Strategic Surge Partnerships with external 111 and/or CAS providers who have the ability and capacity to manage an agreed percentage of calls should the provider be unable to manage, and where call balancing is unavailable.

### Location of 111 Call Centre and CAS Services

Key SWL Call Centre Requirements

* Calls into the SWL service **must** be carried out within the boundaries of England and Wales;
* Commissioners put no restrictions on the location of the 111 Call Centre element of the service; the Provider is free to deliver the 111 Call Centre element of the model from wherever they choose. This allows providers to implement a Call Centre model that is:
* Wholly outside London;
* A combination of provision from within and outside London; or
* Wholly based in the local geography;
* The Provider’s standard operating model will be to run a dedicated Call Centre service for the SWL contract during the day; Commissioners will consider a model of service whereby, during agreed hours overnight, the Provider can run a distributed service across multiple contracts and locations. For avoidance of doubt, this is expected to be no more than 30% of weekly operational hours.

Key SWL Clinical Assessment Service Requirements

* The CAS **must** be located primarily within the South West London boundary. For the avoidance of doubt, at least 90% of CAS clinicians will be based within the South West London boundary;
* The CAS **must** use clinicians who are familiar with SWL, its pathways and services available for patients;
* Clinicians **must** be able to support the CAS directly, at a local office, remotely at one of the service bases in SWL or, where appropriate, using secure technology to allow them to consult virtually from their office or home location.

## Clinical and Quality Governance

The Provider **must** comply with all elements of the quality standards detailed in the contract schedules. The Commissioners require a high-quality service for patients within South West London and will want all elements of the standards and, as additionally described below, to be in place for the duration of this contract as evidence of the Provider’s commitment to quality and safety for patients in SWL. The Provider **must** ensure that:

* All expected clinical and quality governance standards covering Patient Safety, Patient experience, clinical effectiveness are complied with during the life of the contract. This includes, but is not limited to:
* National collection of Serious Incident (SI) data;
* National collection of end-to-end review data; and
* Provision of cross provider clinical oversight.

To deliver this, the Provider **must**:

* Work with LAS to establish a robust quality and clinical governance management and monitoring structure that ensures there is comprehensive monitoring, assurance, leadership and oversight with regards to Patient safety, patient experience and effectiveness;
* Ensure that there is dedicated senior leadership to oversee the quality and clinical governance agenda with appropriate policies, procedures and dedicated clinical and quality leads;
* Have a program of review for policies which will be submitted to the Commissioners’ Clinical Review process during service transition and afterwards for review and approval;
* Ensure compliance with Section 28, Coroners’ Requests;
* Work with the Pan-London Clinical Reference Group (CRG) to share learning and discuss specific complaints/incidents that could lead to improvements for patient safety and quality.

A range of metrics and methods will be used to monitor service quality for assurance and compliance. The Provider **must** report these formally at the Commissioners’ clinical quality review group meeting (CQRG), at other required meeting forums/platforms and upon request by the Commissioner. This will include, but is not limited to:

* Quality standards, assurance and reporting:
* Serious incidents;
* Quality alerts;
* Incidents;
* Complaints;
* Breach reviews and harm assessment;
* Safeguarding;
* Infection control;
* End to end case reviews;
* Medicines management;
* Audits;
* Patient feedback;
* Staff feedback; and
* Ensuring staffing and clinical management is culturally sensitive, in accordance with the principles of the WRES
* Workforce.
* Multi-disciplinary Reviews:
* Dedicated monthly clinical quality review meetings;
* Monthly end-to-end meetings;
* Patient and public groups;
* Formal quality inspections;
* Ad hoc commissioner walkarounds;
* Ad hoc conversations with senior quality leads as required;
* Joint working meetings;
* Learning and incidents meetings; and
* Pan London meetings and working groups;
* Coroners reports and reviews
* Quality Improvement:
* Continuous quality improvement through working on applying innovative approaches as well joint working between provider and commissioners on challenging areas, engaging across the system to adapt to the constantly changing landscape in IUC.

## Acceptance and Exclusion Criteria and Thresholds

### Population Covered

The Provider will receive calls from patients who:

* Are registered with a GP within the geographic area of South West London specified in the contract (i.e. the London boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth). This includes patients who are:
* Registered in SWL and
* Calling from within the SWL area;
* Are registered outside the geographic area specified in the contract but who call from a telephone National Numbering Group (NNG) allocated by NHS England to the Provider. This includes patients who are:
* Registered outside of SWL; and
* Calling from within the SWL area;
* 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). This includes patients who are:
* Calling from anywhere in the country regardless of registration;
* Are unregistered and are calling from the geographic area covered by the contract. This includes patients who:
* May be working in the SWL area;
* May be visiting the SWL area;
* May live in the SWL area but are not currently registered with a GP practice.

The Clinical Services Provider must deliver clinical services to all patients whose open cases are transferred to them by the 111 Call Centre provider or through other electronic means.

The Provider should note that, during the life of the contract, changes may occur to the accepted population, depending on NHS rules concerning residents of European Union countries.

### Exclusion Criteria

There **must** be no exclusions for handling call/online contacts presented to the NHS 111 Call Centre and the CAS, apart from those calls being managed by LAS (see section 3).

There **must** be no exclusions for face-to-face appointments in centres.

There **must** be no exclusions to visiting a patient deemed appropriate, where a patient is registered with a SWL practice and lives within 2 miles of the SWL border.

# Service Delivery

## Operating Model – 111 Call Handling

Callers to the SWL NHS 111 service are routed via the national NHS 111 telephony system to the organisation commissioned and via the Patient Relationship Manager (PRM) Platform to receive NHS 111 calls for the geographic area from which the call originated.

The Provider **must**:

* Have the capability for an Interactive Voice Response (IVR) solution. Any implementation must adhere to the Telephony Messaging Strategy in place in London and must be agreed with Commissioners during both service mobilisation and any subsequent service changes;
* Ensure that, as Commissioners, NHS England and pan-London changes develop the IUC pathways and additional items are added or removed from the IVR and telephony front-end, that they can and do implement these changes.

LAS to route callers who are HCPs via the \* lines access:

* \*5 for ambulance crews;
* \*6 for Care home staff; and
* \*7 for Health Care Professionals.

### NHS Call Handling Process

The Provider **must** ensure that:

* When answering calls in the NHS 111 Call Centre, demographic details must be accurately recorded. The Provider will ensure that a patient’s NHS number is verified using the Patient Demographic Service (PDS);
* Callers are dealt within in a courteous and clear, plain English manner. The capture of information, either demographic or for the purposes of assessment, must be carried out in an efficient way in accordance with the relevant CDSS licence and associated training programme. If a Service or Health advisor is unable to proceed with a call, they must seek advice from a Senior Health Advisor or a Clinician.

### Demographics and Anonymous Callers

The Provider **must** ensure that:

* Any caller has the right to remain anonymous. If a caller states that they wish to remain anonymous, the Service or Health Advisor shall still record some demographic details – age is a minimum requirement. This is necessary in order to carry out a safe assessment using the CDSS.

### Out of Area Calls (OOA)

The Provider **must** ensure that:

* On the occasions where a call is received from a patient who is calling from outside the geographic area covered by the Provider contract, they will 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 within the SWL 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 patient 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. The Provider will be expected to implement an electronic process if required during the life of the contract;
* 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;
* They update standard operating procedures, in line with national guidance, with regard to the unlikely event a call back is requested from a patient using NHS 111 Online outside of the geographic area covered by the Provider contract;
* They report on all OOA activity so the Provider and Commissioners are sighted on this and the impact on the commissioned service to allow conversations with NHS England.

### 999 Escalation

It is noted that Ambulance Trusts will deal with border issues using the usual procedures. In addition to Auto dispatch, a London region manual Ambulance Dispatch SOP has been developed to support IUC and CAS services.

The Provider **must** ensure that:

If a call to the service needs to be escalated to the 999 service (i.e., an ambulance needs to be dispatched), it should be dispatched electronically, with verbal transfer capability for business continuity (using audio conferencing with 999).

* In the event of a messaging problem, they have a clinically-safe workaround, as agreed by the Commissioner, which does not involve re-triage;
* All staff supporting the service must follow the Ambulance Dispatch process, including the manual SOP where the ‘autolink’ referrals to LAS999 service will fail to send.

### Confirmation of the Patient’s Registered GP and GP Choice

All GP practices are now able to register patients who live outside the practice area. These GP Choice registrations are made with no obligation on either the GP practice to provide urgent home visits or locally commissioned visiting services. The patient pathway differs between ‘In Hours’ and ‘locally commissioned visiting services’ and whether the patient is at home. The Table below outlines the expected arrangements.

| **Patient Location** | **Services Available** |
| --- | --- |
| Patient at home (away from registered practice) | **In Hours:** Patient shall access the GP Choice service as detailed in the Directory of Services (DoS) via NHS 111. The temporary resident (TR) and immediate and necessary treatment (INT) policies do not apply. Regardless of where the patient is they should be able to be booked into their local GP practice.  |
| **Locally commissioned visiting services:** Patients should access routine, locally commissioned visiting services nearest the patient or other urgent care provision via NHS 111. |
| Patient near registered practice  | **In Hours:** Patient is able to access registered surgery.  |
| **Locally commissioned visiting services:** Patient should access routine locally commissioned visiting services and other urgent care provision, including improved access GP services where commissioned via NHS 111. |

Table 4 - GP Choice Patient Support

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 Immediate Necessary Treatment (INT) scheme except when the critical 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 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 IUC service when they need to access services at home.

The Provider **must**:

* Put in place appropriate technical solutions and or operational procedures to handle GP Choice patients in accordance with the requirements as set out in the table above.

### Callers Not Located with the Patient

Calls may be received from a person who is not located in the immediate vicinity of the patient. In these conditions, the Provider **must** ensure that the Service or Health Advisor must establish, as a minimum, the following:

* If the patient is able to contact the service directly (this is by far the most preferable option);
* If the caller is in the same building as the patient, e.g. residential home;
* If they are able to move so they can see and talk to the patient whilst undertaking the assessment;
* If the caller is phoning from a remote care line Call Centre on behalf of the patient;
* If the patient is contactable, the caller must be asked if they have the telephone number for the patient;
* If there is any reason the patient should not be contacted.

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

If the patient is not contactable, the Service or Health Advisor **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 (GP visit, community nurse etc.); or
* No action required.

If necessary, the Service or Health Advisor **must** seek advice from a supervisor or clinician on what action is appropriate. In all cases, the call must be recorded.

### Non-Symptomatic Calls

Some callers will not be experiencing symptoms and may be calling to seek advice on a health-related matter or will be seeking some form of health information. For these callers, the Provider **must** ensure that:

* The Service or Health Advisor clearly establishes that there are no apparent new symptoms being experienced. Once this is established, the Service or Health Advisor must deal with the call appropriately using tools such as the DoS or NHS.UK if the question relates to service information.

For these callers, the Provider **should** ensure that:

* Wherever possible, for calls that do not receive a clinical consultation, the Service or Health Advisor is in the position to “complete” the call.

### Warm Transfers

If deemed clinically unsafe for a patient to queue, the Provider **must** ensure that:

* This includes a handover conversation between the Service or Health Advisor and the clinician;
* The handover conversation is voice recorded by the Provider;
* The voice call and triage data arecompleted through a guided transferred process to the same advisor;
* Where a warm transfer for consultation from a Clinician is not possible, the caller is called back within an agreed timescale, with clear guidance via an SOP or other form of protocol or guidance.

Where calls cannot be warm transferred to a clinician owing to lack of availability and the call is deemed clinically safe to queue, the Provider **must** ensure that:

* Health Advisor is able to place the call into/send a call over an appropriate electronic interchange to a clinically supervised call-back queue;
* The call-back queue is visible to the clinical navigator;
* The calls going into the call-back queue have a clear clinical priority attached;
* The disposition timeframe for calls is also clear so that calls in the queue are first ordered by clinical priority and then chronology.

The Provider **should** ensure that:

* Where possible and appropriate, the patient is also part of the handover conversation.

### Call Backs from Clinicians

The Provider **must** ensure that:

* Call backs are conducted according to the urgency of the call and within any specified time limits, with the caller given an accurate indication of time;
* Call backs which take place outside of their assigned urgency undergo a clinical audit review.

### Discharge Process

The Provider **must** ensure that:

* Once a call is completed, an outcome reached and any referral made, the patient is given appropriate safety netting advice and asked to re-contact the 111 Call Centre service should symptoms worsen or their condition change;
* They 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.

If a patient receives additional telephone or face-to-face consultation from multiple parts of the IUC Clinical Service, only a final PEM need be sent with the outcome information.

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. This must be agreed with Commissioners.

### Specific Caller Groups

The Provider **must** have processes covering the following specific caller groups for whom particular processes must be followed.

#### Unregistered Callers

Unregistered 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.

#### Repeat Callers

The Department of Health has issued directions to ensure that any health professional assessing a patient’s needs in the GP 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. Therefore, the Provider **must** ensure that this facility is available within the IUC Service.

If a patient (or their carer) calls the SWL IUC Service three times in four days, on the third 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 a clinician. The clinician **must** complete a thorough re-assessment of the patient’s needs and have access to the details of all three calls.

The Provider must have:

* Agreements in place to feed and query the national Repeat Caller Service (RCS) that has been commissioned by NHS England for this purpose. The Provider 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 reporting

#### Frequent Callers

The Repeat Caller requirements detailed above do not apply to that small minority of people who make repeated calls (eight times in one 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 (for example, palliative care or long-term conditions, etc.). The Provider **must** ensure that:

* They have a robust system in place to manage frequent callers; and
* This process is agreed with any individual’s registered GP practice.

#### Frequent Requests for Repeat Items

Supply through the patient’s GP allows the required checks to be completed and is the safest and most cost-effective route to supply repeat items. To avoid the NHS 111 service becoming a route of choice for patients to obtain repeat items, the Provider **must** ensure that:

* Information on previous calls for repeat items is visible to 111 and CAS staff;
* Actions agreed with the practice to reduce need for urgent requests, e.g. enrol patient on electronic repeat dispensing if appropriate, are completed as quickly as possible;
* They link with the Community Pharmacy Consultation Services (CPCS) to share appropriate information about patients making repeat requests.

#### Callers with Additional Needs and Mental Health Conditions

The Provider **must**:

* Adhere to the principles of the Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis[[13]](#footnote-13) (18th February 2014) and work with Commissioners and patient groups to ensure the most convenient and appropriate access to the service;
* Develop the ‘PRESS 2’ operational process that is currently being rolled out across London;
* Work with local Mental Health Services[[14]](#footnote-14) [[15]](#footnote-15) to ensure the Service intervenes early and identifies appropriate callers to refer to local mental health crisis centres;
* Work with Commissioners:
* To work with HLP and NHS England on developing and piloting new initiatives in the ‘Once for London’ Mental Health programme and 111 First, and/or
* Implement changes resulting from the outcome of any such pilots, and incorporating them into BAU as part of facilitating and improving integration between MH and IUC;
* Ensure that clinicians can manage patients with local mental health crisis plans when they are available;
* Ensure that all staff have training in managing calls from patients who need extra support when accessing the Clinical Service, e.g. learning disabilities;
* Ensure that if the disposition is to speak to a clinician within the CAS, the patient would be best triaged and managed by a mental health clinician. Ongoing care and management of these patients can include referral into third sector, primary care, secondary care mental health pathways or psychiatric liaison service in the patient’s local acute trust.

#### Callers with English as a Second Language

The Provider **must**:

* Have a translation service available 24/7/365 to translate calls made in other languages;
* Ensure that access to interpreting services is equitable for all patients;
* Ensure that the quality of interpreting is independently reviewed on a regular basis.

#### Callers with Hearing Impairments

The Provider **must** ensure that:

* They deliver a good-quality service which is adapted to include patients with hearing impairments;
* Service Advisors, Health Advisors and Clinical Advisors understand that such calls exist and how to handle them - no special equipment or services are required.

In the future, it may be a requirement that these calls will be tagged following the first call, and consent to improve the response for these patients will be sought. Calls from this group may be routed to a specific DDI number and have a higher priority than other calls.

A national British Sign Language (BSL) interpreting service has been procured by NHS England. The service is available through NHS Choices or an app, and involves the creation of a video relay link with an interpreter. The interpreter identifies the correct NHS 111 service based on the patient’s postcode and connects the patient to the Provider by placing a voice call to a dedicated DDI. These calls do take longer to handle than a standard voice call due to the interpreting lag but follow exactly the same process. The only difference is that, instead of a phone number, patients using the app have a SIP e-mail style address for call-back. However, it should be noted that to be called back the patient must have the app running and be on a suitably fast Wi-Fi or mobile internet connection. It is not possible to call back an NHS Choices caller.

The Provider **must** ensure that:

* They have provided a suitable DDI for use by the interpreting service;
* They work with LAS and CAS providers to ensure that such calls can be managed effectively where clinical contact or a call back is required;
* They have capability and processes in place to take and manage calls from callers using the BSL video link.

#### Patients with Additional Access Requirements

Providers must ensure that as part of their training, call handling staff receive adequate guidance on how to help patients with additional access requirements, for instance calls from or about people with:

* Learning difficulties or autism; and
* Physical disabilities.

#### Safeguarding

The provider must 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 Social Care and the local safeguarding boards as appropriate. They 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, and training and competency framework for Prevent in line with Bournemouth competencies framework as referenced in Care Act 2014 and associated code of practice.
* 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 must 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.
	+ - 1. *Health Information Callers*

In general, there are two categories of non-symptomatic health information requests:

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

Where there is a non-symptomatic query relating to a health condition, the Provider **must:**

* Ensure that these calls are referred to an appropriate Health Advisor or Clinician;
* Ensure that service information queries can be dealt with using the DoS; and
* Direct callers, where appropriate, to NHS Choices[[16]](#footnote-16) or other NHS 111 online sources of information.

### Outbreak Protocols/Unexpected Demand Changes

Although the Provider is expected to forecast demand for scheduling staff in line with trends and seasonal changes, they **must** work with Commissioners where there is unexpected, short-term demand change. When these occur, the Provider **must**:

* Deliver services to patients;
* Report issues to Commissioners where they arise.

#### Implementation of Flu/Covid Care Home Protocol

The Provider **must** be able to mitigate risks to patients and staff through appropriate prescribing of antiviral medication and vaccination of unprotected patients, in a timely manner (including at weekends), minimising the risk that patients need to be transferred to hospital, as well as reducing demand on primary care and the patient’s own GP.

The Provider **must** ensure that:

* A clinician can assess and prescribe either prophylactic or therapeutic antivirals to all residents as clinically indicated;
* They can direct supply of antivirals from a community pharmacy or local supplier;
* Ensure education to reinforce personal infection control measures – as per NICE guidance[[17]](#footnote-17);
* The care homes are advised about the withdrawal of any pregnant non-vaccinated staff;
* Any remaining staff and residents, who are not vaccinated, are vaccinated via the community pharmacy national advanced service;
* Conveyance to hospital is avoided where possible for Influenza/SARS Like Illness;
* All residents have in place appropriate advance care plans, including fluids, rest and paracetamol; and
* The patient’s own GP is informed of actions within 24hrs.

#### Out-of-Season Requirements

There are occasions where local outbreaks may not be covered by national responses or outside of national protocols e.g. out of season Tamiflu prescribing, and this can cause issues with prescribing or managing the patient effectively. In these scenarios, the Provider **must**:

* Manage patients’ needs proactively even when outside of agreed protocols; and
* Report the issues to Commissioners when they arise.

### Self-Care

The Provider **must** ensure that:

* Self-care advice is managed by an appropriate Clinician (or Senior Health Advisor as defined in the Workforce Blueprint).

## Operating Model – Clinical Assessment Service

The CAS and virtual CAS workforce **must** comprise of both a generalist and a specialised clinical skill mix that meets the current caller health profile for the South West London CCGs.

The Provider **must** ensure that:

* They amend the skill mix in line with changing requirements of the callers to ensure the service always meets the health needs of SWL’s patients;
* The workforce model ensures that there is an accountable GP to oversee the service and will include generalist clinicians such as paramedics, nurses, Advanced Nurse Practitioners and Advanced Clinical Practitioners as well as specialised clinicians from a range of professions and disciplines, including mental health, dental health, midwifery, pharmacy, social care and paediatrics;
* There are prescribing clinicians working within the CAS;
* The CAS and virtual CAS is always overseen by a Lead GP;
* They implement all CAS Workforce Development and London CAS standards as and when they are developed.

### Prescribing

The provider must 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 must ensure:

* Provision of a medical (e.g. GP) and/or non-medical prescriber (e.g. 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).
* Provision of an electronic prescribing system within the IUC CAS, linked to the provider workflow system, to support the issuing of NHS prescriptions.
* Where possible, the Electronic Prescription Service (EPS) is used. Where this is not available, there should be appropriate systems in place to enable fulfilment of a prescription following a consultation.

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 and local/national formularies where available (including consideration of antimicrobial resistance and use of antibiotics). This will include the provider having the IUC formulary loaded onto their workflow system.

### NHS 111 Online

A call entering via the NHS 111 Online channel (where the patient has chosen a call back) will have undergone a similar assessment online prior to being passed to the CAS.

The Provider **must** ensure that:

* Calls received from NHS 111 Online must have, if necessary, PDS match run before placing the call in the appropriate clinical queue for assessment.

### Low-Acuity Ambulance Validation & ED Disposition Validations

The Provider **must** ensure that:

* Where a Service or Health Advisor generates a low-acuity ambulance or an Emergency Department outcome, a clinical review of these calls is performed in line with the national directive, so the patient is referred to the right care setting within the right time.

The Provider **should** ensure that:

* These calls are validated by non-CDSS clinicians; and
* They are booked into an appropriate time-slot commensurate with their Pathways Clinical Consultation Support (PaCCS) outcome and the services prioritised on the DoS.

## Management of End of Life Care (EoLC) Patients

EoLC patients have particular requirements which the service must meet including:

* A modified assessment process;
* Access to EoLC plans, including preferred place of death; and
* Additional considerations for referral and transport to onward services.

The standard NHS Pathways assessment will not always be appropriate for EoLC patients; therefore providers must consider early CDSS exit arrangements where it is identified that a patient has EoLC arrangements in place.

Where possible these patients should be assessed by a clinician in order to account for the complexity of their condition and the non-standard nature of their signs and symptoms.

Several areas have EoLC plans in place. The provider must ensure access to these care plans wherever possible to inform clinical assessment. The provider must also have arrangements in place for access to specialist palliative care advice where necessary.

Once assessment is complete, the provider must take additional care to ensure the patient is referred to the correct service for their care and maximise home visiting where possible.

## Verification of Death

Where verification of death has been requested, an appropriate healthcare professional should be assigned to undertake this. Verification must be undertaken in a timely manner, balanced against the clinical needs of other patients and accounting for the circumstances in which death has occurred.

## Clinical Navigator

The Provider **must** ensure that:

* There is a Clinical Navigator managing the CAS clinical queue 24/7;
* The Clinical Navigator is not a CDSS-based clinician and is able to work independently;
* The Clinical Navigator has oversight of all calls in the clinical queue to ensure that patients do not get lost between clinicians and specialised clinical queues;
* The Clinical Navigator will, where appropriate, assign cases to clinicians within the CAS;
* The Clinical Navigator has the ability to re-prioritise calls, including escalating and de-escalating them, to ensure that patients are dealt with in line with their clinical or changing need;
* Where the Clinical Navigator is not a GP, they have direct access to the GP in the CAS at all times to support queries and review changes in patient need, supporting the overall safety of the CAS and the service as a whole.

## GP in the CAS

The Provider **must** ensure that:

* The CAS and virtual CAS has an accountable GP available 24/7 who is available to provide clinical leadership and support to other clinical team;
* The GP supports the Clinical Navigator when they are reviewing cases in the clinical queue to ensure patient needs are met and the service is operating in a safe manner;
* The GP Lead is available to support non-medical prescribers, where necessary, or prescribe where this is not available through CPCS.

## Clinical Decision Support System

### Operating 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 NHS 111 Online);
* Gathering further information to ensure case streaming to the right clinical care or gather information to aid the clinical consultation process; and
* Supporting the clinical consultation and delivering the right care (this may be remotely within the CAS or by connecting to local pathways of care where this 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 as much as possible, where clinically appropriate, consulted and completed on the phone. Where a face-to-face appointment is needed, this must be directly booked where this function has been agreed. It is important to provide the patient with the confidence that the care they need will be provided and reduce the likelihood that they will defer to a higher-acuity service.

### Role-Based Workflow

The Provider **must** ensure that:

* A Clinical Navigator is always available to monitor and manage the clinical risk within any queues; and
* Clinicians use 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 where there are not 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.

Combining local protocols with clinical algorithms within CDSS or clinical workflow system is acceptable, provided this has 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.

#

# Premises

The Provider **must** comply with all elements of the premises’ standards detailed in the contract schedules.

## General

The Provider **must** ensure that:

* All premises have appropriate CQC registration.

## The 111 Call Centre

The Provider **must** ensure that:

* The 111 Call Centre premises meet statutory requirements and follow best practice Call Centre guidance;
* The centre is fit for purpose, meeting National Building Requirements and provides appropriate space to deal with the call volume and growth of the contract over the term of the contract, as well as any further Covid or other pandemic restrictions. This may require the use of multiple centres;
* Tenancy arrangements, including signed leases, are put in place ahead of contract commencement.

The Provider **may**:

* Utilise more than one Call Centre if that is beneficial to the model of service, service resilience, staffing and service delivery, provided they can be managed within the agreed cost envelope. All centres must fulfil the same criteria and operate as a ‘virtual Call Centre’ – i.e. shared queues, visibility of staff and availability, access to support and clinical advice.

## Face to Face Sites (F2F)

The Provider **must** ensure that IUC centres/F2F sites shall operate on the following basis so that:

* The operating hours and location(s) of the sites may only change in agreement between the Commissioners and the Provider. A formal consultation process may be required if a base’s location, opening hours or opening/closure were to change during the contract term;
* If NHS site(s) are to be used by the Provider, the Provider uses the site(s) only in connection with the provision of the Services and ensures that the Provider staff use the site(s) only for that purpose and in accordance with any lease agreement;
* A formal Heads of Agreement or occupancy licence is entered into between the hosting site(s) and the Provider;
* A formal, agreed escalation plan will be put in place for situations in which the service is unable to achieve stated quality measures.

# Workforce

The Workforce Blueprint sets the key guidance and standards for the IUC workforce.

## Clinical Telephone/Remote Workforce

Within the IUC contact environment, clinicians will perform multiple roles, providing direct patient contact, clinical supervision and support of the non-registered staff working within the environment. There is also an opportunity to consider the rotation of staff through providers across urgent and emergency care to maintain and develop their skills and foster knowledge sharing, 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 competences and capability to work safely and effectively within the remote urgent and emergency care environment.

Providers should consider rotation of staff, across the UEC services, to maintain and develop skills and better understanding of local clinical pathways.

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

## 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, and 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 must ensure that:

* NICE guidance on promoting healthy workplaces is implemented.
* 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.

The last point is important in managing staff turnover, maximising retention and ensuring staff satisfaction. Providers should train their shift leaders in mental health first Aid, so they can identify staff who may needs support and offer it.

## IUC Clinical Assessment Service (CAS) Workforce

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, and others will be contracted in or work from other provider organisations, utilising a range of mechanisms (such as where appropriate, secondments or sub-contracted arrangements). Both of these mechanisms have limitations, and it is important to ensure the appropriate solution is selected. 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.

## Audit

The provider must 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 must implement the recommendations within the Workforce Blueprint product around governance when published.

## Recruitment, Retention and Vacancies

The provider must 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.

## Medicines and Poisons training

All providers must have access to Toxbase, and clinicians using this must have access to appropriate resources and training. It is strongly recommended that all providers register to Toxbase in order to receive appropriate updates and alerts.

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

## Forecasting and Capacity Planning

Forecasting and capacity planning are two distinct activities:

* Forecasting is the planning of future demand and requirements. This encompasses understanding the demand profile expected into a business and to also understand the required number of staff hours (capacity) to meet that planned demand.
* Capacity planning is the adjustment of the resource levels to meet the monthly, weekly and intraday capacity requirements to provide a service within any agreed key performance metrics.

Providers should consider the development of an on-call system for utilising extra capacity developing a local bank of available and appropriate staff.

IUC call handling providers must supply the information to NHS England for forecasting and capacity planning as required. Specialist support from NHS England will be available on request to ensure the data burden is kept to a minimum.

All data will remain confidential and only shared with the key stakeholders for each contract area and all benchmarking data will be anonymised.

## Remote Working

Remote working for telephony and clinical staff should be considered as part of the service.

Providers must have the appropriate technical enablers and operational processes in place to allow staff to work remotely. This should include, but not be limited to, any licence easements and specialist remote working products.

All of the features and facilities available in the contact centre should be extended to the remote worker, including but not limited to, workflow, telephony and voice recording and should form part of a developed SOP.

In addition to remote working, providers could also consider remote recruitment and training.

Staff must meet minimum levels of competency and have completed any preceptorship period before being permitted to work remotely.

### Clinical Support

Clinical support of remote workers should be the same as for those working physically within the service to include access to immediate support and escalation processes (including safeguarding referrals etc). As a minimum, there should be the same level of audit undertaken for remote workers with identified thresholds for review of remote working status. Consideration should be given to whether additional audit and monitoring is required depending on experience.

# Technical Requirements

The IUC service is underpinned by technology. This service specification therefore sets out the standards against which technology must be procured and emphasises the importance of robust resilient solutions. Key elements include:

* Telephony
* NHS 111 Online
* Clinical Decision Support System (CDSS)
* Workflow system
* Directory of Services (DoS)
* Direct booking to onward points of care
* Post Event Messaging (PEM)
* Short Message Service (SMS)
* Interoperability

The underlying principles of IUC technology are that:

* The clinical assessment should take into account any preferences or instructions detailed in a patient’s care plans.
* Clinicians should be able to access the patient’s record (Summary Care Record (SCR)), Enhanced SCR, and GP Connect.
* When required, patients should be referred to the most appropriate location of care in their locality, where technically possible via an appointment booked via NHS 111.
* Prescriptions should be issued electronically for collection at a pharmacy of the patient’s choice, subject to opening hours and other checks deemed necessary by the provider.
* If an ambulance is required, it should be dispatched electronically, with verbal transfer capability for business continuity (using audio conferencing with 999).
* If an appointment is required, it should be booked electronically on behalf of the patient, negating the need for the patient to make a further phone call.

The use of Post Event Messaging and referral messaging using the Clinical Document Architecture (CDA) in electronic form (ITK), migrating to the FHIR standards as they become available.

Further technical information can be found on the NHS Digital website.

## Telephony

### National Telephony

#### Hosting and Charge Reversal

The 111 number is hosted on the national telephone carrier’s network (the 111 carrier) through a contract procured centrally by NHS England. 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 NHS England and not recharged to the provider.

#### Location Based Routing

The underlying principle behind 111 call routing is that the call should wherever 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 (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 Croydon or 2 if you are in East Surrey” style call steering mechanism is used.

#### 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 must 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.

#### Call Steering - Interactive Voice Response (IVR)

The provider may introduce a simple single layer Interactive Voice Response (IVR) to stream callers to the most appropriate resource. For example, “press 1 if you or the person you are calling about is feeling unwell, press 2 for mental health, press 3 for dental enquiries”. The design of any such IVR menu must adhere to the Telephony Messaging Strategy found in Appendix A.

The 111 carrier’s platform is capable of providing Interactive Voice Response (IVR) functionality. 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.

#### 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 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 must 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.

#### 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).

#### 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, NHS England shall consider requests to use National Contingency to cover local Planned Engineering Works.

#### Receiving calls from 111

To deliver the NHS 111 call to IUC 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 IUC provider must issue delivery numbers to which NHS 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.
* Delivery of “Default Routed” Calls.
* Delivery of BSL Calls.
* Delivery of NGT Relay Calls.
* Delivery of Mental Health Calls.
* Any IVR options.

In the event that a call cannot be delivered to the IUC Provider, due to a fault or line congestion, the call will be overflowed to another IUC Provider. If that is not possible, then a message stating “it has not been possible to connect your call” is played to the caller (known as the Technical Difficulties message). The IUC provider must take appropriate action to ensure that calls are not overflowing, and 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 IUC provider must ensure that the chosen carrier has sufficient carrier interconnect capacity and where possible avoid previously ported numbers.

### Local Telephony

#### 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 must provision a minimum of 3 lines for every equipped agent position.

These lines can be conventional ISDN or SIP. With the phasing out of conventional ISDN, IUC providers must have a plan to migrate all their ISDN services to SIP at least 12 months prior to the withdrawal or removal of full support for those services in their area. There is no need to port existing ISDN DDI numbers relating to the delivery of NHS 111 calls to any new services, as new numbers can be built into the national call delivery plan. The porting of individual telephone numbers between carriers involves call redirection which in turn can result in carrier interconnect congestion. The IUC provider must ensure that the chosen carrier has sufficient carrier interconnect capacity and where possible avoid previously ported numbers.

When replacing ISDN with SIP, it is important to remember that unlike ISDN, which is nodal, SIP solutions are centralised, and total outages have been known to occur. To mitigate this, SIP circuits should be resilient and diversely routed. Where this is not possible through one carrier, then multiple carriers should be used. This may require new ducting and wayleaves and as such, can involve long lead times.

The upgrade from ISDN to SIP may involve the purchase of additional hardware or licences, and in the worst-case scenario where the IUC provider’s system is end of life, the IUC Provider may be required to purchase a new system. The IUC Provider should carry out an impact assessment before ordering to ensure these can be terminated on the equipment, and brought into service before the required date.

Where no SIP provision currently exists, ISDN circuits and terminating hardware should remain in place for a minimum of one-week post migration for roll back purposes.

Any new SIP circuits should take account of the following:

* QoS must be implemented for both speech and signalling.
* Any traffic on SIP bearers should be uncompressed for optimum voice quality.
* When ordering multiple SIP circuits, they should be from different providers to ensure diverse routing and resilience.
* SIP Options Ping should be specified when ordering. This is so the 111 carrier knows the status of the end point when trying to deliver the call. For non-registering SIP trunks, the setting is not required as they should have a ‘heartbeat’ register query. Testing will be required before going live to ensure the 111 carriers automatic failover mechanism works as expected.

#### Automatic Call Distribution/PBX

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

Voice traffic must 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 clinical hub, 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 must 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, where broadband quality is less reliable. 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. They also allow the call to be recorded at source on the Clinical Hub voice recording platform which is another essential requirement for all hub calls. The provider must ensure that the procured solution supports home working.

#### Desktop IT Systems

The provider must 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.

#### Call Steering - Interactive Voice Response (IVR) & Announcements

The provider must procure a solution capable of “press 1 for …” type functionality to steer callers to the correct resource. Sufficient ports must 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 must adhere to the IUC Telephony Messaging Standards (see Appendix A).

#### Voice Recording

The provider must ensure that all calls are voice recorded on extension side and that all conversations, including internal consultation and warm transfer requests, are recorded to a legally admissible standard. The provider must adhere to the retention period for voice recordings in their Records Retention Policy, which must align to national guidance.

The provider must store voice recordings in accordance with the Records Retention Period. For the avoidance of doubt, 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.

#### Records Management

The provider must maintain all records in accordance with an NHS Information Governance compliant Records Management Policy. The provider must have in place appropriate systems for the appropriate management of records at the end of any contract, including transfer, ongoing access agreements to meet medico-legal obligations, and appropriate certified destruction.

#### National Real-time Dashboard

The provider telephony system must send information on a 15 minute interval basis to the national real-time telephony dashboard. A specification of this is available on request from NHS England.

#### Resilience and Capacity Planning

At a minimum, the provider’s platforms must employ a geographically separated resilient architecture avoiding single points of failure. All key components must be powered by generator backed supplies with uninterruptable battery backup. Data and telephone lines must be diversely routed and where possible, sourced from multiple carriers or network providers. Any relevant preferential listings should be sought, and all components must 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.

The provider must 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 must therefore undertake pre-busy period inspections to ensure that all workstations and phones are fully functional.

#### Security

The provider must ensure that appropriate security measures, in line with the Data Protection Act 2018 principles, are put in place to protect systems from malicious attack and or loss of data. This must include, but is not limited to:

• Adherence to the National Data Guardian 10 Cyber Security standards.

• Penetration testing of any public internet facing components.

• Deployment of Intruder Protection Systems.

• Behavioural monitoring.

• Anti-Virus (AV) with real time updates.

•Application of all security related patches where there is deemed to be a significant vulnerability.

## NHS 111 Online

The provider must accept calls into their workflow system from NHS 111 Online and ensure interoperability of their systems.

Providers and commissioners will need to consider how the chosen Clinical Workflow System interoperates with NHS 111 Online. In order for NHS 111 Online 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.

The provider must ensure that patient entered information captured by the NHS 111 Online can flow to support the clinical assessment to avoid duplication of effort, and repetition for the patient and clinical staff.

## Clinical Decision Support System (CDSS)

### Operational Principles

The fundamental principle of IUC is to identify what the patient needs as quickly and accurately as possible, and then connecting them with the care they need as seamlessly as possible.

Providers of IUC CAS services need to ensure that the decisions being made about the urgency of presenting patients are underpinned with the best possible information. This information needs to be part of the standard workflow of a patient interaction. Staff need to be directed, guided and/or supported depending on their role, their competency, the complexity of patient case, and the level of clinical decision making they are expected to undertake.

The key stages of the patient journey where the CDSS needs to be applied are:

* Assessing symptoms to initially identify patient need/ risk.
* Gathering further information to ensure case streaming to the right clinical care or to aid the clinical consultation process.
* Supporting the clinical consultation and delivering the right care (this may via the CAS or by connecting to local pathways of care where this has been designed locally).

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

### Procurement of CDSS

The provider must 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 and 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.
* It can be seamlessly connected to the Directory of Service via the defined ITK messaging standards, migrating to the FHIR standards as they become available.
* It has been assessed by MHRA as not being a medical device or be accredited by MHRA as a medical device.
* It meets all relevant Information Governance standards.
* It demonstrates compliance with relevant ISO standards.

### Safety Standards

The provider must ensure that the triage products and CDSS meet relevant safety standards in accordance with CQC guidelines.

### Governance

The provider must ensure required clinical and information governance models to govern the use of the CDSS are in place. This should include consideration of the IUC aggregate data collection, other mandatory reporting, and appropriate assurance to the commissioner.

## Workflow System

The provider must make updates in line with the CDSS release cycle, and will implement any emergency releases in a timely manner.

The system should be patched and up to date to protect against any known vulnerabilities.

The provider must ensure the procured workflow system is backwards compatible with ITK and be moving towards the FHIR standards.

### Access to Records

#### Personal Demographic Service (PDS)

The Personal Demographics Service (PDS) allows the provider to confirm a patient’s demographics, including their name, date of birth, sex, NHS number, 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 must ensure the chosen clinical workflow system has technical integration with PDS, and supports the use of Advanced PDS Tracing. An Advanced PDS trace must be performed by the provider for all patients during their encounter with IUC. Performing an advanced PDS trace must 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 must be performed where applicable – see Repeat Caller Service section 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.

#### Summary Care Record (SCR)

The provider must 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 must 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.

#### Permission to View (PTV)

Providers must record where a caller has given permission to view (PTV) their record or withheld permission to view. This information must be captured on the provider workflow system and passed to any subsequent organisation involved in the patient care.

#### Patient Flags/Special Patient Notes (SPN)

The provider must ensure the chosen clinical workflow system can provide Patient Flag functionality, allowing Health 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.

The provider must 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.

This can be achieved by appointing a lead provider, acting as the data controller, with other providers acting as data processors, or by appointing joint data controllers across the providers.

#### Child Protection Information System (CP- IS)

Child Protection Information System (CP- IS) 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 must 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 must work with the CP-IS programme team to establish appropriate use of CP-IS within the context of the service.

#### Individual Organisation Records

Where a 111 provider has specialist staff to deal with particular patient groups, they should have access to the records for those groups in their local contract area (e.g. mental health).

#### Primary Care/GP Records

The provider must ensure that health care professionals are able to access digital, detailed, primary care/GP records for all, subject to appropriate access controls, using GP Connect HTML view or equivalent. This could be expanded to include other locally held information, such as mental health and discharge information.

#### Regional and National 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.

The provider must ensure that the chosen clinical workflow system has the ability to interoperate with national shared record requirements.

### Electronic Prescription Service (EPS)

The provider must ensure that the chosen clinical workflow system supports EPS.

### Free Supply (FS) of Medications

All workflow systems must be configured to allow free supply of medications where this is required. If this requires the workflow system to be upgraded, this must be implemented.

## Directory of Services (DoS)

The provider must ensure:

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

• The chosen clinical workflow system has technical integration with the NHS Directory of Services (DoS).

• They ensure their systems are up to date with the latest release of DoS.

• Contingency arrangements are agreed with local DoS teams and plans are in place.

### Service Identification Tools (not using a CDSS)

If a provider uses clinicians to undertake patient assessments without using a CDSS, they may wish to access the DoS at the end of the assessment. This helps inform the decisions they make about their patients. In order to do this, they will need to use a range of specialist tools.

Any assessment not using a CDSS must, wherever possible, use the DoS for onward service selection and referral.

There are a number of tools which allow searching of the DoS using service name, service type and/or clinical need.

All services on the DoS are clinically assured. It should be noted that for any service not profiled on the DoS, the risk sits with the referring clinician when directing a patient to these services.

## Direct Booking to Onward Points of Care

The provider must ensure that it has the capability to make direct booking to onward points of care using the available technical systems (e.g. GP Connect, Care Connect), and that its workflow system is fully compliant with these systems.

Where local technical solutions are available, the provider must ensure that appropriate plans are in place for migration to a nationally defined solution when it becomes a viable option.

## Post Event Messaging (PEM)

### 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.

There is work underway to refresh the PEM which will require implementation by the provider once available. Future developments include the additional accessibility flags, changes to the clock start and stop time, and information with regard to the assessment.

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, then a PEM should not be sent regardless of where the call is taken.

The provider must ensure that appropriate permission has been sought from the patient before sending a PEM to any recipient.

### Format

The provider must send PEM using the Clinical Document Architecture (CDA) in electronic form (ITK), migrating to the FHIR standards as they become available.

### Content

The provider must ensure that PEM is clear, concise, and where possible, articulates the primary reason for the encounter. The PEM must 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).
* A summary of the consultation(s).
* A summary of the triage process (where applicable).
* A summary of any advice provided to the patient.

### Recipients

For all IUC encounters (with the exception of those excluded by other criteria), the provider must 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.

If required to do so, the provider must send PEM to other providers within the local IUC model or to any centrally managed repository as specified by the commissioner.

## Short Message Service (SMS)

The provider must ensure SMS capability is in place to enable the provision of self-care and referral information, including but not limited to detail on bookings.

In some instances, such as referral to ED, there is nationally recommended wording which should be used.

## Interoperability

Interoperability between IUC services is a fundamental enabler ensuring that service providers can facilitate a consistent and integrated journey for patients. The highly distributed and varied nature of IUC services and providers emphasises the need for excellent organisational interoperability.

The provider must use a clinical workflow system that can support the following interoperability requirements.

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

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

All patient encounters that are electronically transferred between IUC service providers must follow interoperability standards.

### 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, migrating to the FHIR standards as they become available).

The provider must 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 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.
* 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.

### Ambulance Requests

The provider must ensure that the chosen clinical workflow system supports direct ambulance requests using the ambulance interoperability standards (also referred to as ITK messaging, migrating to the FHIR standards as they become available).

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.

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.

### Continuation of Triage

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

The provider must 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.

### 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 must ensure that the chosen clinical workflow system has ability to integrate with the National RCS. The RCS 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 CAS), the Repeat Caller Service query must be performed by whichever clinical workflow system is used at the first contact.

The provider must ensure for patients referred to Integrated Urgent Care from NHS 111 Online, a Repeat Caller query is performed after the patient identity has been confirmed. If this has not been completed by NHS 111 Online, it must be performed within the receiving clinical workflow system.

Where a patient is highlighted as a repeat caller by the RCS, 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 RCS and does support the identification of frequent callers, or those with designated care plans.

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

# Emergency Planning

## Major Incident Planning

The IUC Service has a number of possible roles in response to a major incident. The Provider **must**:

* Be engaged in planning and preparedness for these roles, and shall take part in the response if required to do so by NHS England, Public Health England (PHE), or a multiagency gold command structure.

Alongside this, the Provider **must** have:

* Staff trained and available to respond to a major incident at strategic level within the organisation;
* Major incident plans in place;
* A programme of exercising and testing plans;
* A plan for implementation of changes to systems to immediately meet the needs of the incident.

In certain major incident situations, such as a major chemical explosion, individuals may contact the IUC Service with concerns or symptoms. The Provider **must**:

* Have mechanisms to identify this type of situation that will link with the appropriate Commissioner, Provider organisations, and public health organisations to ensure appropriate business and service continuity arrangements are put into action.

If a major outbreak of a serious infectious disease occurs (e.g. SARS-CoV-2), the Provider will be an essential component of the response and may experience very high levels of demand. The Provider **must**:

* Have mechanisms in place to be informed of a major incident by the NHS and other agencies;
* Be able to, and actually give out the appropriate public health advice as directed by PHE, or the gold command arrangements which may be in place;
* Participate in the NHS command arrangements, as directed by NHS England and respond to their demands.

## Major Incident Plan and Business Continuity Plan

The Provider **must**, as part of its Major Incident Plan and Business Continuity Plan:

* Have mechanisms, procedures, and policies in place on how they will identify any external forces that may affect services and how they plan to handle these. These external forces may include, but are not limited to:
* Ambulance service strikes;
* Acute hospital declarations of ‘black’ status;
* Resilience groups deciding issues that may affect service and other issues.
* Notify Commissioners, along with providing the plan to address any issues, within 24 hours of any notification being made to them;
* Be fully conversant with the Commissioners’ emergency planning arrangements for major incidents and emergencies and to participate and respond as necessary and appropriate;
* Liaise with and assist other local Providers with capacity management issues as part of the area escalation procedure. This includes, but is not limited to:
* Ensuring any capacity available in its face-to-face services can be made available to support local services which are under pressure.

The Provider **must** ensure that:

* They have a schedule of testing in place, with test plans and results of testing reviewed regularly. The plans and the results of testing must be shared with Commissioners. Commissioners may reasonably request a test of all or any element of the test plans be performed within a specific time period.

##

## NHS 111 Escalation and Contingency Process

The Provider **must**:

* Be compliant with the national business continuity process[[18]](#footnote-18);
* Be compliant with the NHS 111/IUC London Escalation and Contingency Process;
* Participate, where appropriate, in the pan-London surge hub process to provide both notification of escalation needs and also provision of support to local services where there is capacity available within the IUC service.

### National Contingency

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

The provider must 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.

Providers may use national contingency under the following circumstances:

* Planned Engineering Works (PEW).
* Technical failure where callers have no access to NHS111 and local efforts to remedy will take over 1 hour.
* Site evacuation.
* Clinical safety concerns.

The provider must ensure:

* Prior to requesting activation of contingency, they have determined the percentage of calls they require diverting and what that equates to on an hourly basis.
* As a minimum, approval is agreed by the provider’s senior on-call clinician.
* A record of any decision is made within the existing shift log.

Further information is available in the National Business Continuity Escalation Policy.

The provider must 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 NHS England will consider the use of National Contingency to cover PEW where there is a high risk of severe disruption to services.

### Targeted Contingency

Targeted Contingency allows a percentage of calls to be taken away from a struggling provider and delivered to one or more nominated recipients, with an agreed percentage split if there is more than one recipient. Unlike National Contingency which can only be used in exceptional circumstances, Targeted Contingency can be used to support front end access issues. When pre-defined answered in 60 and abandonment trigger points are reached, a struggling provider can seek assistance through the national on-call arrangements. If there are other providers with capacity to assist, Targeted Contingency is established through negotiation with the recipient(s). In times of extreme demand when one or more provider is performing significantly better than others around the country, those providers shall not unreasonably refuse any requests to become recipients of Targeted Contingency.

The provider must ensure:

* Local organisational policies and operational procedures should outline arrangements for managing targeted contingency.
* Service managers have access to the National Real Time dashboard to inform their decisions.
* Prior to requesting activation of contingency, they have determined the percentage of calls they require diverting and what that equates to on an hourly basis.
* As a minimum, approval is agreed by the provider’s senior on-call clinician.
* A record of any decision is made within the existing shift log.
* Escalation processes are in place to inform the commissioner of any requests to use or receive Targeted Contingency.

### Public Health Emergencies and Major Incidents

There are a number of things that could be classed as a health emergency or major incident, including:

* A pandemic/ epidemic.
* Health related emergencies.
* A train crash, major explosion, or similar incident.
* A release of chemicals into the population.

If a provider is notified of a local incident or public health emergency, they must inform the central NHS England IUC team and the commissioner as a matter of urgency to coordinate management and command arrangements. Dependent on the scale of the emergency, NHS England may choose to set up a national helpline.

The provider must be engaged in planning and preparedness for public health emergencies/ major incidents and take part in the response if required to do so by NHS England. Please refer to the business continuity section for further information.

Providers should be alert to individuals presenting with concerns or symptoms which may be the result of a chemical explosion, or other incident leading to multiple presentations with similar symptoms and notify the relevant authorities.

The provider must ensure they have:

* Staff trained to respond to a major incident at strategic level.
* Major incident plans in place.
* A programme of exercising and testing plans.
* A plan for implementation of changes to systems to immediately meet the needs of the incident. Any such plans should be published.

The provider must comply with EPRR Guidance if and when applicable. Further information can be found in Appendix A and the NHS Standard Contract.

# Service Standards

## Compliance with General Standards and Regulations

To adhere to the key requirements of the IUC service, the provider must ensure they are compliant with all national standards including:

* The IUC service is delivered in accordance with best practice in health care and must 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:
	+ Accessible Information Standards
	+ Common law duty of confidentiality
	+ Code of Confidentiality, Records management
	+ Standards issued by the Care Quality Commission, including Essential Standards of Quality and Safety
	+ Data Protection Act 2018
	+ NHS Constitution
	+ All National Institute for Health and Clinical Excellence (NICE) guidance that is relevant to conditions presenting in urgent care
	+ National IUC Key Performance Indicators
	+ NHS Complaints 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
	+ Health and safety legislation (Health and Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999).
* Full compliance with Care Quality Commission registration requirements.
* They lead Serious Incidents investigations where appropriate and must adhere to local policies.
* Any actual or potential breaches of confidentiality including loss of data and cyber security incidents are reported in accordance with the NHS Digital and NHS England guidance.
* A written complaints procedure is in place (in line with the NHS Complaints guidance).
* All Information Standards Notifications issued by NHS Digital are implemented in a timely fashion where applicable to the service.
* All 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 are adhered to.
* Relevant ISO standards should be adhered to, including
* ISO 9001 – Quality Management Standards
* ISO 27001 – Information Security Standards
* ISO 22301 – Business Continuity Standards

## Equality and Health Inequalities

Provider must ensure:

* They make all reasonable endeavours to support the Commissioner in carrying out their duties under the Health and Social Care Act 2012, in respect of the reduction of inequalities in access to health services, and in the outcomes achieved from the delivery of health services. Providers must implement any Health Inequalities Action Plan as set out by the commissioner.
* They do not discriminate between or against Service Users, Carers or Legal Guardians on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, or any other non-medical characteristics, except as permitted by Law.
* They comply with the obligations contained in section 149 of the Equality Act 2010, the Equality Act 2010 (Specific Duties) Regulations and section 6 of the HRA (see Appendix A).

## Performance Management

Data and metrics in relation to the IUC service are critical for monitoring, service design and to ensure service resilience. This section outlines the requirements for data provision and how data is used to report performance.

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 NHS England and commissioners. Elements of this information will be published by NHS England to provide transparency and visibility.

Regular reporting of data will be required covering the entirety of the IUC service by contract areas. Reporting will involve the provision of data to NHS England (and local commissioners as stipulated). The provider must ensure, in collaboration with the commissioner, that information is provided to meet the requirements outlined in this service specification.

On occasion, additional data items may be requested on an ad hoc basis. Where this is the case, the provider must share any such data on request.

## Data Collections and Reporting

### IUC Aggregate Data Collection (ADC)

Providers must ensure the data required to populate the IUC Aggregate Data Collection (ADC) is collected and reported. The IUC ADC forms the minimum level of data provision to NHS England for performance monitoring and a number of the data items within this collection are used to produce the national IUC KPIs.

A lead supplier of data and information must be specified by the commissioner who will collate and coordinate requests for data and information that covers the commissioned IUC service (the contract area). Any sub-contracted providers must share and provide information about their service to the lead data supplier in line with specified data collections. This will ensure that, in multi-provider areas, there are clear responsibilities on the collation and supply of data to NHS England, and across services and their commissioners.

Details of the IUC ADC specification and associated guidance documents are available on the NHS England website. This includes the timetable outlining when data should be submitted for both the weekly and monthly data items. These documents are regularly reviewed to ensure necessary changes are made as the service evolves to meet the needs of patients. Providers must ensure data complies with the specification outlined in the latest versions of these documents to ensure high levels of data quality.

The provider must report against all relevant aspects of the ADC within the specified timescales unless otherwise agreed with the national IUC team.

The lead data supplier must submit aggregated/collated data for all providers within the contract area via NHS Digitals Strategic Data Collection Service (SDCS) unless otherwise directed.

Daily collections of some data items are also required during periods of high activity (e.g. winter, pandemic response). Providers must supply such data as requested.

NHS England will publish a subset of the ADC data 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 must ensure that data provided is of adequate quality and completeness. In the absence of data, estimates may be provided subject to NHS England and commissioner approval of the methodology used.

In the future NHS England intend to collect data at patient level and this may require providers to supply data via NHS Digital’s Data Processing Service (DPS). Therefore, providers should consider any preparatory steps required in order to comply with submission requirements for these metrics once agreed.

### Forecasting and Capacity Planning

IUC call handling providers and NHS England have an established forecasting and capacity planning process in place for ‘6 weeks out’. Providers must supply the information required to NHS England as requested, including all staffing information (e.g. numbers or call handlers by staff type). Specialist support from NHS England will be available on request to ensure the data burden is kept to a minimum.

## IUC Key Performance Indicators (KPIs)

The IUC service is monitored nationally via a set of Key Performance Indicators (KPIs). The KPIs have been designed to measure the performance of the whole of the integrated urgent care system. Although some KPIs will be attributable to a single organisation, many will be achieved by more than one organisation working together. The KPIs should be considered as a set reflecting the different aspects of the service, no single indicator has predominance over another.

The current version of these KPIs can be found on the NHS England website.

Providers must supply the IUC ADC data to report on these KPIs, either directly or via the lead data supplier for that contract area (as defined by the commissioner).

Where the commissioner has defined additional local KPIs for the monitoring of their contracts, data should be supplied for the production of these. Any local variation to KPIs does not replace the national KPI minimum standard.

## Dashboards

The provider must integrate with local and/or national dashboards rendering real time and historical performance data.

The dashboard will collate (including but not limited to):

* Automatic Call Distributor (ACD) performance data including calls offered, calls answered, abandonment and speed to answer.
* Resource availability and utilisation.
* Clinical queues.
* Pseudonymised Post Event Messaging (PEM) for syndromic surveillance.

## Surveys and Patient Experience

Patient and staff feedback are a fundamental part of understanding the performance of the IUC service and whether it is meeting patients’ needs. Feedback allows the experiences of patients and staff to inform service design and changes. Although local variation is acceptable, consistent approaches to core elements within surveys are key to enabling comparison across services nationally.

### Patient Experience Survey

It is good practice to undertake patient experience surveys in order to understand whether services are meeting patient expectations. There is also a need to understand this at the national level. Until mid-2021, this was monitored through the NHS 111 Patient Experience Survey, for which providers were expected to submit national returns on a 6-monthly basis. From 2021, NHS England are reviewing this survey. Further details will be shared with providers once available.

### Staff Surveys

It is good practice to undertake staff surveys in order to identify issues and improve working conditions. This aids in the retention of staff, and can also have a positive impact on productivity. The provider should give consideration to staff surveys 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.

# APPENDIX A

|  |  |  |
| --- | --- | --- |
| Title  | Description  | Link  |
| 2021/22 priorities and operational planning guidance  | Guidance setting out setting out priorities for the year ahead (2021/22).  | <https://d.docs.live.net/745c0dfc3fb6a832/Documents/2%20Interim%20Projects/SWL%20CCG/IUC%20Business%20Case/111%20Activity%20Cube.xlsx>  |
| Accessible Information Standards  | Standard which sets out a specific, consistent approach to identifying, recording, flagging, sharing, and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment, or sensory loss.  | <https://www.england.nhs.uk/ourwork/accessibleinfo/>  |
| Advanced Service Specification - NHS Community Pharmacist Consultation Service (CPCS)  | Updated CPCS service specification following 2019 publication  | <https://www.england.nhs.uk/wp-content/uploads/2019/10/CPCS-Advanced-Service-Specification.pdf>  |
| Care Quality Commission – The Fundamental Standards  | The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.  | [https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjdrIvW4\_3wAhV5AWMBHXADAIgQFjAAegQIAxAD&url=https%3A%2F%2Fwww.cqc.org.uk%2Fsites%2Fdefault%2Ffiles%2Fdocuments%2Fquick\_guide\_to\_the\_essential\_standards.doc&usg=AOvVaw2KdmObJQTZ\_0F56hcLmKh\_](https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjdrIvW4_3wAhV5AWMBHXADAIgQFjAAegQIAxAD&url=https%3A%2F%2Fwww.cqc.org.uk%2Fsites%2Fdefault%2Ffiles%2Fdocuments%2Fquick_guide_to_the_essential_standards.doc&usg=AOvVaw2KdmObJQTZ_0F56hcLmKh_%20)  |
| Central Alerting System  | The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and care | <https://www.cas.mhra.gov.uk/Home.aspx>  |
| Child Protection Information Sharing Project – NHS Digital  | Information Sharing project (CP-IS) is helping health and social care staff to share information securely to better protect society's most vulnerable children  | <https://digital.nhs.uk/child-protection-information-sharing>  |
| Clinical Governance in Integrated Urgent Care – Guidance for Commissioners  | Guidance documents for commissioners explaining how the clinical guidance framework fits into Integrated Urgent Care  | [https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/clinical-governance-in-iuc-guidance-for-commissioners](https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/clinical-governance-in-iuc-guidance-for-commissioners%20)  |
| Commissioning Framework and the National Urgent and Emergency Care Ambulance Services Specification  | Document to be used when commissioning the regional ambulance service in accordance with the NHS Standard Contract.  | [https://www.england.nhs.uk/publication/commissioning-framework-and-the-national-urgent-and-emergency-ambulance-services-specification/](https://www.england.nhs.uk/publication/commissioning-framework-and-the-national-urgent-and-emergency-ambulance-services-specification/%20)  |
| Commissioning Person Centered End of Life Care: A Toolkit for Health and Social Care  | Updated toolkit with a range of practical resources to support those involved in commissioning for person centred end of life care.  | [https://www.england.nhs.uk/publication/commissioning-person-centred-end-of-life-care-a-toolkit-for-health-and-social-care/](https://www.england.nhs.uk/publication/commissioning-person-centred-end-of-life-care-a-toolkit-for-health-and-social-care/%20)  |
| Commissioning Standard for Urgent Dental Care  | Standard and guidance for commissioning urgent dental care  | [https://www.england.nhs.uk/wp-content/uploads/2019/07/commissioning-standard-for-urgent-dental-care.pdf](https://www.england.nhs.uk/wp-content/uploads/2019/07/commissioning-standard-for-urgent-dental-care.pdf%20)  |
| Coronavirus (COVID-19): Verifying death in times of emergency  | Guidance designed to clarify existing practice for the verification of death outside of hospitals and to provide a framework for safe verification of death in this coronavirus (COVID-19) emergency period.  | [https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verifying-death-in-times-of-emergency](https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verifying-death-in-times-of-emergency%20)  |
| Digital Inclusion for health and social care  | Information and barrier to digital inclusion  | [https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/what-digital-inclusion-is#barriers-to-digital-inclusion](https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/what-digital-inclusion-is%23barriers-to-digital-inclusion%20)  |
| Emergency Preparedness, Resilience and Response (EPRR)  | Programme of work and documentation containing guidance for responding to incidents and emergencies.  | [https://www.england.nhs.uk/ourwork/eprr/](https://www.england.nhs.uk/ourwork/eprr/%20)  |
| End of Life Care Resources  | Resources are available to support clinicians, commissioners and service providers designing and implementing end of life models of care. This includes ‘End of Life Care Sustainability Transformation Partnership (STP) Support Packs’ | [https://www.england.nhs.uk/eolc/](https://www.england.nhs.uk/eolc/%20) [https://www.england.nhs.uk/eo c/resources-for-commissioners/](https://www.england.nhs.uk/eo%20c/resources-for-commissioners/) |
| Exemptions from the prescription charge - Pharmaceutical Services Negotiating Committee  | Free supply of medication / exemption from prescription charge  | [https://psnc.org.uk/dispensing-supply/receiving-a-prescription/patient-charges/exemptions/](https://psnc.org.uk/dispensing-supply/receiving-a-prescription/patient-charges/exemptions/%20)  |
| Health and Social Care Act 2012: fact sheets  | A series of fact sheets explaining aspects of the Health and Social Care Act 2012.  | <https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets>  |
| Health Building Note 00-03: Clinical and clinical support spaces  | “Best practice” guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.  | <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147845/HBN_00-03_Final.pdf>  |
| Human Rights Act 1998  | UK Public General Acts  | <https://www.legislation.gov.uk/ukpga/1998/42/contents>  |
| Integrated Urgent Care (including NHS 111) Statistics  | Statistics and data from the Minimum Data Set (MDS) and Aggregated Data Collection (ADC).  | [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/%20)  |
| Integrated Urgent Care Aggregate Data Collection Specification  | Document describing the data that lead commissioners should ensure are provided for their Integrated Urgent Care (IUC) service.  | [https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/07/Integrated-Urgent-Care-Aggregate-Data-Collection-Specification-v1.6.pdf](https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/07/Integrated-Urgent-Care-Aggregate-Data-Collection-Specification-v1.6.pdf%20)  |
| Integrated Urgent Care Key Performance Indicator and Quality Standards (2018)  | Document outlining the Integrated Urgent Care (IUC) Key Performance Indicators and other standards which commissioners must apply in relation to the service.  | [https://www.england.nhs.uk/wp-content/uploads/2018/06/integrated-urgent-care-key-performance-indicators-quality-standards-revised-050219.pdf](https://www.england.nhs.uk/wp-content/uploads/2018/06/integrated-urgent-care-key-performance-indicators-quality-standards-revised-050219.pdf%20)  |
| Integrated Urgent Care Workforce Blueprint  | Suite of documents developed to ensure that there is a sustainable and optimal IUC call centre workforce with the right skills, behaviours, and competencies.  | [https://www.england.nhs.uk/urgent-emergency-care/nhs-111/integrated-urgent-care-nhs-111-workforce-blueprint/](https://www.england.nhs.uk/urgent-emergency-care/nhs-111/integrated-urgent-care-nhs-111-workforce-blueprint/%20)  |
| ISO 18295-1:2017 - Customer contact centres — Part 1: Requirements for customer contact centres  | ISO standard relating to contact centres  | [https://www.iso.org/obp/ui/#iso:std:iso:18295:-1:ed-1:v1:en](https://www.iso.org/obp/ui/%23iso%3Astd%3Aiso%3A18295%3A-1%3Aed-1%3Av1%3Aen%20)  |
| Technical & Interoperability Standards  | Document providing an interoperability specification to be used for the exchange of pathways information for transfer of care between the NHS 111 service providers.  | [https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/integrated-urgent-care-technical-and-interoperability-standards](https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/integrated-urgent-care-technical-and-interoperability-standards%20)  |
| IUC Telephony Messaging Standards  | Document defining a set of standards for Integrated Urgent Care (IUC) Telephony Messaging (the recorded announcements, prompts and music heard by callers to 111)  | [https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/iuc-telephony-messaging-standards](https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/iuc-telephony-messaging-standards%20)  |
| NHS 111 National Business Continuity Escalation Policy  | Policy which outlines a process whereby calls from a provider who has suffered a significant failure can be re-routed to other providers.  | [https://www.england.nhs.uk/wp-content/uploads/2014/02/nhs111-escl-pol.pdf](https://www.england.nhs.uk/wp-content/uploads/2014/02/nhs111-escl-pol.pdf%20)  |
| NHS Community Pharmacist Consultation Service (CPCS) – integrating pharmacy into urgent care  | Information and resources around integrating pharmacy into urgent care  | [https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacist-consultation-service/](https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacist-consultation-service/%20)  |
| NHS Complaints Guidance  | Patient Guidance for making complaints about an NHS service  | [https://www.gov.uk/government/publications/the-nhs-constitution-for-england/how-do-i-give-feedback-or-make-a-complaint-about-an-nhs-service](https://www.gov.uk/government/publications/the-nhs-constitution-for-england/how-do-i-give-feedback-or-make-a-complaint-about-an-nhs-service%20)  |
| NHS Constitution for England  | The principles and values of the NHS in England  | [https://www.gov.uk/government/publications/the-nhs-constitution-for-england](https://www.gov.uk/government/publications/the-nhs-constitution-for-england%20)  |
| NHS Digital  | NHS Digital homepage  | [https://digital.nhs.uk/](https://digital.nhs.uk/%20)  |
| NHS Digital: Improving our Data Processing Services (DPS)  | Guidance on how NHS Digital are developing their Data Processing Services to transform how data is collected, processed and used to improve health and care.  | [https://digital.nhs.uk/data-and-information/data-insights-and-statistics/improving-our-data-processing-services](https://digital.nhs.uk/data-and-information/data-insights-and-statistics/improving-our-data-processing-services%20)  |
| NHS England Safeguarding  | Information and resources around the NHS commitment to safeguarding vulnerable patients  | [https://www.england.nhs.uk/safeguarding/about/](https://www.england.nhs.uk/safeguarding/about/%20)  |
| NHS England Specialist Level Palliative Care: Information for commissioners (April 2016) | Guidance providing a clear description of what should be provided in terms of specialist level palliative care for people with progressive, life-limiting illness who have complex needs, and/or those whose usual care teams require the expert advice, guidance, and support of those with specialist knowledge and skills in palliative care | [https://www.england.nhs.uk/publication/nhs-england-specialist-level-palliative-care-information-for-commissioners-april-2016/](https://www.england.nhs.uk/publication/nhs-england-specialist-level-palliative-care-information-for-commissioners-april-2016/%20)  |
| NHS Long Term Plan  | Document setting out plans for re-designing patient care over the next 10 years (first published Jan 2019)  | [https://www.longtermplan.nhs.uk/online-version/](https://www.longtermplan.nhs.uk/online-version/%20)  |
| NHS Operational Planning and Contracting Guidance (2020-21)  | Document outlining operational planning and contracting guidance for 2020/21 in line with the NHS Long Term Plan ambitions.  | [https://www.england.nhs.uk/wp-content/uploads/2020/01/2020-21-NHS-Operational-Planning-Contracting-Guidance.pdf](https://www.england.nhs.uk/wp-content/uploads/2020/01/2020-21-NHS-Operational-Planning-Contracting-Guidance.pdf%20)  |
| NHS Out of Hours formulary drug tariff  | National Out-of-Hours Core Formulary containing the *minimum* list of drugs that patients should be able to access.  | [https://www.drugtariff.nhsbsa.nhs.uk/#/00804172-DD/DD00804065/Part%20XVIIC%20-%20National%20out-of-hours%20formulary](https://www.drugtariff.nhsbsa.nhs.uk/%23/00804172-DD/DD00804065/Part%20XVIIC%20-%20National%20out-of-hours%20formulary%20)  |
| NHS Outcome Framework Indicators  | Eleven indicators identified for health inequalities assessment which have been used to guide reporting in 2016/17 using data available on NHS Digital’s website.  | <https://www.england.nhs.uk/about/equality/equality-hub/nhs-outcome-framework-health-inequalities-indicators/>  |
| NHS Standard Contract 2017/18 and 2018/19 Technical Guidance  | The NHS Standard Contract 2017/18-2018/19 Technical Guidance outlining the changes made to the 2016/17 Contracts, providing general guidance on contracting, and outlining the key topics in the Contracts. It also includes a summary guide to completing the Contracts.  | <https://www.england.nhs.uk/wp-content/uploads/2016/11/7-contract-tech-guid.pdf>  |
| NHS Standard Contract 2021/22 – General Conditions  | NHS Standard Contract to be used when producing new NHS contracts  | <https://www.england.nhs.uk/wp-content/uploads/2021/03/4-FL-GCs-2122.pdf>  |
| National Integrated Urgent Care NHS 111 Dashboard Requirements  | Information regarding the IUC NHS 111 Dashboard provides NHS England with a near real-time national view of IUC NHS 111 service provider performance.  | Available upon request: england.integratedurgentcare@nhs.net  |
| Primary and community care Health Building Note 11-01: Facilities for primary and community care services  | “Best practice” guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.  | <https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2014/07/health-build-pc.pdf>  |
| Quality Improvement for General Practice  | Guidance for GPs and Practice staff to improve quality of services.  | [https://www.rcgp.org.uk/-/media/Files/CIRC/Quality-Improvement/RGCP-QI-Guide-260216.ashx?la=en](https://www.rcgp.org.uk/-/media/Files/CIRC/Quality-Improvement/RGCP-QI-Guide-260216.ashx?la=en%20)  |
| Quick Guide: Best use of unscheduled dental care services  | Practical information for dental providers and commissioners on what they can do to improve dental unscheduled care for patients over the winter period, and beyond.  | <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/quick-guid-unscheduled-dental-care.pdf>  |
| Reasonable Adjustments - NHS England  | Reasonable adjustments are a legal requirement to make sure health services are accessible to all disabled people.  | <https://www.england.nhs.uk/learning-disabilities/improving-health/reasonable-adjustments/>  |
| Records Management Code of Practice 2020  | Latest iteration of the code of practice for record retention and management  | [https://www.nhsx.nhs.uk/information-governance/guidance/records-management-code/](https://www.nhsx.nhs.uk/information-governance/guidance/records-management-code/%20)  |
| Records Management Code of Practice 2020  | A guide to the management of health care records  | [https://www.nhsx.nhs.uk/information-governance/guidance/records-management-code/](https://www.nhsx.nhs.uk/information-governance/guidance/records-management-code/%20)  |
| Strategic Data Collection Service (SDCS)  | Information and guidance around the use and purpose of SDCS.  | [https://digital.nhs.uk/services/strategic-data-collection-service-sdcs](https://digital.nhs.uk/services/strategic-data-collection-service-sdcs%20)  |
| Summary Care Records in community pharmacy - NHS Digital  | Summary of work undertaken to ensure all pharmacies can access Summary Care Records including benefits and how to view them.  | [https://digital.nhs.uk/services/summary-care-records-scr/summary-care-record-scr-in-community-pharmacy](https://digital.nhs.uk/services/summary-care-records-scr/summary-care-record-scr-in-community-pharmacy%20)  |
| The Equality Act 2010  | UK Public General Acts  | [https://www.legislation.gov.uk/ukpga/2010/15/section/149](https://www.legislation.gov.uk/ukpga/2010/15/section/149%20)  |
| The NHS Outcomes Framework 2015/16  | Outline and guidance of the purpose of the NHS outcomes framework.  | [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/385749/NHS\_Outcomes\_Framework.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/385749/NHS_Outcomes_Framework.pdf%20)  |
| Urgent community response – 2 hour and 2 day response standards (2020-21 technical data guidance)  | Technical guidance supporting the collection and recording of the relevant urgent community response data to ensure a standardised approach across England.  | [https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/B0252-Urgent-community-response-2-hour-and-2-days-standards-guidance-30-November-2020.pdf](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/B0252-Urgent-community-response-2-hour-and-2-days-standards-guidance-30-November-2020.pdf%20)  |
| Verification of death in this period of emergency: standard operating procedure (SOP)  | Guidance around verification of death in hospital and community settings during a period of emergency.  | [https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verifying-death-in-times-of-emergency#verification-of-death-in-this-period-of-emergency-standard-operating-procedure-sop](https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verifying-death-in-times-of-emergency%23verification-of-death-in-this-period-of-emergency-standard-operating-procedure-sop%20)  |

1. https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf [↑](#footnote-ref-1)
2. <https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf> [↑](#footnote-ref-2)
3. https://www.longtermplan.nhs.uk/ [↑](#footnote-ref-3)
4. Investment and evolution: a five-year framework for GP contract reform to implement The Long Term Plan. NHSE. 31 January 2019 [↑](#footnote-ref-4)
5. PAR468 - 2021/22 priorities and operational planning guidance, NHSE, 25 March 2021 [↑](#footnote-ref-5)
6. Integrated Urgent Care Aggregate Data Collection Specification 2021-22, NHSE, Version 1.0, April 2021 [↑](#footnote-ref-6)
7. <https://www.england.nhs.uk/publication/technical-guide-to-ccg-allocations-2019-20-to-2023-24-spreadsheet-files-for-ccg-allocations-2019-20-to-2023-24/> [↑](#footnote-ref-7)
8. https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current [↑](#footnote-ref-8)
9. https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework [↑](#footnote-ref-9)
10. https://www.england.nhs.uk/commissioning/regulation/ccg-assess/iaf/ [↑](#footnote-ref-10)
11. [Integrated Urgent Care Service Specification addendum: NHS 111 First A new way to manage access to emergency departments, NHSE 2020](https://future.nhs.uk/NHS111covid/view?objectId=89057349) [↑](#footnote-ref-11)
12. https://heeoe.hee.nhs.uk/gp\_out\_of\_hours [↑](#footnote-ref-12)
13. https://s16878.pcdn.co/wp-content/uploads/2014/04/36353\_Mental\_Health\_Crisis\_accessible.pdf [↑](#footnote-ref-13)
14. https://www.swlstg.nhs.uk/ [↑](#footnote-ref-14)
15. https://www.slam.nhs.uk/ [↑](#footnote-ref-15)
16. http://www.nhs.uk/pages/home.aspx [↑](#footnote-ref-16)
17. <https://www.nice.org.uk/Media/Default/About/NICE-Communities/Social-care/quickguides/Infection%20prevention.pdf> [↑](#footnote-ref-17)
18. https://www.england.nhs.uk/publication/nhs-111-national-business-continuity-escalation-policy/ [↑](#footnote-ref-18)