Outline Specification for an Integrated Urgent Care Service for Bristol, North Somerset and South Gloucestershire

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1 Introduction

Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) are working in partnership to recommission an Integrated Urgent Care (IUC) service for the residents of BNSSG. The procurement is initiated by the need to recommission the NHS 111 service and General Practice Out of Hours (GP OoH) service and to meet the mandated requirements of the national IUC specification.

We believe that the learning from the development of the 111 service, over the past four years, since its introduction and the current configuration of urgent care services affords us a knowledgeable platform from which we can forge ahead and benefit from this recommissioning opportunity. We need to ensure that the NHS111 element of the service is responsive and the triage pathway is reviewed and changed, where appropriate, to best meet patients' needs. The 111 element of the service must deliver a prompt triage, working closely with the multi-disciplinary CAS with links to both in hours and out of hours GP services. The transformation of these services needs to move from an 'assess and refer' to a 'consult and complete' model of service delivery. We envisage a much closer working relationship between the services within the CAS (albeit that some elements are virtual) as a central service.

The Commissioners are looking for a single integrated service where there is shared responsibility across the whole of the patient pathway. The aims of the service are to;

- Reduce the number of times a patient is triaged so that the patient is only re-triaged / reassessed when there is a clinical need[1]
- Reduce unnecessary clinical intervention at all points in the patient pathway including reducing attendance at Emergency Departments
- Reduce inappropriate ambulance dispatches
- Increase the number of patients who can be safely managed in their own homes or community
- Empower patients to manage their own condition (self-care) where medically appropriate

Commissioners are keen to drive 'channel shift', whereby patients are cared for in the lowest acuity clinically suitable setting and want to use this reprocurement to contract in a way that incentivises these 'front door' providers to deliver pathway change. The IUC service must work closely with existing and emerging models of urgent care including ED streaming and GP localities.

The three elements of the service (NHS111, GP OoH and CAS) are to be combined into a single service with Key Performance Indicators (KPIs), governance policies etc. that cover the patient journey from the initial phone call to the completion of the patient care episode.

[1] This will, in a small proportion of patients, include serial assessments over the episode of care to enable the patient to remain in the community and prevent unnecessary admission to secondary care

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We wish to streamline services and make patient pathways simpler, getting people to the end point of care as directly as possible with less points of interaction, avoiding unnecessary duplication of triage or being handed from service to service.

BNSSG Commissioners are, at the same time, developing a Integrated Care Bureau (ICB) for admission avoidance, facilitated discharge and access for patients known to community services. The Provider will need to work closely with the ICB which is one aspect of the Primary and Community Care Sustainability and Transformation Plan (STP) workstream. Initially the ICB's role will be to support people to stay at home (admission avoidance), support people to return home (facilitation of discharge) and to support known service users but there is potential for its role to expand and the new IUC Provider will need to be able to flex in light of this. These developments will afford Commissioners and the community an opportunity to provide better joint care.

The CCG's are seeking an experienced, dynamic forward thinking Provider, or collaborative of providers, who will work well as part of a wider urgent care system, have a track record of innovation and can drive system change.

2 National and Local Context

The NHS continually evolves and changes, at the time of developing this specification there are key strategic approaches which will shape thinking on delivery especially:

- The single voice of the executive commissioning team
- Transforming Urgent and Emergency Care Services in England, August 2015
- Commissioning Standards Integrated Urgent Care, September 2015
- The emerging models for primary and community based services
- The Improved Better Care Fund to facilitate integration
- Five Year Forward View[2] [3]
- BNSSG Sustainability and Transformation Plan (STP) work and Local Digital Roadmaps

Over the years the NHS has spent a lot of time developing alternative options for acute or emergency care for people who, for whatever reason, did not use primary care services when they should or could have. This has led to a range of developments including minor injury units, urgent care centres, walk in centres, etc.

BNSSG is no different from other communities in this respect, and because of the mixed economy and demographics of the three clinical commissioning groups, with urban centres and rural population, local identities and structures have developed over time to meet very local needs. However the NHS111 and GP Out of Hours services have, since 2013, covered the whole of BNSSG.

[2] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

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The focus of development for emergency and urgent care has been on managing increasing demand on all services and concern about understanding patients' inappropriate use of Emergency Departments. People tend to choose the healthcare option which is most convenient, one that they have used previously or that which they perceive as providing a one stop service without requiring onward referral.

There is no doubt that the current range of options for patients can be both confusing and counterproductive. They can be costly to the health economy because of duplicated services and patients using high cost services for minor conditions. The Provider, working with Commissioners, will need to ensure that the new service design simplifies access for patients to appropriate care.

At the BNSSG NHS111 / OoH and Single Point of Access workshops held in spring 2017 commissioners heard a very clear message there is a requirement to align governance arrangements so that clinicians work to consistent clinical pathways. There must be mechanisms in place to avoid duplication of triage and "hand offs" between the Provider and other services. Within this service we therefore expect a single governance structure spanning the whole patient pathway.

3 Whole System Integration and Co-ordination

It is recognised that urgent care service delivery is complex. To deliver an effective service, the Provider will need to establish constructive working relationships with a number of other organisations and work to ensure there is seamless transfer of care between providers.

More broadly, the Provider will need to work alongside other service providers in support of the development of the new integrated community model of care.

The BNSSG health and care system is currently on a journey: from a more fragmented and dis-jointed out-of-hospital provider environment, with insufficient focus on proactive health management, to a model where the out-of-hospital system and the secondary care system are more in-balance and working together in a more integrated and cohesive way, with strong central leadership and a focus on proactive health management across the entire system. This is illustrated in the figure below;

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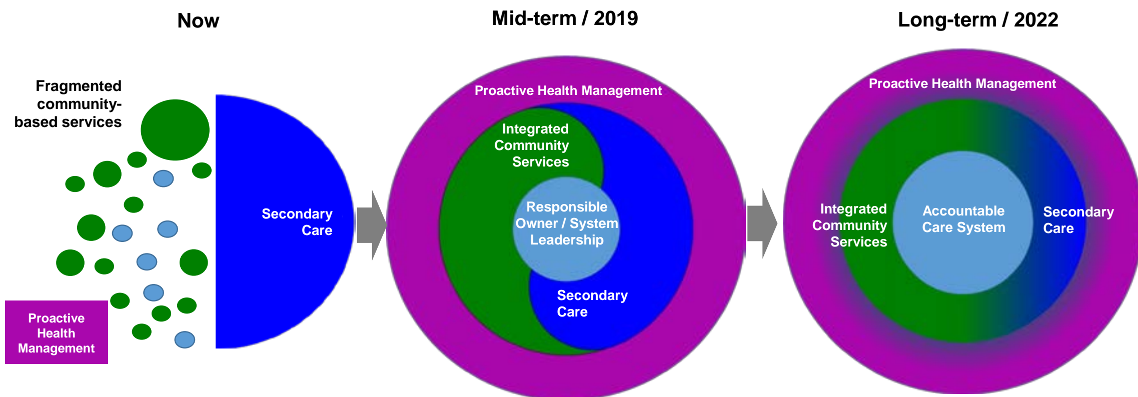
We’re on a journey to shift the balance



The immediate focus is on the creation of an organised, coordinated and effective out-of-hospital provider environment that is seen as the main conduit for meeting a person’s health and care needs. This new out-of-hospital environment sees primary care, out of hours, community services, mental health, the ambulance service, the local authority and the third sector working much more collaboratively around a single, person centred care plan.

In the longer term, a more integrated model which supports an integrated, accountable care system is envisaged but the priority now is to bring together the currently fragmented community model, including general practice.

BNSSG CCGs have set out their plans to support the development of provider collaborative working based around localities of at least 100 000 population[4]. This focusses initially on the development of GP leadership which is critical to the success of the model and to enabling the provision of higher acuity services in the community. The Provider will be expected to be fully engaged in the development of these locality provider models and the principles set out for the development of that model, in particular the integration of provision in and out of hours care across 7 days a week.

The following principles will be applied to commissioning and developing the integrated community model of care. It should:

- Be commissioned at a scale that maximises the most effective use of resources to deliver the required outcomes and to enable providers to develop workable systems of care - suggested to be at least 100k population
- Be driven by a systematic and evidence based assessment of population and patient need
- Make best use of existing resources (e.g. money, workforce, estates)

[4] https://www.bristolccg.nhs.uk/media/medialibrary/2017/09/gov_body_3-10-17_item7.5.pdf

to deliver required population outcomes
- Balance care between out-of-hospital care and secondary care to deliver the best outcome for patients within the resources available and ensuring funds follow the patient
- Promote proactive care and health management, keeping more people safe and well at home, encouraging independence and supporting them to take an active role in managing their own care.
- Integrate mental, emotional and physical wellbeing at all levels
- Integrate provision in and out of hours and across 7 days/week
- Enable full involvement and integration of social care, the independent sector, community and the third sector, recognising their unique contribution and expertise
- Enable innovation in developing the workforce to work in new ways and in new roles
- Maximise the use of technology and encourage and respond to patient and public digital literacy
- Focus initially on the few priority areas in each locality where change potentially has greatest impact for people and for resources

Within the STP there are several elements described as part of the integrated community model, which have tended to remain constant throughout various iterations and are as follows:

- GP practices working at scale (clusters or supra clusters)
- Supported self-care and social prescribing
- Integrated Multi-Disciplinary Teams (at practice, cluster and “supra-cluster” level), including care home support
- Integrated hubs including diagnostics and support for the most complex and acutely ill patients that do not require acute hospital care
- Early Supported Discharge, rehabilitation and reablement services
- Admission avoidance services including urgent assessment and rapid response
- Single Point of Access
- Supported by system wide agreed clinical pathways for key conditions or cohorts

In addition, the Provider will need to develop close working relationships with the following services in particular:

- Community care teams who are responsible for enabling people to be cared for at home. They work closely with social care alongside the voluntary and other NHS providers
- Mental health services to enable a whole person approach to emergency care
- Secondary care particularly emergency departments and ambulatory emergency care.
- South Western Ambulance Service Foundation NHS Foundation Trust (SWASFT)
- Urgent Care Treatment Centres as they are developed across BNSSG, which will require GP medical input and will operate 12 hours a day

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- Primary care: The move to seven day working in primary care has not had a significant impact on urgent care services in BNSSG as the activity is pre-booked/planned. The national Improved Access in primary care agenda requires additional same day and pre-booked activity to be delivered in non-core hours

Policies and procedures need to be developed locally by the Provider, overseen by the Commissioners, so to ensure that a coherent service model is set up that delivers the best possible patient pathways and experience.

Sustainability and Transformation Plan

Commissioners are keen to put Primary Care at the forefront of urgent care provision, recognising the contribution that primary care makes to the urgent care system and also the opportunities it presents. Primary care will be supported to develop and change and bring to the system approaches for multidisciplinary team working, care planning and clinical risk management.

Reflecting national strategy and guidance, in particular the Five Year Forward View, commissioners will work together with the evolving STP to agree on appropriate centralisation of services across BNSSG. Sustainability of services will be delivered by ensuring the necessary workforce training is in place, development and retention and succession planning opportunities are fully maximised.

Commissioners are keen to enhance and transform urgent care pathways, including better use of the full range of community and social care services, and ensuring when patients do require an admission to hospital we have direct admission pathways to the right specialist and do not get referred via ED. The BNSSG population needs to be able to access urgent care services seven days a week so a seven day service provision with equitable clinical outcomes is required. Commissioners are committed to developing single pathways so no matter where our population presents within the urgent care system; they receive the same high standard of care and clinical outcomes.

Commissioners want a system that is responsive to the needs and views of the people of the Bristol, North Somerset and South Gloucestershire region and strives to continually improve based on their feedback.

4 Accountable Providers

Through this procurement exercise the Commissioners will secure service integration and strong system leadership as a key element of the urgent care system. Our review of contract models means we want a single lead accountable provider organisation if one organisation does not provide the whole service.

The key requirements will be the following and these will be the factors on which any proposed model will be judged:

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- Will the model allow for continued development across the whole patient pathway?
- Will the model avoid duplication and unnecessary re-triage?
- Will the model be able to maintain a shared commitment to achieving higher quality of care at lower cost?
- Will the model allow for the creation of a culture of shared teamwork and commitment?
- Does the model describe how the interdependence of the organisations involved will be used to lever alignment?
- Does the model demonstrate adequate financial modelling and sustainability for the Provider?
- Does the model describe how it will optimise use of workforce across the wider system?
- Is it clear who takes responsibility for clinical integration?
- Is the lead in terms of relationship with Commissioners able to hold accountability on behalf of the various providers in the model?
- Is it clear which provider is responsible for implementing best practice and providing assurance that this is in place across the care continuum?
- Is it clear who is responsible for leading and ensuring that patient experience is at the centre of the service model and ensures the patient's voice is heard continuously and responded to?
- Is the Provider clearly taking responsibility for the Service performance and contribution to overall system performance and sustainability?
- Are there clear arrangements in place for which organisation is leading on the measurement of performance and contribution to the critical success factors?

5 Joint Commissioner Agreements

In principle, when patients need to be seen they should be seen in the most appropriate location clinically but also the one closest to their own home. This means that there will be occasions where out of area flow will occur and patients will be seen in urgent care services which are not directly commissioned by BNSSG CCGs. Commissioners expect the Provider to work collaboratively to achieve this for the population.

6 Service Description

The vision for the IUC Service is to deliver a "consult and complete" model of urgent care access that can streamline and improve patient care across the urgent care system.

The introduction of an IUC CAS will fundamentally change the way patients access health services. It will mean patients will receive a complete episode of care concluding with either: advice, a prescription, or an appointment for further assessment or treatment.

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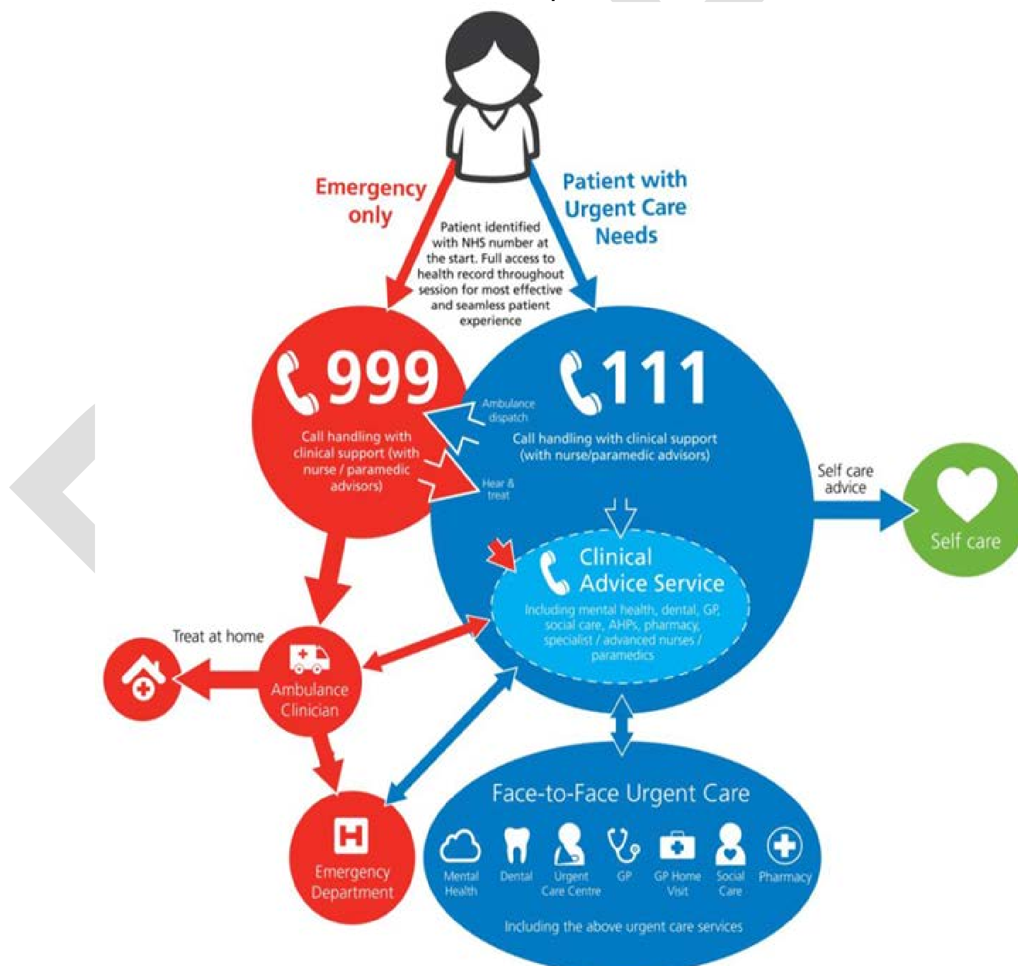
This IUC Service specification is a service which is an essential component of a landscape of multiple providers and services who, by working together, can offer optimal urgent care provision for people whose needs cannot be met by in-hour's primary care services or self-help options. The service needs to provide:

- A telephony call handling and initial assessment for callers (NHS 111)
- A Clinical Assessment, Advice and Treatment service (CAS)
- Primary care treatment centres and home visiting services for people who need to be seen by a primary care service during the out of hours period
- HMP Bristol – OoH urgent prison healthcare

For clarification, the management of dental care is excluded from the IUC service. We will require the IUC Provider to have Interactive Voice Recognition (IVR) in place to direct circa 20,000 calls per annum to the dental helpline.

6.1 The Model

The national model as shown below has been discussed in the BNSSG workshops, GP forum meetings, project group and the Urgent Care Control Centre meeting and is the basis for our BNSSG service description;



Key components of the new model of care

The landscape for IUC is continuing to develop. As such there are areas which will continue to evolve as we work through the procurement discussions and ensure an agreed implementation of the new service model. Whilst the Commissioners have a number of key requirements they are keen to work with bidders through the bidder discussion phases to test their ambition and opportunity to optimise care for the community.

The Commissioners expect to develop a functionally integrated model of delivery in partnership with the Provider and the final specification which will be co-produced through the procurement process. We envisage an approach where the full functionality of the service will evolve over the first year of the contract.

This section describes our developing ideas around the various aspects of the new model of care moving us from our current standalone and silo service provision.

In hours, patients will be encouraged to call their own GP practice first but they may choose to call NHS111 or use NHS111 on-line.

To streamline the patient care pathway for urgent cases direct booking to an in-hours GP appointment will need to be implemented but how this can best be achieved requires discussion and agreement with GP practices.

During the out of hours period, when GP practices are closed access to urgent care will be via NHS 111and the pathway will follow that set out in the high level diagram below.

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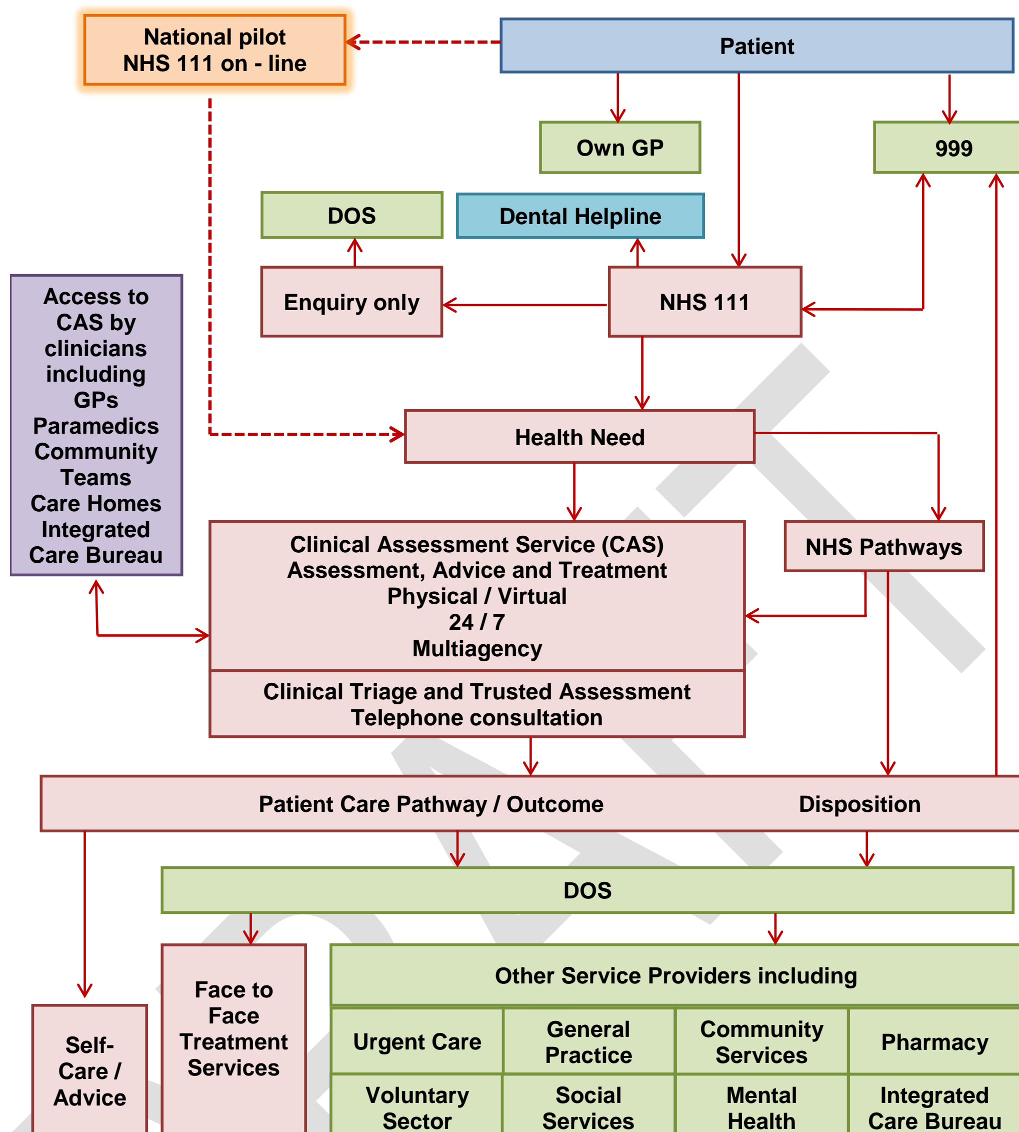

6.2 Critical Success Factors

The critical success factors that the Commissioners expect to achieve through recommissioning is an IUC Service which:

- Delivers consistency of response for people and equitable access to NHS services, based on need
- Provides access to a single clinical triage where needed (without unnecessary duplication) and directs patients to appropriate places to receive urgent care
- Values and contributes to a culture of self- help and personal knowledge. It reduces dependency and avoids paternalistic responses to the public
- Contributes to the CCGs' wider target to reduce avoidable attendances and admissions to hospital in a sustainable way
- Has sufficient capacity and capability to be able to meet both predictable demand and surges in demand

- Supports the system wide achievement of national emergency care targets for the NHS
- Has an ability to escalate operations and flex criteria to support when there is pressure in other parts of the urgent care system
- Has a robust and demonstrable clinical integration and governance process between the various providers who form part of the service and with key members of the system, especially Emergency Departments, 999 and community care teams
- Ensures that the best practice in urgent care is provided for patients.
- Is able to demonstrate the provision of a good quality service for patients and that those patients express satisfaction with the service they receive and can demonstrate an increasing confidence in the offer
- Is able to stay within its' allocated budget and demonstrate an ability to reduce demand and spend in the Ambulance and Emergency Department services. The service must be able to demonstrate value for money

The Provider will have a Service Development Improvement Plan (SDIP) agreed with Commissioners showing the timeline and measureable targets for the development of the new service against which Commissioners will closely monitor progress.

6.3 Public Expectations

In developing this specification members of the public, through representative groups' attendance at workshops, have expressed their views of the important aspects of urgent care. The key issues identified are consistent with findings from the national engagement undertaken by the NHSE as part of the review of urgent and emergency care services.

The following has been developed to reflect what a good service would look like from an individual's view:

- Easily accessible
- Delivered in the right place by the right people at the right time
- Delivered by appropriately trained staff
- Clear in what can be expected and when
- Information shared between healthcare professionals and services
- Integrated with health, mental health services and social care services
- Delivered locally so that people know the services available
- Supports self-care, resilience and independence
- Information is clear and can be understood
- Culturally aware
- Communication is open and honest
- Responsive to feedback and learns from it

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6.4 Local Outcomes

The following outcomes are required and measures are within the quality section.

- People will have a positive experience of care and support
- Everyone is treated as an individual in accordance with their needs and in a way that is free from discrimination
- People experience a service which meets their needs and promotes independence and quality of life
- People feel empowered to manage their own health
- Services are accessible, equitable, sustainable and flexible for all patients, regardless of geography or diagnosis
- Communication is clear and information is provided in appropriate formats
- The service communicates in an inclusive, open and honest, easily understood manner so that people are respected, involved and informed about their care
- Services are managed and delivered as locally as possible so they can integrate more easily with other local services
- The service can demonstrate that it is knowledgeable, high quality, evidence based, safe and delivered at the right time, in the right place by the right people, by a trained workforce
- An information technology system allows the seamless transfer of / access to appropriate clinical information/notes across all services
- There will be clear leadership, accountability and assurance and will work in partnership with other organisations for the benefit of the patient

7 Service Delivery

The IUC Service will deliver the following;

7.1 NHS 111

The current NHS 111 service was procured for BNSSG as part of the national programme and became fully operational in April 2013 and at the same time GP Out of Hours services was recommissioned. These services were mobilised in an incremental way from February to April 2013 with the whole of BNSSG going live with NHS111 calls and a new GP OoH service.

Currently over 6000 people a week call the 111 service in BNSSG although there are seasonal variations, with peaks in demand similar to the national picture e.g. Saturday mornings. Particular challenges in call volumes occur on bank holidays especially when these days create a “four day” weekend e.g. Christmas and Easter.

The Provider shall receive calls and provide consultation for patients who:

- Are registered with a GP within the geographic area specified in the contract

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- 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
- Call NHS 111 but cannot be identified geographically and are therefore sent to the provider via the NHS 111 national telephony platform (according to their allocated share); and
- Are unregistered and are calling from the geographic area covered by the contract

The following core principles reflect the national ambition of NHS 111. People contacting NHS 111 for urgent care needs expect the service to:

- Be always available 24 hours a day, 365 days a year
- Be accessible, personalised and based on their individual needs
- Have knowledge of when they have previously contacted NHS 111 so they do not need to repeat their story
- Be able to connect them to a clinician with access to important health records and notes
- Be safe and give the right advice based on the best and most up to date clinical and medical knowledge available
- Definitively resolve health concerns without the need to go anywhere else
- Book appointments with the GP OoH service
- Dispatch an ambulance without delay
- Be accessible through digital or online channels both to give better access to information and to meet specific needs people have
- Make sure that specific health needs, such as palliative care, mental health and long term conditions are properly catered for

Additionally, Commissioners would add the following as further core principles:

- A service which has a good knowledge of the local service provision and be able to work with callers to use the best local options for urgent care using the NHS Directory of Services (DoS) and MiDoS
- A service which instils confidence in its callers as being a good service that they would use again and recommend to friends and family
- A service that, whilst maintaining a safe approach works with commissioners and in line with national directives, identifies groups of patients for whom direct transfer to a clinician without completing the entire algorithm assessment is appropriate
- A service that embraces new technology such as voice recognition utility.
- A service which identifies through clinical audit and other methods people who do not take the advice given to them, understands the impact of this on other services and the actions necessary to resolve these
- A service which understands its potential for positive impact on the use of urgent care service and choices people make and work actively to secure these
- A service which has transparent and connected governance processes both internally and with the linked services

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7.2 The Clinical Assessment Service (CAS)

The CAS is a clinical assessment, advice, and treatment service which incorporates the following;

The introduction of an IUC CAS will fundamentally change the way patients access health services but it will mean patients will receive a complete episode of care concluding with:

- Advice
- A prescription
- An appointment for further assessment or treatment

Whilst it is recognised that this opportunity is much greater than the joining of the two current distinct services, in reality the resources that are immediately available to the Provider are based on the existing financial envelop.

It is also recognised that the development of an effective CAS relies heavily on the governance arrangements in place for the smooth navigation and support of the caller through the various options for care and is much more than just a sub-contracting arrangement where the specialism is not provided directly.

Commissioners are also keen on exploring further opportunities to expand the effectiveness and usefulness of a CAS to the local community and again would be interested in ideas and opportunities identified by providers where the CAS offers other and different service and support mechanisms.

The development of the CAS is likely to be more evolutionary as the Provider and Commissioners work together to explore the benefits of having a multi-professional service and as learning from other areas becomes available. There are some minimum requirements which the Commissioners expect to see as core for the start of the contract:

- A multi-professional team of people, the majority of whom are co-located but will benefit from additional members virtually for periods of surge and specialist support
- The immediate multi-professional team funded directly through the service will include GP's, nurses and mental health practitioners as a minimum and other professionals including, paramedics and pharmacists
- The exact skill mix and availability of enhanced clinical competencies will be worked through as part of the procurement process
- The integration of mental health services will be an early service priority for the CAS, working with local providers and mental health commissioners
- The ability to optimise pharmacy capacity and skills
- The ability to direct book patients into in hours and out of hours GP appointments and will have functional integration with the clinical systems used by local GP practices We will expect the Provider to work closely with local general practice to agree systems before the introduction of direct booking in hours to general practice
- The CAS should expect to focus on groups of callers whose needs are not fully met by the clinical triage tools – for example young children, people with complex co-morbidity etc.
- The ability to automatically identify patients that are registered under the GP Choice scheme when they access the service
- The chosen clinical workflow system has the ability to query the Child Protection Information System (CP-IS)
- Have has accurate up-to-date information regarding information regarding local capacity, including new GP extended access offer, and to make appointments
- Can prescribe electronically
- Can electronically send self-help information to the patient in order to complete the call
- Can safely share clinical information with all other providers
- The IUC service is designed around the holistic needs of patients who are carers and carers who are patients – both adult and child carers
- The CAS will support the optimal level of referrals to 999 services and the Emergency Departments in line with the Ambulance Response Programme (ARP) recommendations. The Provider will undertake clinical validation of these types of dispositions in line with Urgent Care commissioning standards, associated national guidance and CDSS Licence requirements
- The CAS will aim to support the needs of callers and complete the episode of care where possible and either refers through to face to face or visiting services where appropriate
- All clinicians will be expected to work with a CDSS or an agreed clinical protocol

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- Where the service needs to pass the care of the person onto another service entirely the process for doing this must be as seamless as possible and ensure that information collected must be safely transferred
- The Provider will also provide a care home line, which will enable dedicated access to care home staff to get urgent clinical advice
- Peer support – the CAS will provide a valuable support for other health care professionals (HCPs) working in the community. The Provider will be expected to provide, as a core service, direct access to the CAS for HCPs throughout the 24 hour period. It is acknowledged that the level of need may vary depending on the availability of other services. It is expected that this access to advice and support could be used by the following (but not exclusively):
  - Other GPs where there is a need to hand on information about a patients on- going care
  - Laboratories who may have urgent results which affect patient care
  - ED clinicians
  - Community Service staff
  - Care homes
  - Public health nurses
  - Palliative care teams
  - Paramedics and Emergency care practitioners.
  - Mental health practitioners
  - Rapid response teams
  - Social care services
  - Other statutory organisations working in the out of hours services, e.g. police
- The CAS will have access to key clinical systems such as the, the in hours GP EMIS record, Summary Care Record (SCR), and any other relevant systems for clinical recording, information and decision support, and clinical communications
- In line with national guidance having been assessed as not requiring an emergency ambulance following categories will be directed straight to the CAS :
  - Patients under 2 year old
  - Patients over 85 years old
  - All patients with Special Patient Notes (SPN) or patient alerts

As confidence in the new service model and dialogue continues with the Provider it is expected that there will be further opportunities for integration which should be capitalised upon.

The CAS should be able to receive calls from the Online 111 system. Information taken from the Online 111 system should be made available to the CAS so the patient doesn't have to start the triage process again.

The CAS should be able to request an ambulance electronically.

The CAS as part of the IUC Service must be prepared to work with Commissioners to identify gaps in service provision or failures in response from other services.

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7.3 Face to Face Treatment Services

Face to face contact with the patient will be delivered through Primary Care Centres (PCC) or home visits and will cover the hours when primary care core services are not available.

Providers will identify locations from which they propose to deliver the services within their bid submissions stating the reasons for their choices. New locations are encouraged where there is good supporting rationale. Opportunities for co-location and / or integration with Integrated Hubs, Urgent Care Treatment Centres and /or emerging local cluster models should be explored to maximise use of resources.

Following telephone triage by NHS111 or the CAS, patients requiring face to face consultations will be expected to attend the PCC at the given appointment time. On arrival patients will be greeted by a receptionist and directed to the waiting area. Consultation rooms which offer privacy will be used by the practitioners when seeing patients. As a result of the consultation the patient will receive:

- Advice / self-help / social prescribing
- Appropriate treatment
- Where applicable medication
- Instruction / advice to attend their own practice and within what timescale

A PCC must be suitably staffed with a reception and an adequate number of consulting rooms. If a nurse practitioner is left alone at base (for example during the overnight period because a GP is out on home visits) the nurse practitioner must be sufficiently competent as an independent practitioner and prescriber and have the ability to immediately contact a GP for advice.

The reception desk should meet the current standards for disabled access, safety of staff and appropriate communications, including a hearing loop for hard of hearing patients. The consulting rooms must similarly meet current standards for size, infection control and staff security.

PCCs should have sufficient parking commensurate with the volume of patients likely to be seen at the centre. All buildings must be fully Disability Discrimination Act (DDA) compliant and offer appropriate numbers of disabled parking facilities. Also consideration must be given to parents accessing the service with small children, push chairs etc.

The reception and clinical rooms must be suitably equipped with telephones and IM&T systems providing full voice and data recording systems, access to the clinical systems and to national NHS Digital applications and services.

A security assessment must be undertaken and the appropriate level of equipment and safety design for staff must be built into the facility. There should be heightened security measures for areas containing particularly sensitive items and / or key operational equipment, documents, records etc. Closed Circuit TV monitoring should be available as a minimum in waiting areas and reception.

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Compliance with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance is required.

National Building Requirements define the standards of the above facilities and will be complied with.

The Service must adhere to the local health and safety and clinical governance protocols of any host organisation.

PCCs need to be easily accessible as the lack of an available alternative would encourage people to use Emergency Departments which are not in the best interest of the patient or the services.

Accessibility

Patients who need to travel to a PCC for face to face services should be able to access these services within their geographical area. The nature of the locality creates challenges with distance and / or traffic in mind, but it is inevitable that the further people have to travel the potential for them to default to other closer options are more likely and therefore this needs to be complied with.

The facility must meet with all the statutory standards expected of it at the time of the contract award and continue to remain abreast of any and all changing standards that apply. It must comply with all the relevant regulations to deliver a patient experience that is in line with NHS guidelines including but not limited to:

- Health and safety
- Infection control in the built environment (Department of Health March 2013). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170705/HBN_00-09_infection_control.pdf
- Equality Act October 2010
- Care Quality Commission

In addition, the Provider should consider and be able to demonstrate that they have reflected the requirements to deliver the best patient experience and incorporated these into design considering in particular:

- Helpful signage and direction markers
- Child friendly and safe environment
- Be supportive of people who may have physical or mental health needs
- People with sensory impairment
- Sufficient parking for cars
- Adequate sizing of space and facilities
- The availability of refreshments
- Accessibility by public transport
- Security of staff and visitors

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In terms of the tools required for clinical teams to be able to see, assess, diagnose and treat in the setting without requiring the patient to move to another service the following tools would be expected as a minimum:

- The ability to communicate / share information with other professionals, including telephones
- An agreed supply of emergency medicines and electronic prescribing (EPS)
- Access to patient records, assessment and appointment systems, including the Summary Care Record, and the appropriate equipment and network infrastructure to support use such as personal devices (laptop / PC / tablets), prescription printers, access to the Health and Social Care Network (HSCN) and the internet
- Access to NHS mail
- Basic clinical equipment suitable for both children and adults including appropriate resuscitation equipment
- Basic diagnostics – for example urinalysis, glucometer, SpO2 monitor, , pregnancy testing, peak flow meter and other items recommended by the Provider and agreed with commissioners where it could actively contribute to the avoidance of transfer of care or admission
- Basic treatment and clinical supplies such as urinary catheters, nebulisers, intravenous cannulation etc.
- Access to the DoS through MiDoS to direct patient appropriately if additional Clinical / Social Care support is required

At the time of the procurement, redesign plans are in place to which will move towards the development of a locality based integrated out of hospital model led by primary care, supported by multi-disciplinary cluster working. Any development or changes will be notified to the Provider and an opportunity to explore the consequences and opportunities this provides as part of the procurement process.

Out of Hours home visiting

The IUC Service should have sufficient resources to be able to offer a home visiting service for specified groups of patients for medical Out of Hour service. The visiting service should have an integrated approach ensuring that the right health or social care professional (including voluntary resources) could be mobilised to support the patients and therefore close working links with community service providers is required. The decision that a home visit is needed can be made by a suitably trained member of staff working in either the CAS, Ambulance service
or by other members of community urgent care services where suitable referral guidelines / home visiting policy have been developed.

Home visits should only occur where it is clinically necessary for the patient to be seen by a clinician and the patient cannot reasonably be expected to travel to a PCC.

Such a visit should be an exception and would ordinarily only be expected in the following circumstances:

- Patients with terminal illness

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- Patients who are truly "bed bound"
- Patients for whom a car journey could lead to unnecessary deterioration of their condition or unacceptable discomfort
- When necessary, in accordance with local agreement, to pronounce life extinct

And

- The decision to offer a home visit will be made by the clinician with due regard to the needs of the patient at the time

It is recognised that home visiting is more labour intensive than PCC based care however the rate of home visiting will be monitored to provide reassurance that there is equity of access based on the clinical need. The Provider will be expected to be able to demonstrate equity in the decision making processes used to arrive at a decision to offer or deny a home visit. This procurement requires the delivery of a home visiting service that is expected to have close links with community services to ensure a joint approach to best patient care.

Commissioners would be interested to explore the potential to reduce visiting where safe to do so, using technology e.g. telehealth care, virtual clinic.

In undertaking home visiting, the Provider must be able to demonstrate that they can carry this out ensuring the safety of patients and clinicians and that clinical equipment provided enables the attending clinician to assess, diagnose and treat in situ and arrange for on-going care. Clinicians should be provided with portable electronic equipment and connectivity that enables them to see relevant clinical information to support decision making and enable them to take notes and update records.

It is desirable for the IUC service to drive the management of people at home / in the community who otherwise might have been admitted to secondary care. Critical to this is the relationship between this service, the patient's main primary care service and community services and that the clinical risk is held jointly. This is supportive of the commissioners' desire for 'channel shift' whereby patients are cared for in the lowest possible acuity (that is clinically appropriate) setting, and will require the IUC service provider to work collaboratively with these other partners as part of the wider urgent care system.

7.4 Prison OoH Healthcare for HMP Bristol

There is one prison within BNSSG covered by this IUC Service. HMP Bristol is a Category B remand prison with an operational capacity of 614. Prisoners can arrive at HMP Bristol straight from Police Custody or the Courts, or be transferred from another prison.

NHS England commissions Inspire Better Health (IBH) to provide all primary and community health services to the population of HMP Bristol. IBH is a partnership of Bristol Community Health Community Interest Company, Avon & Wiltshire Mental Health Partnership NHS Trust, Hanham Health (GP services) and subcontractors. BCH is the lead provider. IBH is commissioned to provide the same range and

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quality of services for the prison population as the general public receive in the community. This includes, for example:

- Daily GP clinics, the provision of GP assessments during the evening (up to approximately 8pm) for new arrivals to the establishment as part of reception screening and first night assessments (particularly for patients with substance misuse needs)
- An GP clinic on a Saturday for urgent cases
- The provision of a medical service 52 weeks per year
- 24 hour nursing cover for the substance misuse wing of the prison.

Therefore the use of the NHS111 / OoH provider is minimal. If advice or a GP should be required during the Out of Hours period the prison nursing team would make contact on behalf of the prisoner. They will require direct access to the GP service either for telephone advice or to request a visit but the number of incidents is very low (activity figures to follow). Protocols are in place to facilitate prompt GP access during the Out of Hours period.

A separate arrangement exists with HMPs Eastwood Park, Leyhill and Ashfield in South Gloucestershire and so these are explicitly excluded from this specification.

7.5 Management of un-resuscitated deceased persons

Confirmation of life extinct during the out of hours period - the Provider may be called upon to confirm the death of a patient at home in line with a procedure agreed with the Avon Coroner. This may be a GP or other appropriately qualified clinician and will for expected and unexpected but no surprise deaths.

In exceptional circumstances where an appropriately qualified nurse is not available to confirm a death in a nursing home, the Service will be called upon to do so.

7.6 Transfers of Care to other providers

The workforce of the IUC Service needs to be able to deal clinically with all of the referrals it receives itself, or where it is outside of their clinical role, have developed excellent working relationships to transfer the patient so they receive the best care possible. The receiving service of onward referrals must, immediately, be sent clinical information is an easily understandable, user friendly format. See section 8.4 Post Event Messages and Clinical Communications.

7.7 The Directory of Services (DoS)

The NHS DoS is provided and maintained by the Commissioners through the local DoS team. The Provider will be expected to work closely with the team to ensure that any error, omissions or improvements can be worked upon jointly for the good of all of the urgent care services and the patient.

Selection of the correct service on the NHS DoS is a key part in ensuring patients are directed to the appropriate service and not to a service they choose. The

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Provider will train their staff so that this is understood and those services that are at the top of the DOS returns are predominantly used.

The Provider must not develop their own directories but work with the local DoS team to ensure the robustness of the core NHS DoS for the area. The scope of the directory content is widening to increase the number of options to support self-care.

A single directory identifying skills, availability and capacity within any given area will enable the IUC service to have a clear view of services that meet the need of any patient presenting to them. Full details of all locally available services will be maintained in the NHS Directory of Services which contains a detailed breakdown of the specific clinical skills each service can provide, their opening hours, their capacity and their referral criteria. This information can then be used to avoid sending patients to services with restricted capacity, instead redirecting these patients to services with greater capacity as well as ensuring the patient is directed to an appropriate service that can deal with the patient's needs.

- The NHS DoS is a Commissioner owned database provided and maintained by the Urgent Care Commissioners through the Regional DoS Team. Data within the NHS Directory of Services is subject to robust governance procedures and will be signed off by the Commissioners
- The service provider is responsible for ensuring that throughout the term of the contract, the service will be listed on the NHS Directory of Services and is up to date. They must work closely with the Regional DoS Team to ensure their profiles are designed and implemented to support patients receiving their care as close to home as possible
- The service provider will be expected to access the NHS DoS to identify the most appropriate service for their patients. This may be by utilising DoS returns within the NHS111 system or by using MiDoS. Any anomalies or admissions identified in the DoS returns will need to be highlighted to the Commissioners and the Regional DoS Team to ensure improvements can be worked upon jointly for the good of all of the urgent care services and the patient
- The service provider must have regularly updated Standard Operating Procedures for managing the day to day use of the NHS DoS. These procedures must include a clear business continuity plan in the event of NHS DoS failure

The service provider will provide management information to the Commissioners regarding the demand, usage and performance of NHS DoS services in order to enable intelligent commissioning.

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8 Service Requirements

8.1 Telephony Requirements

The Provider must comply with national requirements.

Specific Caller Groups

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

Unregistered Patients

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

Repeat Callers

In 2005 the Department of Health 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.

If a patient (or their carer) calls NHS 111 three times in 4 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 GP must complete a thorough re-assessment of the patient's needs and have access to the details of all three.

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

Frequent Callers

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

Mental Health and Vulnerable Callers

The Provider shall adhere to the principles of the Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis (18

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February 2014) and work with commissioners and patient groups to ensure the most convenient and appropriate access to the service.

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

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

Health Information Callers

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

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

Where there is a non-symptomatic query relating to a health condition this must be referred to an appropriate Health Advisor or clinician. Service information queries can be dealt with using the DoS. In addition, callers could be directed to NHS Choices or other on-line sources of health information.

Health Care Professional Calls

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

NHS England is currently evaluating a number of pilot sites that have supported staff working in Care Homes. This provides rapid access to a GP via NHS 111, as a way of avoiding unnecessary ambulance conveyance or A&E attendance. This information will be made available once fully evaluated.

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Rapid Access to GP (star – line) – Clinical Support

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

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

Calls in and contacts where English is not the first language

The Provider needs to have a translation service available to translate calls and support professionals in clinical consultations where it is necessary, where staff do not speak the relevant language. Advisors need to know how to organise a translator of suitable skills without delay. The service must have arrangements in place to access interpreting services to ensure equitable access for all patients.

Text relay / Type Talk calls from the deaf

The service infrastructure must be Type Talk friendly and calls may arrive from the deaf via a text relay translator. Advisors need to understand that such calls exist and how to handle them. No special equipment or services are required. It is a requirement that these calls will be tagged following the first call if the caller consents to improve the response for these patients in the event of future calls.

Vulnerable Callers

Staff need to be trained in how to manage calls where specialist support may be required for callers with learning difficulties and other vulnerable groups.

Telephone systems and Infrastructure

The Provider must have in place telephony systems, network infrastructure and fully tested operational policies and procedures to ensure high performance and continuity of service during the period of operation.

As a minimum this will include:

- Adequate quantity of public network circuits to accommodate anticipated volumes of traffic over the life of the contract
- Provision of infrastructure such as dual carrier provision of circuits to minimize single point of failure

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- Resilient telephony system scalable to handle expected call volumes over the life of the contract
- Automatic failover to alternative service platform during periods of failure
- Fully tested and documented procedures in handling call activity, handling off of calls to other agencies
- Contingency procedures for manual handling of calls

The Provider must set out the network architecture detailing all components that are involved in the delivery of calls from the public network to and within the Provider's system.

Call Recording

The Provider will have in place systems capable of recording calls made into, within and out of their proposed system. Additionally the service shall have the facility of providing an announcement advising callers that their calls may be recorded for training and quality control purposes. All records should be retained in line with NHS records management policy, currently the *Records management code of practice for health and social care 2016*[5]. The current standard under review is that calls from adults will be retained for 8 years and calls from or about children will be retained until their 26th birthday. The Providers are also required to ensure that systems are in place to comply with regulations concerning child protection and vulnerable adults. The Providers must comply with the statutory requirements of Care Act 2014, Children's' Act 2004 and Working together to safeguard children 2015. It is important that the Provider can demonstrate a simple extraction of call data for audit purposes as well as dealing with patient complaints.

Call routing

NHS 111 currently uses the location of the caller to identify where a call should be routed on the basis of Routing Areas. For landlines these are based on the National Number Group (NNG) including for calls where the Calling Line Identity (CLI) is "withheld". The NHS 111 national routing plan is updated as and when changes are notified, the service provider must maintain their telephony infrastructure in accordance with the national routing plan. There is the possibility postcode area / territory routing may be introduced / used in conjunction with IVR messages, time of day routing to achieve inbound call control for which the service provider must have the capability to introduce.

For mobile phones the mast location or the Emergency Area is used.

In special cases the NHS 111 infrastructure is capable of routing on the entire telephone number so that specific telephone numbers can be routed to special Direct Dial Inwards (DDI) numbers (known as "tagging").

[5] https://digital.nhs.uk/article/1202/Records-Management-Code-of-Practice-for-Health-and-Social-Care-2016

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Tagging of calls from specific groups

The Provider will make available dedicated access codes for care home staff (either by an alternative direct dial or by interactive voice recognition, for example) to enable them to get urgent advice from a GP in the out of hours period. The codes will allow them to bypass 111 call handlers to speak directly to a GP or get a call back.

8.2 Systems Integration

Interoperability within the Integrated Urgent Care environment is detailed in the Interoperability Standards https://www.networks.nhs.uk/ The standards define the technical standards that must be used for the transfer of data where applicable, to and from NHS 111 application systems and the applications that integrate with NHS 111 service providers.

The Provider must consider its role in terms of integration of systems to improve and facilitate patient continuity of care, for example the Provider would be expected to:

- Be able to receive 111 messages via an Interoperability Toolkit (ITK) / Clinical Data Architecture (CDA) compliant route (ITK / CDA)
- Be accredited as an ITK compliant sender and receiver. The Provider must ensure that the system vendor complies
- Have technical integration with national DoS services
- Be Patient Demographic Service (PDS) compliant - all IUC applications must connect directly with the Spine web portal and the ability to perform an advanced trace to obtain patients NHS Numbers and other details
- Be able to identify a patient if demographic information from 111 part of the service is not completely correct and be able to feed this back
- Be able to match 111 dispositions to ambulance response times for urgent care
- Be able to book, cancel or change appointments for any patient direct with GP practices and other providers where the capacity is possible in the receiver (this is mandatory for all services provided by Out of Hours) as part of system workflow
- Be able to configure Post Event Messages (PEM) to meet GP practice, ED and onward provider needs in terms of content, clarity and brevity. The expectation is that the mode will be ITK compliant for the majority of practices and should be the route of preference wherever able to be so
- Be able to identify and track repeat callers and take appropriate action by having access to the national repeat caller database
- Have access to and contribute data to the local shared record (currently Connecting Care)
- Commit to integration with Summary Care Records line with the BNSSG wide developments
- To have clinical workflow systems which use Patient Flags / Special Patient Notes and ensure that these can be read and used effectively
- Be responsible for encouraging the use of SPN by providing a simple to use system for uploading information by practices

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- To share appropriate and relevant information electronically with all the services across the IUC Service to prevent multiple assessments and duplication of effort. Be able to send prescriptions to a local pharmacy via the Electronic Prescribing System (EPS)
- Have data sharing agreements both within the service and across the wider health and care system, backed up by a Privacy Impact Assessment / Data Protection Impact Assessment signed off by the commissioners to enable sharing of information.

EMIS clinical systems (CCMH and GP) (provided by EMIS Health are widely used in the local health community. EMIS Health is currently the provider of the primary clinical record for all General practices, all Adult Community Services and several other services (e.g. St Peters Hospice, Primary Care Access Services) across BNSSG. The BNSSG health community is also part of the EMIS pathfinder programme. The ability of the IUC Service systems to integrate with, or share information with EMIS will be a key requirement for the service.

8.3 Information Management and Technology

The Provider must comply with national requirements including the NHS111 wider system requirements and interoperability.

The Provider must put in place the information technology infrastructure and systems and the service management arrangements necessary and information governance necessary to support the delivery of a 24 / 7 IUC Service that meets the needs of Commissioners.

The Provider must have a secure Information Technology (IT) infrastructure that should underpin and support all the requirements mentioned in this document. In particular IT infrastructure should include:

- Resilience and redundancy to ensure there is no single point of failure and that the service can continue to be delivered to a high quality in the event of failure such a building, power etc.
- An up to date IT infrastructure and systems which must have full and current documentation including technical architecture topology diagrams
- An technical infrastructure and systems which should be sufficient to deliver a satisfactory and timely service to the patient regardless of level of usage, even at peak times
- A service and its technical solution which should be scalable so that capacity can be added if demand increases beyond the predicted volumes

Clinicians should be supported by clinical and management information in electronic information systems that are integrated along the care pathway, and the ability to transfer information between clinical service providers.

The Provider will be expected to keep pace with demand to utilise technological developments, for example web based technologies, SMS texting, telehealth solutions, to innovate how the public can interface with the community urgent care

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services. The Provider will be expected to drive the use of technology to optimise patient experience while maintaining good clinical governance.

The Provider would be expected to support national and local developments such as mobile DoS, Online 111, web based information and mobile information services for patients. The Provider will be required to work with commissioners to agree the development and implementation of NHS111 on-line.

The Provider must provide real-time access to information to support clinical and commissioning requirements. Therefore the Provider must:

- Provide all the clinical and other systems (e.g. for clinical records, administrative functions such as appointments, management, HR and financial etc.) to enable the IUC Service functions to be carried out effectively and safely, while maintaining the best patient experience
- Provide “Live” time data to NHS Digital for the national IDT system
- Use the local system management tool (currently Alamac) and partake in the associated processes e.g. conference calls, system escalation
- Provide a mechanism for all data to be exported regularly from the system and transferred to any specified destination in a recognised acceptable format
- Have a reporting solution must be in place that enables the Provider to meet local and statutory reporting requirements
- Provide a data dictionary of all fields within the application in line with the NHS data dictionary where relevant
- Be able to access patient’s primary and community care record where consent exists
- Provide clinical content for ambulance dispatch where needed that has been developed in partnership across the urgent care system
- Be able to interface with the Capacity Management System (CMS) NHS Directory of Service (DoS) and MiDoS system supported by the Commissioners
- Be able to demonstrate compliance with the current NHS interoperability specifications
- Have data quality processes and checks in place to ensure that the data recorded is complete, accurate and timely, and that duplicate or empty records are managed and causes of poor data are addressed (e.g. training)
- Have plans in place, agreed with other system providers e.g. ambulance service, to manage the implementation of IT updates and software version releases

8.4 Post Event Messages and Clinical Communications

The Provider must comply with the requirements set out in the national specification.

The IUC Service should have robust arrangements in place that give all the clinicians working for their service access to all the records of previous consultations. All records must be structured and searchable so that important information is easily accessed.

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A number of requirements have been mandated by NHS England on OoH providers regarding 111 referrals:

- It must be clear that the message originated in 111 when the information is passed on to the patient's GP surgery, or to any other downstream medical provider including ED
- The original IT system reference (case-ID) must be preserved to enable the call to be traced back if necessary
- The number of referrals from 111 must be recorded and reported to commissioners

These requirements are mandatory for transfer of information to the patient's surgery, but for consistency should be viewed as such for transfer of information to any other medical service provider.

NHS 111 must share information in the form of the PEM immediately with onward providers e.g. ED. This information must be in a user friendly format.

When the information needs to be transferred electronically to another service provider, evidence to demonstrate that patient consent to transfer has been obtained will be required. The clinical data may comprise of an automatic transfer of relevant data, including patient details and assessment completed to date to transfer to the receiving organisation to inform the response and minimise the need for the patient to repeat information. The information should be in a format that is has been agreed with recipient and commissioners to ensure that it is clear and concise.

8.5 Information Sharing and Post Event Messages

The Provider must comply with the requirements set out in the national specification.

The General Data Protection Regulation (GDPR) comes into force in May 2018; all parties should be aware of their obligations arising under GDPR and any further amendments to Data Protection Legislation and must comply with these obligations.

As specified in the contract all parties must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the NHS Information Governance Toolkit (or any successor framework) – for the avoidance of doubt satisfactory compliance is currently considered to be a Level 2 or higher. All parties must complete the Information Governance Toolkit for the most applicable organisational type – where there is any doubt the organisational type must be agreed with the commissioner.

For the Provider, the goals of information sharing, within the current technological and Information Governance (IG) constraints, are that:

- The patient can be transferred from NHS 111 / CAS element of the service to the OoH service and other community urgent care services providers using ITK with a failsafe backup to NHS mail
- The most complete information relating to the patient is available to the treating clinician at the point of treatment

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- The treating clinician must provide the clinical outcomes, ideally the primary reason for the encounter, a summary of the treatment via an electronic PEM provided to the patient's GP practice by 0800hrs the following working day
- The message should be sent at the end of the encounter to avoid multiple messages

At a minimum, the Provider needs to be able to:

- Receive referrals from 111 and Online111 using the 111 interoperability architecture ITK / CDA
- Transmit end of treatment summaries to the GP practice via ITK where the receiving system is capable of receiving messages via ITK, and via NHS mail where ITK is not available

In order to achieve this, the IT system used to support the IUC Service must be accredited to both send and receive via ITK.

In BNSSG there are plans to improve accessibility to patient's own GP records by other services, which would then support greater continuity of care. The ultimate aim is that the treating clinician will have full read and write access to the patient's records at the point of treatment. The treating clinician will be able to attach the end of treatment summary directly to the patient's record at the end of the treatment rather than creating a separate document that needs to be subsequently attached by the patient's GP practice.

It is possible that BNSSG may have only achieved some progress towards full data sharing. Sharing strategies will be based on a combination of:

- Access to Summary Care Record (SCR) and the local integrated clinical record system (currently Connecting Care) which will provide detailed summary record for local patients
- Access to any SPN or care plans that relate to the safe treatment of the patient
- Read only access to the patient's record
- Transmission of the End-of-Treatment summary to the patient's practice using the 111 interoperability architecture (ITK / CDA) or NHS mail if the GP system has not been accredited to receive 111 messages via ITK
- Full read and write access to the patient's record

The Provider will be expected to be familiar with and understand the complexity of the clinical IT landscape and demonstrate that they have an appropriate system, or systems, in place to:

- Provide complete patient information to the treating clinician at point of treatment
- Ensure that the details of the treatment are passed on to the patient's GP

The clinical IT landscape becomes even more complex when IT systems supporting other medical providers, such as Accident and Emergency departments (A&E) or

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pharmacies are considered. Given this complexity, it is very likely that more than one approach will be required to ensure that patient data is available regardless of the system on which it is stored.

Whatever the IT picture is at the time of tender, the Commissioners will continue to strive to improve information sharing, and during the contract the IT landscape will continue to evolve. Therefore the Provider will need to:

- Accept the changing IT landscape
- Sign up to the Local Digital Roadmap / Digital STP plans
- Contribute to any relevant work to improve the underpinning IM&T infrastructure across the BNSSG health community – particularly around information sharing

Permission to View (PTV)

In situations where the patient may call one organisation then be passed to others, as part of receiving care, any information provided to patients must explain this. This includes capturing permission to view (PTV) of any records. The information provided on the original call must provide a clear and succinct explanation that sets the clear expectations for the patient on how their information will be accessed and used. When closing a call, a summary of what will happen next should include any information that will be provided.

8.6 Protection and retention of information

The IUC Service can expect that a high proportion of people are contacting the service on behalf of others and the service must be able to demonstrate how it ensures that the person who needs their care has consented to this where possible to do so.

All NHS organisations have a duty under the Public Records Act to make arrangements for the safe keeping and eventual disposal of all types of their records. In addition, NHS organisations are required to have robust records management procedures in place to meet the requirements set out under the Data Protection Act 1998 (soon to be the General Data Protection Regulation) and the Freedom of Information Act 2000. Detailed guidance on all aspects of record keeping and protection of information can be found in Records Management Code of Practice available at
https://www.gov.uk/government/publications/records-management-code-of-practice-for-health-and-social-care

8.7 Public Health England (PHE)

The) aim of PHE is to protect the public from threats to their health from infectious diseases and environmental hazards. It identifies and responds to health hazards and emergencies caused by infectious disease, hazardous chemicals, poisons or radiation.

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The PHE uses sophisticated syndromic surveillance systems to monitor seasonal outbreaks of community-based infections (e.g. influenza and norovirus) and major public health incidents. The agency's systems provide data in near real-time relating to the health outcomes of an incident. This is used to inform both policy makers at national and local level and front line healthcare workers involved in providing clinical data.

The syndromic surveillance systems rely on the automated supply of specified anonymised data from clinical information systems whose specification, transfer and use is governed by a Caldicott compliant information sharing agreement between the PHE and the data supplier. This includes the community urgent care services.

The data capture necessary for the PHE's syndromic surveillance systems does not impose extra data capture requirements on the service over and above what is necessary to conduct a search of a directory of local services. These processes will be automated to ensure that there are no additional requirements imposed on the Provider.

The Provider will be required to:

- Enter into an information sharing agreement with the PHE for the secure supply of specified anonymised real-time data for public health surveillance purposes
- Ensure that a data sharing agreement is included within contracts with all organisations involved in the delivery of the Service
- Ensure that appropriate governance arrangements are in place such that all NHS, third sector or commercial organisations participating in the delivery of the service are enjoined in the commitment to supply the real-time specified data-set to the PHE
- Ensure the PHE is alerted if any concerns about general communicable diseases which would support any case finding required, and
- Support the PHE in access to pharmacy via the DOS / prescribing of antibiotics if prophylaxis treatments are required

8.8 Special Patient Notes / Clinical Alert Messages

It is expected that the Provider will be an advocate of the use of shared information to support continuity in patient care. In BNSSG, in advance of the potential to share full patient records, SPN and care plans are in use to support clinicians working out of hours.

These are notes held by various services to support the decision making process that may be needed when the patient presents to a service which may not know them so well as their own GP or specialist. They are intended to pass important information that supports the on-going management of care and avoids a retrograde step in care. The current out of hour's service acts as the host for SPN and this is expected to continue as a role for the Provider of the service until such time as greater reliance can be placed on the use of summary care records and enhanced care records.

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

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

There are aspirations in BNSSG to improve the accessibility to the patient's GP record by other services through the local shared record (currently Connecting Care), which would then support greater continuity of care. Providers will be required to work with commissioners to facilitate this development and contribute to any shared record.

8.9 Clinical Governance

Clinical governance arrangements are central to the effective operation of a high quality IUC Service which puts patients' safety first.

Strong relationships and partnership working need to be established between all providers involved in the pathway so that issues can be identified early, and service improvements made.

The Provider must participate effectively in these arrangements as an integral part of the 24 / 7 urgent and emergency care service within BNSSG.

Across the Provider and all partner providers, as a minimum, there will be in place:

- Clear lines of accountability throughout the whole patient pathway, not only whilst the person is using the IUC Service
- Clear engagement and support by the Provider for the clinical governance arrangements in partner provider organisations. All providers have an equal accountability for the delivery of the patient pathway and for the clinical governance process
- Active delivery of clinical assurance for IUC Service administered by the Provider and led by the Commissioners via a local governance forum, with effective clinical leadership and clear lines of accountability to the Commissioners. This brings together clinical leaders within the IUC Service with clinical leaders within all of the NHS and social care providers to whom patients may be referred, enabling them to develop a real sense of ownership of their local pathways
- A robust policy and process setting out the manner, in which all incidents will be identified, reported and managed in line with the NHS Duty of Candour. The policy must adhere to the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and include the principals and process for applying the Being Open Policy. Systems for the reporting of, investigating and learning from such incidents must be clearly described. The clinical leadership of the IUC service must play an appropriate role in

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understanding, managing and learning from these events, even where they have originated in a partner provider organisation. Where an incident occurs that spans other organisations the service should work with those organisations to undertake a joint investigation process, sharing the learning with the Commissioner and other bodies as relevant

- Detailed knowledge of the different stages in the patient's journey through the IUC Service, including an understanding of the way in which potential shortcomings at any stage in that journey will be identified
- Clear and well-publicised routes for both service users and health professionals to feedback their experience of the Service, with agreed timeframes for completion, ensuring prompt and appropriate response to that feedback with shared learning between organisations, including feedback to the individual who was the source of the comment
- Regular & detailed surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional important insight into the quality of the Service. The Provider will be encouraged to find innovative technological solutions for rapid feedback
- Regular staff training and refreshing where required on updated policies and procedures, to ensure quality of service is maintained
- Regular review by clinical leadership of the quality of the calls and interactions especially where their outcomes have proved problematic, with involvement of partner providers
- Provision of accurate, appropriate, clinically relevant and timely data about the Service demonstrating that it is meeting the quality standards set out in this specification
- Provision to report against agreed Quality Schedules
- Data quality maintenance checking processes and policies within the service, and procedures for acting on feedback

8.10 Continuous Audit and Improvement

The IUC Service will be expected to take part in audits and needs assessments to ensure quality assurance and identify any gaps in service provision. This includes both call audits and clinical effectiveness audits.

Call handlers and clinical advisors must undergo a continuous process of audit in line with the requirements of any Clinical Decision Support System (CDSS) licence and as specified in this document. This must be a process which not only identifies where specific staff members have gaps in skills and knowledge but also must allow for continuous improvement of all staff. The audit process must identify key areas where additional training, modifications to existing training or feedback to other providers is needed.

The audit process itself must be quality assured and as a minimum there should be both internal and external review of the auditors.

Audit by clinicians is preferable to reflect the wider assessment role provided by these individuals and must reflect the competences with the Royal College of General Practitioners, Urgent and Emergency Care Out of Hours Clinical Audit toolkit (2010).

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A process will be in place for support and management of staff who are repeatedly non-compliant with audit or are placed repeatedly on action plans.

The IUC Service must meet all national standards of service quality including those set out on the following policy documents:

- Integrated Urgent Care Key Performance Indicators
- NHS 111 Commissioning Standards NHS England June 2014
- National Quality Requirements in the Delivery of Out-Of-Hours Services, DH, July 2006, Gateway ref: 6893
- DH fact sheet 7: commissioning out-of-hours services, December 2005, Gateway ref:5917
- Recommendations from Dr David Colin -Thomé and Professor Steve Field report on Out of Hours (2010)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014National Service Frameworks (NSFs)
- Department of Health Direction on Confidentiality (DH 2000)
- NHS England Serious Incident Framework 2015
- Data Protection Act 1998
- Freedom of Information Act 2000 and
- Information Governance standards as set out in National Programme for Information Technology 2006 – 2007

The Provider must be aware that this specification may be subject to change in the light of changes in the National OoH and NHS111 Quality Requirements and any other amendments or additions to the relevant legislation. The Provider will recognise the possible changes to the “in” and “out” of hours times and have mechanisms in place that adjust resources and costs appropriately.

8.11 Pharmacy

The Provider will need to meet the pharmaceutical needs of the BNSSG population where these are urgently needed in the out-of-hours period and cannot be handled by other providers.

Clinical Assessment Service
Pharmacy is an area which can be developed significantly to support urgent care, and reduce the escalation of urgent care needs. The employment and use of pharmacists in the CAS is expected to optimise care and skill utilisation.

The use of non-medical prescribers such as nurses and pharmacists in addition to medical prescribers is to be encouraged.

Community Pharmacy
When the Provider’s clinicians deem it appropriate for a patient to be issued with a medicine in the out-of-hours period, this will usually be by prescribing on form FP10 for subsequent dispensing at a community pharmacy.

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There are opportunities in BNSSG to optimise the use of community pharmacists to support the urgent care needs of the public. Community Pharmacists could be commissioned to support the system by providing services such as a minor conditions / ailments service that involves pharmacist being able to treat certain conditions that would normally require prescription medication being available under Patient Group Directions (PDGs) or by using more independent pharmacist prescribers within community pharmacies.

There are a range of 100 hour pharmacies across BNSSG which have provided a considerable amount of support to the current GP OoH services.

The BNSSG CCGs have commissioned services in place that aim to meet the needs of the majority of patients that call NHS 111 simply because they have run out of their regular repeat medication from their GP. In addition NHS England has commissioned a pilot of a national service that aims to meet these needs too.

Community Pharmacists are also commissioned through NHSE to stock certain medication for 'urgent / palliative' care and ICU service should be aware of this and ensure they report any difficulties of obtaining certain medication.

Repeat prescribing

There are some particular issues in relation to repeat prescribing where the CCG's would want to actively reduce the need of these to be provided out of hours and outside the relationship with their main primary care service who are responsible for ongoing monitoring and maintenance.

It is expected that where patients need drugs or treatment that they are prescribed by suitably trained healthcare professionals (GP's, registered prescribers or pharmacists). Where prescriptions are provided they will usually be provided in line with the BNSSG Joint Formulary, but will need to acknowledge visitors to the area may be requesting alternate drugs.

There is an expectation that the IUC Service will meet the requirements set out in:

https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/80-repeat-med-guide-nhs111.pdf

Pharmacies within BNSSG will be used to their maximum effect to benefit the public in receiving swift care closer to home, wherever possible[6].

Whilst needing to ensure that, in exceptional circumstances, people are able to obtain repeat prescriptions where the outcome could be a serious impact on their disease or illness, routine repeat prescription issue is to be discouraged. This is seen as a way of positively reinforcing long term condition management by primary care, not as a punitive measure.

[6] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/quick-guid-comm-harm-urgent-care.pdf

The process by which this is discouraged will be agreed by commissioning leads with the service provider. It is expected that the service provider will adhere to this process and monitor that clinical staff are adhering to this policy. This is a really important issue for the community and will only be effective if everyone is consistent in their approach so may be subject to penalties if not adhered with.

NHS England is currently undertaking a pilot NHS Urgent Medicine Supply Advanced Service (NUMSAS) and should NHS England decide to continue this service when the pilot ends on March 2018[7] the ICU service will link to this.

Compliance with BNSSG Joint Formulary[8] and Prescribing Policies
The ICU service should adhere to the BNSSG Joint Formulary and prescribing policies including the over the counter medicines. Prescribing will be monitored to ensure safe and effective prescribing.

Medicine Supply and Legislation
The Provider will need to ensure that it complies with current home office legislation with respect to licenses for the storage of controlled drugs. The Provider should nominate a lead clinician as a point of contact in relation to controlled drugs. The Provider will need to inform the Controlled Drugs Accountable Officer at NHS England of any incidents that arise concerning controlled drugs for the purposes of sharing learning and preventing harm.

Where prescribing on form FP10 is not appropriate, direct supply will need to take place whereby the Provider's clinicians issue medication from stock. Such medication should be over-labelled in accordance with the legislation, and licensed suppliers of over-labelled packs will be able to meet the Provider's need in this respect, as well as the Provider's need for non-over-labelled stock where medicines (such as injections) are personally administered to patients.

The use of Patient Group Directions (PGDs) should be minimised and the majority of medication issues should be authorised by a qualified medical or non-medical prescriber. Commissioners will only authorise a limited number of Patient Group Directions (PGDs) for use by the Provider.

For the avoidance of doubt, the Provider will be responsible for the cost of the following:

- The cost of controlled stationery such as FP10SS forms
- The cost of any medication prescribed on FP10 forms (to which VAT is not charged)
- The cost of medication and other diagnostic agents used in the course of providing the service (to which VAT is charged)

The Commissioner will be able to authorise the Provider to directly access controlled stationery and ensure that the Provider is invoiced for both the cost of the stationery and the medicines prescribed using that stationery.

[7] http://psnc.org.uk/services-commissioning/urgent-medicine-supply-service/
[8] http://www.bnssgformulary.nhs.uk/

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The costs referred to above will be funded by the Commissioner as part of the overall service charge. Indicative costs for these are available based on the period April 2013 – March 2017 when commissioners have paid for these costs themselves.

8.12 Service Resilience

The Service needs to be reliable, so the Provider must have robust and tested business continuity procedures in place to ensure that their service is resilient.

The Provider must have:

- A secondary Direct Dial Inwards (DDI) number capable of handling call volumes connected to the Provider which as far as possible is located in a separated location, telephony services provider and routing
- Contingency plans in place to maintain the service to patients in the event of an incident at their main call handling location which prevents its use. The Provider must confirm that they have suitable infrastructure and procedures in place to continue handling calls in case of such emergencies
- Infrastructure and operating procedures to ensure business continuity in the event of a power failure
- A fully resilient and in place solution available so that, in the event of a catastrophic event, calls can be routed to the contingency site
- The ability to implement a local message on their Automatic Call Distributor (ACD) in case of a specific local event. The service must have the ability to implement within an hour
- Contingency plans for the impact of short term external factors on the availability of call handlers and clinicians in sufficient numbers to meet the demands on the service
- Contingency plans and approaches to recruitment and retention issues which may be longer term
- Contingency plans for the manual handling of calls
- Contingency plans to overcome the sudden loss of clinical face to face capacity
- Contingency plans to access the NHS DoS in the event of connection issues to the National system

8.13 Principles as they apply to property

The model of integrated care services based in the community partly relies on facilities and services provided as part of other contracts.

Out of Hours GP treatment facilities are largely provided from clinical settings which are already in use for large parts of the week delivering other services.

The Provider will also have to make provision for some costs which are used solely by them and shared with other premises occupants, for example:

- Staff

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- IT licences and equipment
- Network links
- All drugs, medical equipment & consumables

A new Provider is not obligated to use existing sites but they are logistically and practically of use as they meet clinical and patient need requirements.

In the event the current facilities are used the new Provider will need to agree a licence for use with the relevant owner. Additional costs of new locations would have to be met within the financial envelope.

9 Service Exclusions

There are exclusions to the IUC Service within the geographical coverage and boundaries of the service.

The exclusion criteria below are based on the integrated service face to face treatment services but advice should be given from NHS111 or CAS as appropriate:

- People in police custody
- People who are prisoners in South Gloucestershire (but does cover prisoners in HMP Bristol)
- Any inpatient in acute hospital care (physical and mental health)
- Patients who are recorded on the violent patients register, for whom different arrangements are in place for primary care unless there is agreement
- A person requiring treatment for injury at the scene of a road traffic accident
- Women requiring intrapartum care
- Clinical conditions where it has been agreed with specialist services that the person needs to be cared for by a specialist service. In these instances the circumstances for groups or individuals need to be jointly agreed and may include agreement with Commissioners
- Drug & alcohol dependency: people with dependency should always be able to access the services but in relation to specialist help it is recommended that for methadone users a case by case decision is made with background advice, in line with protocols agreed with specialist services. There would be very few circumstances when on-going support is needed, but the Provider is expected to have an ongoing relationship with the providers of specialist support to agree and update working protocols
- Mental health: as above people with mental health needs must be able to access the service but the services should have agreed protocol in place to deal with exacerbations and acute mental health presentations. The use of shared records and SPN will be encouraged to provide the optimal care. The Provider is expected to have an ongoing relationship with the providers of specialist support to agree and update working protocol

Callers who access the Service from outside the boundary area via 111 must be treated in the same way as if they have made contact within BNSSG. It is the responsibility of the Provider to have made sure their DoS entries are accurate in

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term of details and communications routes to be used by all 111 service across the country**.**

10 Integrated Urgent Care Services Responsibilities

The Commissioner responsibilities will be to:

- Maintain an up to date NHS DoS and referral protocols with other service providers, including population of the NHS DoS which requires Commissioners to ensure all providers supply correct information and also update the live status of their service capacity. Providing tools to interrogate the NHS DoS, social care and voluntary databases as well as 'live' time capacity updates such as MiDoS
- Develop robust integrated provider assurance process which will review all aspects of the contract including finance, activity, quality and patient safety
- Develop community wide urgent care outcome indicators and a whole system approach for urgent care (over time in line with national guidance)
- Act as data controllers and will have access as required to all data
- Publicise IUC Service locally
- Ensure through robust commissioning that the SCR, special patient notes and end of life care records are up to date and available to IUC Service

Provider responsibilities are to delivery of a clinically safe, person centred services as required by this specification.

The Provider is required to operate according to the following principles:

- The use of a range of interactions with the patient to diagnose and treat, for example telephone / technology, face to face in a health facility or face to face by home visiting
- The ability to refer callers to other providers without the caller being re-triaged
- The ability to transfer clinical assessment data to other providers and book appointments where appropriate, assuming Interoperability Toolkit (ITK) as the route for transferring data
- A clinically diverse and experienced workforce model but with effective use of other members of the multidisciplinary team
- The provision of excellent and helpful management information and intelligence to commissioners regarding the demand and usage of non-emergency but urgent care services, enabling evidence-based commissioning and proactive support to be offered to specific client groups
- A business continuity and disaster recovery for local incidents and emergencies
- An improved patient experience because it has access to important health information and preferences such as that held in the NHS Summary Care Record, and End of Life (EoL) care registers
- The ability for callers with care plans, SPN and other arrangements to be easily identified and managed according to locally agreed pathways

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- Support a seamless service to ensure the patient is directed to the appropriate service irrespective of where the patient first contacts. (i.e. online NHS111, Telephone 111 or 999)

11 Service Management

The Provider must have:

- Detailed business continuity and disaster recovery procedures in place that will be followed in the event of service failure
- Business continuity and disaster recovery testing and associated schedules
- Demonstrable IT Infrastructure Library (ITIL) maturity levels or equivalent and have robust systems in place to monitor the application and to ensure that they can maintain full operations should an outage of the system occur
- The ability to produce detailed service management reports in accordance with ITIL (or equivalent) best practice
- Proactive monitoring and management of the information technology to ensure that problems are avoided or resolved quickly and that potential issues can be managed and prevented
- The ability to provide monthly service management reports containing the following as a minimum:
    - Availability reports
    - Capacity reports
    - Planned maintenance
    - Incident reports
    - Change Control reports
    - Failure Test reports
    - 'Live' time data feeds to NHS digital to support the use of the national IDT system.

12 Reporting Requirements and Principles of Performance Management

Performance Management

The approach to performance management is based on the following principles.

Evidence: Compliance with the requirements (and standards) can only be demonstrated through the production of appropriate evidence. In many cases such evidence can be submitted in writing or electronically, or through face to face meetings or visits. Failure to provide this evidence of performance will be treated as a performance breach with consequences.

***Multi-professional team approach*:** A team of well-informed outsiders will invariably identify opportunities for quality improvement that are unclear to insiders.

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Regular Reporting: The nature of the demands that arise in urgent care is such that regular reporting (sometimes daily) on a number of key standards is necessary to ensure the on-going safety of the IUC Service and the wider urgent care landscape. In this regular reporting, it is critically important that the data is disaggregated in such a way as to reveal the manner in which the service performs at different times of the day and days of the week, notably at peak times such as Saturday mornings and the third day of a Bank Holiday weekend.

Ad hoc Reporting: Commissioners are required to respond to requests from NHSE, Freedom of Information requests etc. that require ad hoc information and therefore Providers will need to respond as requested.

Partnership responsibility: reporting is a two-way process and there is an equivalent level of responsibility on the Commissioner to respond promptly and constructively to the reports that it receives as there is on the Provider to submit those reports.

Integrated Provider Assurance Meetings

The lead commissioner is Bristol CCG and they will appoint a contracts manager to oversee the management of the contract. The formal process will be through an integrated contract and quality performance meeting (ICQPM), initially to be held monthly but frequency may decrease over time.

The meeting brings together all aspects of assurance needed for the Commissioners and will include review of:

- Patient safety and quality
- Clinical governance
- Performance
- Finance
- Activity
- Key aspects of the service

A feedback mechanism will be implemented for the Service to ensure that Commissioners are made aware in real time of any issues or concerns about the provision of this new service.

Commissioners will ensure that any feedback received is forwarded to the Provider for investigation, responses are reviewed and a report will be cascaded to the responsible person for originally submitting feedback. Any improvements or changes to the Service, clinical or managerial will be overseen by the Commissioners through integrated performance review. Performance monitoring requirements are detailed below.

The Commissioner and Provider minimum datasets must be populated so that information and intelligence is provided to Commissioners to inform the on-going design and place of the IUC Service in their urgent care service. The datasets will also be used to monitor and report on the performance of the service and will be developed jointly by the Provider and the Commissioners, but will cover all indicators

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described in this specification and required nationally e.g. including Reporting Analysis and Intelligence Delivering Results (RAIDR), Intelligent Data Tool (IDT) reporting.

The Provider will also be expected to contribute to any national and local data collection as needed, for example the National Primary Care Foundation led national benchmarking exercise, and including amending their reporting in a timely fashion as national data reporting specifications evolve.

Privacy impact assessment / data protection impact assessment

A privacy impact assessment / data protection impact assessment must be undertaken by the Provider for the Service using the BNSSG template which will be provided. This is to ensure that patient identifiable information is being used and shared appropriately and that the anonymised or pseudonymised information is used wherever possible. The Commissioner and Provider will complete the PIA at the commencement of the service and provide regular annual reviews throughout the duration of the contract.

Reporting requirements

Commissioners have set out an initial framework of requirements for performance and quality monitoring (see appendix 2), including national and local indicators but need to be developed and agreed through the procurement process. These will be kept under regular review with the Provider to ensure that they effectively represent the performance of the service.

Requirements are organised as follows:

- Integrated Urgent Care Key Performance Indicators
- National Quality Reporting (NQR) requirements
- Local Quality Reporting (LQR) requirements
- BNSSG quality schedules
- A data dump of all data fields allowing comprehensive analysis by Commissioners will also be required

Compliance with Key Performance Indicators (KPIs) will be linked to payments, as outlined in the contract.

Data definitions will be agreed between Commissioners and the Provider before contract award.

National Quality Reporting requirements (NQR)

The IUC Service will deliver the National Quality Requirements for OoH and must be reported to Commissioners. Commissioners will be keen to work with the Provider to deliver more meaningful KPI’s where necessary but obligations for reporting and benchmarking must be adhered to.

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Key Performance Indicators (KPIs)

At the time of procuring the service there is a draft proposal from the National 111 team in relation to overarching key performance indicators which may take the place of other indicators in the system.

The Commissioners want to enter into dialogue with the Provider and with the wider system to explore the benefit of various indicators and also understand if some indicators will be stepped down to make way for new ones i.e. the national system indicators may take the place of NQR's for GP OoH services.

Therefore at this stage there are a range of possible indicators included for consideration but these will be refined during negotiation with the preferred bidder.

Indicators that apply currently include:

- National draft system wide indicators and data collection specifics
- National Quality Requirements for Out of Hours services
- Locally developed KPI's for BNSSG IUC Service (see appendix 2)

Equalities Monitoring

The Provider will gather equalities information on which patients are accessing the service, and use this information in conjunction with information about patient experience, to ensure the service is accessible to all.

13 Patient and Carer Experience

The Provider will be committed to developing an approach with commissioners to engage with patients and carers to test and evaluate the service. Service evaluation will include patient and carer experience, an understanding of patient aspirations for the service and an audit process to review that the patient comments have been acted upon.

Any approach to patient engagement should always:

- Ensure that the required sensitivity and confidentiality is applied
- Be targeted to the correct medium (i.e. using web only for those audiences that are digitally aware)
- Incorporate fresh opinion from the relevant audience

Commissioners would expect to have advance sight of any patient engagement activity and the express permission to be granted from the relevant CCG(s) where required.

Reports outputs and outcomes of any such activity would be shared with the relevant governance structure and Commissioners.

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There is an opportunity to:

- Work with existing multiple patient groups across BNSSG
- Work with 3rd sector on service developments that may include targeted and specific patient groups
- Offer opportunities for patients to “test” the service
- Invite comment on ideas for service development
- Develop local networks with Commissioners that include patients with a specialist interest in the service and have a sound understanding of the systems, limitations and challenges of the service
- Carry out workshops in depth interviews, focus groups, online communities, telephone interviews email, newsletters (list is not exhaustive)

The Provider must develop a fully integrated and collaborative patient engagement strategy.

The Provider will have a systematic process in place to regularly seek out, listen to and act on patient and carer feedback on their experience of using the service, ensuring that they deliver a patient centred service.

This must include:

- Clear and well publicised routes for patients, carers and health professionals to feedback their experience of the service
- Prompt and appropriate responses to that feedback
- Friends and Family Test
- Regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional insight into the quality of the service
- Systems in place to collate aggregate and triangulate feedback from a range of sources such as complaints, surveys, social media and online resources including NHS Choices
- Digital solutions for capturing patient experience should be explored (i.e. text and email)
- Monitoring patient experience survey results and develop action plans to improve performance
- A transparent approach that allows patients / users to see the views and experience of other patients and service users and the responses made by the service

Complaints and feedback

The Provider will need to consider any reported patient feedback, including patient complaints that have been made about the service. Any patient complaint will need to be processed and responded to in line with CCG’s policy.

The Commissioners also have a system for collating GP queries and feedback about services commissioned and any relating specifically to the service will be shared with the Provider as appropriate and discussed and the performance review meetings.

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14 Equality and Diversity

The public sector equality duty 2011 that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
2. Advance equality of opportunity between people who share a protected characteristic and those who do not
3. Foster good relations between people who share a protected characteristic and those who do not

These are sometimes referred to as the three aims of the general equality duty. The Act explains that having **due regard** for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

Providers should not discriminate between or against patients and carers 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.

All health services must be accessible, and the Provider must provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, verbal or learning impairments).

The Provider must carry out an annual audit of its compliance with this obligation through implementing the Accessible Information Standard and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result.

In terms of reducing inequalities service development should be guided by the needs to the most vulnerable in society. This includes those facing barriers posed by rurality, poverty, language, stigma and discrimination.

NHS providers are required to implement the NHS Equality Delivery System (EDS2) as a tool for evidencing progress on discharging their responsibilities under equality legislation. EDS2 has four goals:

- Better health for all
- Improved patient access and experience
- Empowered, engaged and included staff and

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- Inclusive leadership at all levels

Public bodies have a duty to consider the needs of all individuals in their day to day work in developing policy, in delivering services and in relation to their own employees which is encapsulated in the NHS Equality Delivery System with its specific patient and staff focussed goals and outcomes which came into effect in April 2012. This includes recoding demographic data relating to the protected characteristics which are:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Race including national identity and ethnicity
- Religion or belief
- Sex
- Sexual orientation and
- Pregnancy and maternity

The service must communicate contact information regarding vulnerable patients to their primary carer where there is known explicitly consent by the patient to do so.

15 Workforce Requirements

In order to deliver the IUC service, the clinical workforce will require specialised skills and competences as defined in the Integrate Urgent Care / NHS 111 Workforce Blueprint. Publications Gateway Reference 07132 was released in October 2017 and identifies roles that are necessary for the delivery of the IUC service. As the wider blueprint is developed, this section will be incorporated into the overall document. This will be a Document Relied On.

The Provider will be responsible for the sufficient recruitment and training of clinicians and supporting infrastructure staff to provide the service. The Provider is required to demonstrate their ability to recruit, train and manage an effective workforce within a comprehensive workforce plan and must demonstrate effective plans to manage sickness levels and retain skilled staff. The Provider must be able to demonstrate how it will play its part in the use of our primary care workforce across the system, supporting a co-ordinated use of our workforce.

The Provider is required to have sufficient staff available, of the appropriate calibre and skill mix, to meet the demands and maintain the key performance indicators at all times. This will be across the different times of day, night, week, season and time of year, including all bank holidays. Demand is variable with all of these factors but patterns of demand are broadly predictable.

The service is expected to have an experienced and competent person taking responsibility for forecasting demand and ensuring that the service is staffed sufficiently. In addition, the service is expected to have resilience options for increasing staffing at short notice to meet unexpected peaks in demand.

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The call handling role of the 111 telephony service can be very challenging, especially as call handlers are not required to have clinical experience or training, and are using a system to help direct people to the right services to meet their clinical needs. The Provider is expected that all training requirements and standards placed upon it by the system providers are adhered to. The Provider must be able to demonstrate that they have done as much as practically possible to ensure that all staff in the service are confident in their own practice but have the optimal clinical back up and operational capacity to support them in dealing with complex needs at all times.

In addition to the CAS role, clinical back up is required at all times for call handlers and clinical support also needed for peers in the various work settings. The Provider must provide clinical support for call handlers which offers direct advice and guidance and oversight, the role of clinical floor walkers should be available at all times in the service. It is important to the local Commissioners that opportunities for education and learning and development as well as ongoing audit are operationally available.

An overarching requirement is that all staff must be trained in recognising and dealing with vulnerable adults and children. The Provider must have in place approved policies which comply with statutory requirements. All staff must be trained in the recognition of safeguarding issues for children and adults and there are robust polices to support them.

A skilled workforce competent in caring for patients with all types of urgent health needs is expected but because of the high level of contacts relating to the needs of children, the Provider will need to be able to demonstrate a sufficient number of staff trained to meet the clinical needs for paediatrics.

Staff also need to be skilled in dealing with patients who may find the stresses of needing urgent care creates greater anxiety of confusion e.g. people with dementia, people who do not have English as their first language and people who are often marginalised by statutory services.

Staff in clinical roles should be practitioners registered with the relevant healthcare professional body. All staff involved in the delivery of the IUC Service must be able to communicate clearly and effectively with the local population at all times. Recruitment of staff should include an assessment of English language skills but provision, and associated training, should also be in place for staff whose first language is not English.

Working in urgent care environments can be challenging and stressful for staff and the Provider will need to be able to demonstrate their commitment to the physical and mental health and wellbeing of their staff.

Workforce and Employment Practice

The following information is designed to ensure the Provider is able to demonstrate that their workforce policies, processes and practices comply with all relevant

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applicable UK employment legislation and best practice (these provisions also apply to locums and sub-contractors).

The Provider must comply with the provisions of:

- The NHS Employment Check Standards
- The Code of Practice for the International Recruitment of Healthcare Professionals (2004)
- Care Quality Commission Outcomes Framework
- The Cabinet Office Statement of Practice (COSoP) for transfers of employees into or out of the public sector, and to transfers between different parts of the public sector
- IR35 Tax Regulations for Off Payroll Workers supplied by an intermediary

The Provider must also:

- Keep up to date with current applicable UK Employment and equalities legislation and associated codes of practice
- Keep an audit trail of Disclosure and Barring Service (DBS) checks which will be made available to the Commissioners on request (with renewals of checks being carried out at three yearly intervals)
- Ensure that there are robust arrangements in place to ensure that staff maintain their professional registration and revalidation requirements and that lapsed registrations are prevented
- Identify and address staff conduct and performance issues arising from patient complaints
- Ensure compliance with the Working Time Directive
- Ensure that robust induction and mandatory training programmes and clinical supervision as necessary are in place
- Appraise and assess the practical competency of all staff to carry out the duties of roles and manage their performance. The Provider must ensure that all staff (of all grades and professions) who are directly involved in supporting the service, have the necessary training, qualifications experience, competence, accreditation and skills to undertake their roles (and possess the necessary indemnity insurance)
- Ensure that staff will be adequately trained and competent to deal with medical emergencies safely and appropriately
- Ensure that there are contingency plans in place to cover for planned and unplanned absence
- Whenever applicable comply with the relevant legislation and guidance on staff transfers / transfer of undertakings (Protection of Employment) (TUPE)
- Whenever applicable the Provider shall comply with the Fair Deal for Staff Pensions and be aware of the Principles of Good Employment Practice

Where clinical staff are working at an enhanced level over and above that required to maintain professional registration (e.g. Extended Scope Practitioner, GP with Special Interest (GPwSI), Practitioners with Specialist Interest (PwSI), the Provider must ensure that these staff have the necessary training, qualifications, experience, competence, accreditation and skills to undertake these roles (ensuring that where

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necessary, external approval and / or accreditation for the provision of the service by this practitioner(s) has been obtained by the Deanery / relevant accrediting body. Appropriate supporting governance arrangements must be in place.

General Practitioners

The lessons from the "Take Care Now" case must be built into systems and processes for the recruiting and inducting staff before they start to provide the service.

The basic requirement is that all GP's performing Out of Hours services must:

- Have been DBS checked on appointment and the Provider must be aware and act upon its responsibilities to report any misdemeanours which could affect this status
- Be on the national GP performers list

The Provider must have confirmation of this with the relevant sub regional team of NHS England. If the GP had not gained their medical qualification in an English speaking country the Provider must ensure that an International English Language Testing System (IELTS) level 7 language certificates is provided and has been obtained in the last two years. Alternatively proof of an equivalent level of language competence should be provided. The GP should have been interviewed to establish their competency to provide out of hours services. The Commissioner will ask for evidence to demonstrate this has been achieved.

The GP should have their identity checked by the Provider - original documentation must be checked prior to the first shift. The GP must have undertaken a detailed induction programme on local policies and procedures. The GP must have completed a minimum of one session of service supported by a GP trained and qualified to supervise during out of hour's services, before being allowed to operate unsupervised. An appropriate further assessment should be carried out and supervision must continue if any concerns are identified. The Provider must have completed all the checks themselves and not relied on a third party agency.

Nurses and other clinical staff

All clinicians must hold a current registration with the relevant professional body and be able to demonstrate continuing professional development and relevant skills and experience in urgent care.

The Provider should indicate their proposed staffing structure (by category of performer) in their proposal. All supporting staff e.g. nursing, administrative must also be added. The bidder must state clearly how planned and unplanned leave and sickness will be covered for the duration of the contract.

The Provider must ensure that all, nurses and staff hold an up to date DBS check and are suitably qualified. The Provider must demonstrate that there will be appropriate staff appraisal and review systems and support for staff development and training to ensure continuing professional development.

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Training

The Service will be required to support GP registrars in undertaking sessions of providing Out of Hours services as part of their GP training. The Service shall be accredited by the local Deanery as a training organisation for GP registrars. GP registrars shall be supernumerary, and not relied upon for service provision.

The Service is required to demonstrate that they comply with South West Deanery requirements to support ongoing GP registrar education and training.

- The Service will be required to provide the Commissioner with shift capacity available to support GP training
- The Service will be required to report to the Commissioner the number of shifts covered by a GP trainer and a Registrar
- The Service will be required to demonstrate that Registrars have the opportunity to fulfil their out of hours training requirement of 72 hours per annum

Pay rates

The Commissioner will not dictate the pay rate of GP's or other clinicians but will be mindful of the pay rates required to attract a predominantly local workforce which is desirable for the service. This will be factored into the appraisal of any submissions for the service.

We would anticipate that the principle of working towards 'living wages' as opposed to national minimum wages is something the Provider would also aspire to and make progress towards.

Management and Clinical Leadership

The Provider will share with the Commissioners a detailed staffing structure of the service. This must set out the managerial, operational and clinical responsibilities for the provision of the service. Commissioners should be made aware of any significant changes in organisation structures.

16 Statutory Duties

This section highlights the key statutory requirements that the Provider will need to comply with.

Safeguarding and promoting the welfare of children

Section 11 of the Children Act 2004[9] places a duty on Clinical Commissioning Groups and other NHS bodies to safeguard and promote the welfare of children. Statutory guidance on this duty is available at: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[9] http://www.legislation.gov.uk/ukpga/2004/31/section/11

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The Provider will be responsible for compliance with their duty to make arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 and with statutory guidance in Working Together to Safeguard Children (HM Government 2015), and to follow the South West Child Protection Procedures (2013) – http://www.swcpp.org.uk

The Provider must have due regard to this guidance and have procedures in place to safeguard and promote the welfare of children.

Safeguarding vulnerable adults

The Provider will comply with Safeguarding Vulnerable People in the NHS – Accountability and Assurance NHS England 2015, the Care Act 2014 and the Prevent Strategy 2011.

Health providers are required to demonstrate that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Boards and in regular monitoring meetings with their commissioners.

Health providers must ensure staff are appropriately trained in safeguarding children, safeguarding adults, Prevent, domestic violence, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) at a level commensurate with their role and in line with the intercollegiate document 2014, and future guidance that may be produce to support training of staff.

All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate.
- A suite of safeguarding policies including a chaperoning policy
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competences 2014
- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect
- Effective arrangements for engaging and working in partnership with other agencies
- Identification of a named doctor and a named nurse for safeguarding children. In the case of independent providers, this could be a named professional from any relevant health or social care background. Also in compliance with section 11 of Children Act a named professional who has direct reporting to board level is required
- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled

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- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the Mental Capacity Act 2005 and the Children Act 1989 / 2004

Care Quality Commission

All providers of health services are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported.

The Providers must be registered with the Care Quality Commission at the commencement and for the duration of the contract.

Policies and Procedures

The Provider will be expected to put in place policies and procedures adhering to best practice and all relevant national guidance including in the following areas:

- Central alerting system - regarding alerts and urgent patient safety guidance
- Reporting and management of serious incidents
- Reporting and management of incidents and near misses
- Safeguarding children
- Safeguarding vulnerable adults
- Domestic abuse
- Reporting and management of complaints
- Evaluation, clinical audit and research
- Development, dissemination and implementation of evidence based guidelines
- Adhere to information Governance toolkit

As a key part of the contract monitoring there will be an expectation of tangible demonstration of learning from experience being embedded into practice.

17 Environmental Sustainability

The Commissioners recognise that its actions as an organisation have an effect on the local, regional and global environment. The Commissioners are committed to continuous improvement in environmental performance and the prevention of any actions that may cause damage to or do not support attempts to improve sustainability of the environment.

The Provider is expected to comply with environmental regulations, legislation and codes of practice as the minimum standard. This includes complying with the standards set out by the Sustainable Development Unit called "Sustainable Development Strategy for the Health and Social Care System" (2014)[10].

[10] http://www.sduhealth.org.uk/policy-strategy/engagement-resources.aspx

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The Provider will be signed up to the NHS Good Corporate Citizen Assessment Model and produce a Board approved Sustainability Development Management Plan and defined in the NHS Carbon reduction Strategy for England - Saving Carbon, Improving Health' NHS Carbon Reduction Strategy for England (January 2009)[11].

18 Emergency Care Networks and local urgent care governance

The Provider will be required to actively participate in:

- Daily system management
- System escalation
- A&E Delivery Board and associated structures
- Winter planning - mutual aid and ability to flex when the system is under pressure

Additionally all of the system resilience groups feed into a Severn Urgent and Emergency Network (SUECN).

19 Response in a Major Incident

The Provider 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 must take part in the response if required to do so by the PHE, Commissioner or multi-agency "gold" command structure.

The Provider must have mechanisms to be informed of a major incident by the NHS and other agencies and to give out the appropriate public health advice as directed by the PHE or the "gold" command arrangements which may be in place.

If a major outbreak of a serious infectious disease occurs, or there is a relevant health or civil incident, then the Provider will be an essential component of the response. It is expected that the Provider will be part of the NHS command arrangements. The Provider will respond as directed by the Commissioner.

The IUC Service must have:

- Staff trained to respond to a major incident at strategic level
- Major incident plans in place
- A programme of exercising and testing plans

As a key part of the contract monitoring there will be an expectation of tangible demonstration of learning from experience being embedded in practice.

[11] http://www.sduhealth.org.uk/policy-strategy/engagement-resources/nhs-carbon-reduction-strategy-2009.aspx

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20 Marketing and Communications

It is not evident that the public are always aware that primary care, including pharmacy, is available in the Out of Hours' time period and increasingly obvious that minor injury services, Walk in Centres etc. are not well understood.

The Provider will be required to demonstrate how it actively advertises to help people understand availability and what the IUC Service can offer and takes special effort to make contact with those groups who are often hard to reach.

It is expected that the models of delivery will embrace new technologies to offer a wide range of accessibility which may attract different patient groups. The Provider would also need to demonstrate how it interacts with other key service providers to provide accessible services. Relationships and options for innovative working with the care home sector are particularly of interest.

The challenge to all providers of urgent care in such a mixed environment is to help people understand their particular role and when best to use it.

The NHS 111 service will create change as people are directed to more and different options, but the expectations of the public around seven day services is challenging.

The Provider will be expected to demonstrate how it works with Commissioners and other urgent care providers to support patient choice whilst directing to the best service, which it is acknowledged, can be a difficult juggling act.

Reasonable adjustments should be made to ensure that all public information is easy to read and accessible to people. All organisations that provide NHS or publicly funded adult social care must identify and record information and communication needs with service users:

- At the first interaction or registration with their service
- As part of on-going routine interaction with the service by existing service users

Since 31 July 2016 all organisations that provide NHS or publicly funded adult social care must have fully implemented and conform to the Accessible Information Standard. The Provider is expected to demonstrate their compliance with this standard.

The Provider must ensure they train staff with regards to anonymous patients and have policies and procedures to support vulnerable individuals where anonymity could cause problems. The Provider should have measures in place to prevent the creation of duplicate records and to integrate or link identified duplicates, particularly for anonymous patients. The Provider must ensure they train staff in recognising and supporting users with additional needs to ensure equitable access to the service. Particular groups may find telephone based clinical triage services difficult and the Provider will be expected to demonstrate through their training of staff and protocols how these groups are supported, e.g. people with a learning disability or dementia.

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It is expected that the IUC Service will contribute towards providing information regarding the patient journey, developing case studies regarding patient experience and patient surveys to ensure patients have been provided with treatment where recommended. It is expected that patient experience will be collected and examined to determine if the service can be deemed ‘good’ from a patient’s perspective.

21 Demographic Information

The population total across BNSSG is 968,314, with 17.5% of the population living in the most deprived quintile areas of England (IMD2015), this equates to 164,613 people across BNSSG[12].

The expected growth rate over next 6 years is as below.

Population Change for South West

	(2017/18)	(2018/19)	(2019/20)	(2020/21)	(2021/22)	(2022/23)
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Bristol	0.98%	0.95%	0.87%	0.82%	0.79%	0.79%
North Somerset	0.99%	1.02%	1.01%	1.00%	0.99%	0.94%
South Gloucestershire	0.80%	0.83%	0.82%	0.78%	0.77%	0.77%
Source: Office for National Statistics, 2012 based population projections (2014)						

The IUC Service will be available in each BNSSG CCG, to everyone whether they are residents or visitors to the area.

There will also be reciprocal arrangements agreed with neighbouring Out of Hours services so that residents who live in border areas can access the closest possible treatment centre when needed. Providers will need to develop relationships with Bath and North East Somerset, Gloucestershire, Somerset and Wiltshire.

Bristol (JSNA 2016 - 17)

Bristol has the highest healthy life expectancy of all the Core Cities but for several health outcomes, the city performs poorly relative to the England average. Crucially, even on indicators where Bristol performs well overall, significant inequalities within the city remain and has several wards on the top 100 most deprived in England.

The population of Bristol is now almost 450,000 people and has grown at a faster rate than nationally, especially in the inner city. The population is relatively young with a high but falling birth rate, but there has been an increase in older people in the North and West inner locality. The city is increasingly diverse especially amongst children, and Somalia and Poland are the most common countries of origin for non-UK born mothers.

[12] https://www.bristolccg.nhs.uk/media/medialibrary/2017/07/PrimaryCareStrategy_FINAL.pdf November 2016

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Whilst life expectancy has shown a gradual improvement over the last 25 years, for men, it remains significantly below the England average. The gap in life expectancy between the most and least deprived areas of Bristol has increased in recent years for both men and women, although it is similar to the other Core Cities. Even for healthy life expectancy, the gap within the city is significant and compares unfavourably with other local authorities nationally.

Bristol's overall deprivation score has deteriorated in the last five years, although the city remains less deprived than most of the Core Cities. Average earnings in Bristol are above the Core City average but the gap between high and low earners is increasing.

North Somerset (JSNA 2015)

According to the 2014 Office for National Statistics (ONS) mid-year estimates, the resident population of North Somerset was 208,154. This figure is lower than the GP registered population of 215,010. It has been suggested that this discrepancy has occurred as the midyear estimates account for the number of residents living in North Somerset, whereas the GP registered estimate accounts for people registered with a North Somerset GP. These people may live slightly outside the North Somerset catchment area but go to the doctors in North Somerset hence will also be included in the figure.

The population of North Somerset is less ethnically diverse than England and Wales with 97% of people living in North Somerset classifying themselves as belonging to a white ethnic group, a decrease of one percentage point since 2001. Of those from a black or minority ethnic group 44% classified themselves as Asian and a further 37% classified themselves as mixed race.

In terms of the Indices of Deprivation (ID) 2015, North Somerset has 18 areas in the most deprived quartile in the country. All of these areas are in Weston-super-Mare. There are areas in North Somerset within the most deprived 1% nationally and within the least deprived 1% nationally. This results in North Somerset having the 3rd largest inequality gap out of the 326 English districts (calculated using the difference between the highest and lowest area scores in a district).

South Gloucestershire (2016)

South Gloucestershire currently has a total resident population estimated to be 275,000 (ONS 2015-based mid-year estimate) South Gloucestershire is predominately rural although most of the population live in the urban areas. The South Gloucestershire population has grown over the past decade by 10% and is projected to rise by a further 17% by 2037. The biggest increases will be in the older age groups. At least 30,000 new homes are planned to be built by 2036 in South Gloucestershire. The level of deprivation in South Gloucestershire is generally very low with the majority of areas being among the least deprived nationally. However pockets of overall deprivation exist, and deprivation related to access to services and education add complexity to the picture.

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Overall health in South Gloucestershire is good and has been improving. Life expectancy is higher than the national average and has been rising. Mortality rates for most diseases, including cancer and heart disease, are below the national average and have fallen over the last decade. Those living in deprived areas continue to experience comparatively poor heath, with a life expectancy gap of 6.3 years for men and 5.1 for women between the 10% most affluent and least affluent areas within South Gloucestershire.

The Joint Strategic Needs Assessments for Bristol North Somerset and South Gloucestershire can be found on the links below.

Bristol Joint Strategic Needs Assessment (JSNA)
https://www.bristol.gov.uk/policies-plans-strategies/joint-strategic-needs-assessment-jsna

North Somerset Joint Strategic Needs Assessment (JSNA)
http://www.n-somerset.gov.uk/my-council/statistics-data/jsna/joint-strategic-needs-assessment/

South Gloucestershire Joint Strategic Needs Assessment (JSNA)
http://www.southglos.gov.uk/health-and-social-care/staying-healthy/health-strategies/joint-strategic-needs-assessment-jsna/

BNSSG health facilities / services information

Local Area Services
Across BNSSG there are three EDs, two in Bristol and one in North Somerset. Each CCG area has a local community services provider however NHS111 and GP Out of Hours services span the whole of BNSSG.

Weston in North Somerset is a holiday destination and the visitor population can expand rapidly, and sometimes in periods of unexpected good weather this seasonal change can be very rapid.

There are two large universities in Bristol and many higher education colleges across BNSSG which attract large numbers of students, many of whom do not know their way around our local health system and are of a generation that expects to have clear and quick responses when necessary. The University of Bristol Student Health Service offers a full range of NHS primary care services to students and their dependents.

This is intended to support the bidders in understanding the environment in BNSSG in which an IUC Service is expected to make a significant contribution to the urgent care landscape.

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BNSSG - wide services
Below is a summary of the key BNSSG wide services. This list is not exhaustive and there are other services within each locality.

Acute hospitals

- North Bristol NHS Trust (known as Southmead Hospital)
- University Hospitals Bristol NHS Foundation Trust (including Bristol Royal Infirmary, Bristol Royal Hospital For Children, Bristol Haematology and Oncology Centre, Bristol Heart Institute Clinical Services, Bristol Eye Hospital, University of Bristol Dental Hospital, St Michaels Hospital and South Bristol Community Hospital)
- Weston Area Health Trust (known as Weston General Hospital)

Mental Health Providers

- Avon and Wiltshire Mental Health Partnership

Community Service Providers

- Bristol Community Health CIC
- North Somerset Community Partnership
- Sirona care and health CIC

Minor Injury Units (MIUs) & Walk in Centres (WiC)

- Broadmead WiC
- North Somerset Community Hospital MIU
- South Bristol WiC
- Yate MIU

Social Care Providers

- Bristol City Council
- North Somerset Council
- South Gloucestershire Council

Ambulance Services

- South Western Ambulance Service NHS Foundation Trust (SWASFT) - 999 emergency service
- E-zec Medical Transport Services Limited – non emergency patient transport services (PTS)

22 Service Information

Additional information may be requested by bidders to assist with development of bids, information requested by one bidder will be shared with all other bidders.

As much data will be provided as is practically possible for the bidders to be able to use to determine the capacity needed to meet usual and surge demand for the population and the projected utilisation of the service. The following may be available upon request:

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- Activity data
- Sitrep data for NHS111
- Contract performance data for NHS 111
- Mapping data for OoH Service
- Map of locations for BNSSG of OoH Services

23 Documents Relied Upon

To avoid extending the content of the specification bidders should be aware that there are key documents, which include national standards which must be expected to be the minimum standard for the delivery of the IUC Service. Providers are required to meet the service requirements standards set out in these documents. The list below is not exhaustive but should be used as a guide.

This specification is underpinned by a number of key national documents relating to the developing integrated urgent care models. This specification does not attempt to replicate these, but highlights the key issues for BNSSG.

A new Integrated Urgent Care Service specification from NHS England is due to be published in 2017 and the Provider must meet the requirements set out in this document once published.

Key documents include:

Integrated Urgent Care Service Specification 25 August 2017
https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf

NHS 111 Commissioning Standards June 2014
https://www.england.nhs.uk/wp-content/uploads/2014/06/nhs111-coms-stand.pdf

Integrated Urgent Care Key Performance Indicators
https://www.england.nhs.uk/wp-content/uploads/2016/11/iuc-kpi-nov16.pdf

Commissioning Standards Integrated Urgent Care
https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf

Urgent Treatment Centres – Principles and Standards July 2017
https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

NHS 111 National Business Continuity Escalation Policy 2014
https://www.england.nhs.uk/wp-content/uploads/2014/02/nhs111-escl-pol.pdf

NHS 111 Minimum Data Set specification v0.901 November 2016
https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/

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National Quality Requirements for Out-of-hours Services 2006
http://webarchive.nationalarchives.gov.uk/20130123210223/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137271

NHS 111 Clinical Governance Toolkit 2015
http://webarchive.nationalarchives.gov.uk/20161103214538/https://www.england.nhs.uk/wp-content/uploads/2015/03/nhs111-clincl-govrnce-tool-kit.pdf

CQC NHS GP practices and GP out-of-hours services Provider Handbook 2015
https://www.cqc.org.uk/sites/default/files/20150327_GP_practices_provider_handbook_appendices_march_15_update.pdf

Royal College of General Practitioner Urgent and emergency care clinical audit toolkit
http://www.rcgp.org.uk/clinical-and-research/clinical-resources/urgent-and-emergency-care.aspx

Records Management code of practice for health and social care DoH July 2016
https://digital.nhs.uk/information-governance-alliance

NHS E Urgent and Emergency Care Delivery Plan April 17

UEC Delivery Plan April 17

NHS E Integrated Urgent Care: Guidance on the Implementation of a Clinical Hub

IUC Guidance Clinical Hub

NHS E Integrated Urgent Care / NHS 111 Workforce Blueprint

20171013 IUC_NHS 111 Workforce Bluepr

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24 Contract Requirements

One contract will be issued for this service. The NHS standard contract in force at the time will be the contract used for the service. Bristol CCG will act as the lead commissioner on behalf of the three CCG’s if they have not merged into one, and The contract length is expected to be 7 years with potential for extension for any number of periods up to a maximum of 3 years. The contract is expected to be

signed to commence service delivery on the 1st April 2019 but the date to be determined dependent on public holidays.
At this stage it is expected that the full service as detailed within the final specification will become operational on this date but there will be some flexibility in extended mobilisation if agreed by the Commissioners and Provider as the right solution for the community.

The contract value is expected to be designed in accordance with the national guidance set out in the Monitor Guidance – Urgent and emergency care – a potential new payment model.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/452925/UEC_LPE.pdf

Use of Subcontract or Outsourcing

The success of the model will be dependent on a transparent working relationship between the parties, particularly around the performance of the Provider and any sub-contractors that are used. Providers will be required to identify any sub -contractors that will be relied upon to deliver the services within the Selection Questionnaire. Sub-contracting arrangements will also form a part of any awarded contract. The Commissioner recognises that sub-contracting arrangements may be subject to change and therefore the Provider should notify the Commissioner immediately of any change in the proposed arrangements. The Provider will be responsible for ensuring timely and robust reporting from any of their sub-contractors used.

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

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

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

25 Future Requirements

NHS 111 Online
There is a requirement for NHS 111 Online to be delivered as part of the Next Steps on the NHS Five Year Forward View published in March 2017.

The technical and financial implications of this are unknown at this stage but the Provider must be willing to work with Commissioners to enable access to NHS 111 via the web in the future.

Post Event Messaging
Post event messaging needs to be informative and easy to understand. The Provider will need to work with Commissioners, other providers and NHS Digital to ensure continued improvement of PEM.

26 Quality

National Outcomes

The provision of a high performing, safe and effective delivery of an IUC service can be mapped to the following domains within in the NHS Outcomes Framework[13]

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/513157/NHSOF_at_a_glance.pdf

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Local Outcomes

The locally defined outcomes are listed below and will form part of the negotiation process.

Outcome 1 – Service User Experience

- People will have a positive experience of care and support
- Everyone is treated as individuals in accordance with their needs and in a way that is free from discrimination
- People experiences a service which meets their needs and promotes independence and quality of life
- People feel empowered to manage their own health

Outcome 2 – Service access

- Services are accessible, equitable, sustainable and flexible for all patients, regardless of geography or diagnosis

Outcome 3 – Communication

- Communication is clear and information is provided in appropriate formats
- The service communicates in an inclusive, open and honest, easily understood manner so that people are respected, involved and informed about their care

Outcome 4 – Integration of Services

- Services are managed and delivered as locally as possible so they can integrate more easily with other local services

Outcome 5 – Delivery of safe, high quality, evidence based services

- The service is knowledgeable, high quality, evidence – based, safe and delivered at the right time, in the right place by the right people, by a trained workforce
- An information technology system allows the seamless transfer of / access to appropriate clinical across all services

Outcome 6 – Workforce Requirements

- There will be clear leadership, accountability and assurance and will work in partnership with other organisations for the benefit of the patient
- The service listens to feedback received throughout to ensure that they continue to learn, develop and implement changes.
- There is greater cultural awareness so professionals can better understand the communities they work with
- Cultural competence is reinforced through continuous professional development and overall organisational performance against equality objectives

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27 Appendix 1 Glossary

Term	
A&E	Accident and Emergency
ACD	Automatic Call Distributor
ARP	Ambulance Response Programme
BNSSG	Bristol, North Somerset, South Gloucestershire
CAS	Clinical Assessment Service
CCG	Clinical Commissioning Group
CDA	Clinical Data Architecture
CDSS	Clinical Decision Support System
CIC	Community Interest Company
CLI	Calling Line Identity
CMS	Capacity Management System
COSoP	The Cabinet Office Statement of Practice
CQC	Care Quality Commission
DBS	Disclosure & Baring Service
DDI	Direct Dial Inwards
DOH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DoS	Directory of Services
ECG	Electrocardiogram
ED	Emergency Department
EoL	End of Life
EPS	Electronic Prescribing Service
EDS	Equality Delivery System
GMC	General Medical Council
GP	General Practitioner
GPwSI	General Practitioner with Special Interest
HCP	Health Care Professional
HMP	Her Majesty's Prison
HSCN	Health and Social Care Network
IBH	Inspired Better Health
ICB	Integrated Care Bureau

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ID	Indices of Depravation
IDT	Intelligent Data Tool
IELTS	International English Language Testing System
IG	Information Governance
IM&T	Information Management and Technology
INR	International Normalised Ratio
IT	Information Technology
ITIL	Information Technology Infrastructure Library
ITK	Interoperable Tool Kit
IUC	Integrated Urgent Care
IVR	Interactive Voice Response
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LQR	Local Quality Requirement
MCA	Mental Capacity Act
MIU	Minor Injury Unit
NHS	National Health Service
NHS 111	A national single point of access for unscheduled care - a free to call service available 24-7 that helps patients, via a call-handler using DoS, to find the most appropriate service available to them based on distance and medical needs.
NUMSAS	NHS Urgent Medicine Supply Advanced Service
NQR	National Quality Requirements for the Delivery of OoH Services
ONS	Office of National Statistics
OoH	Out of Hours
PCC	Primary Care Centre
PDS	Patient Demographic Service
PEM	Post Event Message
PGD	Patient Group Directions
PwSI	Practitioners with Special Interests
RAIDR	Reporting Analysis and Intelligence Delivering Results
Referral	Transfer of care for a patient between services, where there is an agreed protocol for doing so and the arrangements for sharing data and transferring responsibility are in place.
Re-triage	Triage is the process of prioritisation. Re-triage is defined as a caller being re-assessed on receipt of the referral by a call advisor or clinician with a view to re-prioritising the patient (see Triage).

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SCR	Summary Care Record
Self-care	Actions and attitudes which contribute to the maintenance of well-being and personal health and promote human development. In terms of health maintenance, self-care is any activity of an individual, family or community, with the intention of maintaining health or wellness, improving or restoring health, or treating or preventing disease.
Self-care	Management of a patient's symptoms by themselves, without further contact with the health service unless their condition worsens or their symptoms persist for 3 or more days.
SDIP	Service Development Improvement Plan
SUECN	Severn Urgent and Emergency Network
SWASFT	South Western Ambulance Service Foundation NHS Foundation Trust
Signposting	Directing a caller to another service that is outside the scope of NHS 111 and therefore no referral protocol exists.
SLA	Service Level Agreement
SMS	Short Message Service
SPA	Single Point of Access
SPN	Special Patient Notes
STP	Sustainability and Transformation Plan
Triage	A process of prioritisation. When a caller contacts NHS 111 and is triaged as needing to receive services from a primary care organisation, it is up to that receiving organisation to determine how they provide services to that patient (e.g. GP phone consultation or GP clinic appointment).
TUPE	Transfer of Undertakings (Protection of Employment)
UCC	Urgent Care Centre
Urgent healthcare	The range of healthcare services available to people who require, or who perceive the need for, medical advice, diagnosis and / or treatment quickly and unexpectedly.
Warm transfer	A telephone call that is transferred from one individual to another (usually call advisor to clinician in the context of 111) while the caller is still on the line. The clinician acknowledges the transfer of the caller prior to the advisor backing out of the call
WiC	Walk in Centre

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28 Appendix 2 Local Quality Reporting Requirements

The following table of LQRs must be delivered and reported as specified. These are in addition to the Integrated Urgent Care Key Performance Indicators https://www.england.nhs.uk/wp-content/uploads/2016/11/iuc-kpi-nov16.pdf

Compliance with any national reporting requirements now and in the future, including Reporting Analysis and Intelligence Delivering Results (RAIDR) and the Minimum Data Set (MDS), is essential.

Ref	Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	KPI
Quality						
LQR 1	The patient will receive the right outcome at the right time and in the right place reducing the number of repeat calls because a patient could not access care from service referred to e.g. closed	90%	% of patients accepting the first or second service type from the DOS Clinical audit is also undertaken to demonstrate remedial actions taken to address gaps/changes required in service delivery/availability	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	

LQR 2	Review of patient journey from end to end incorporating NHS 111, OoH, SWAST and hospital provider is undertaken to ensure learning takes place across the system.	Quarterly review meeting	Quarterly report. Evidence of learning embedded within practice. Evidence of participation in multi-agency Reviews Evidence of responding to issues identified during Reviews	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 3	Where a patient refuses the recommended service, the Provider records the reason for refusal	95%	% refused dispositions recorded with breakdown by category avoiding the use of “other” as a category	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	

LQR 4	Patients will be referred to the local community pharmacy for repeat prescription requests	10%	% of repeat prescriptions sent to GP OoH service with a clearly identified and documented clinical rationale	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
LQR 5	Only patients that require immediate clinical intervention on route to hospital or require the facilities of an ED will be referred to 999 or ED	70% (To be agreed)	% of green ambulance and ED outcomes validated by a clinician before final disposition is confirmed	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
			Reduction in number of patients attending ED			
LQR 6	Working with other agencies to reduce the total number of contacts made by individual frequent callers each month (as per national definition)	Baseline figure to be captured and improvement target to be agreed.	Reduction in the total number of top ten frequent callers' contacts received each month.	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	

LQR 7	To reduce the number of patients not attending appointments at PCC to maximise use of available resources	Baseline figure to be captured and improvement target to be agreed.	Reduction in the DNA rate at PCCs	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
LQR 8	The appropriate clinical skill mix is employed in the CAS to meet patient need		Quarterly workforce report will demonstrate improvements to clinical skill mix Quarterly workforce report to show variance in shifts, actions taken and impact	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	

LQR 9	Evidence to demonstrate culture of self-help and therefore reducing dependency on the healthcare system	TBA	% patients referred to self-care or a lower level disposition	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
LQR 10	Enhance the patient pathway and expedite care by directing more calls directly to a clinician after module zero	95%	Number and percentage of under 2 year old and over 85 year olds that are directed to a clinician triage	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
			Work with commissioners to identify groups of patients for whom direct transfer to a clinician is the best care pathway	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	

LQR 11	Evidence of the IUC service working with other services to reduce patient demand working with primary care in extended hours to decrease gaps in service provision and avoid duplication		Quarterly quality report	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
	Evidence of the IUC service working if necessary with other urgent care services to shorten the patient's journey and / or improve access to alternatives to secondary care					
LQR 12	Sharing of information between healthcare professionals within and outside the IUC service		Evidence of service where the full patient record/notes is fully accessible by all clinicians	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
			Evidence of the completeness of the IUC staff notes in relation to the patient episode			
			Evidence of PEMS or patients notes being in a user friendly format	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	

LQR 13	Introduce and evaluate new technology to improve patient access to the service and care		Discussion of proposals, appropriate plan and quarterly reporting	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)		
LQR 14	All staff will complete mandated training annually.	100%	Numerator: Number of staff to have undertaken mandated training Denominator: Number of staff	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 15	Appropriate safeguarding policies are in place for adults and children		Quarterly safeguarding report Annual review of the safeguarding policies procedures			

LQR 16	All new staff will complete safeguarding training for adults within the first month of employment.	100%	Numerator: Number of staff to have undertaken safeguarding training (at each level) Denominator: Number of staff who are required to undertake safeguarding training (at each level)	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 17	All non-clinical staff will complete level 2 safeguarding children training within the first month of employment.	100%	Numerator: Number of staff to have undertaken safeguarding training (at each level) Denominator: Number of staff who are required to undertake safeguarding training	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 18	Relevant staff will complete level 3 Safeguarding children's training within the first month of employment.	100%	Numerator: Number of staff to have undertaken safeguarding training (at each level) Denominator: Number of staff who are required to undertake safeguarding training (at each level)	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	

LQR 19	All staff will complete Mental Capacity Act training within the first month of employment.	100%	Numerator: Number of staff to have undertaken MCA training Denominator: Number of staff required to undertake MCA training	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 20	All staff will have been Disclosure and Barring Service (DBS) vetted and passed prior to employment in accordance with the / Provider Policies.	100%	Numerator: Number of staff to have been DBS vetted Denominator: Number of staff required to be DBS vetted	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 21	The vacancy rate for non-clinical staff will remain below 8%	<8%	Numerator: FTE in post Denominator: Establishment	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	

LQR 22	The vacancy rate for clinical staff will remain below 5%	<5%	Numerator: FTE in post Denominator: Establishment	Standard contract performance measures	Quarterly	
LQR 23	Overall Sickness absence will remain below 6%	<6%	Numerator: FTE days lost Denominator: Establishment	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
LQR 24	Audits will be completed within the terms of the CDSS licence.	As per licence	Numerator: Number of calls audited Denominator: Number of calls taken	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	

Patient Experience / Involvement						
LQR 25	Patients will receive timely response to their contact with the service	All 999, ED and GP 2 hour dispositions following clinical assessment.	Calls will be audited monthly for any patient waiting longer than 2 hours on initial telephone contact for a clinician call back to ensure the safety of the telephone service and reduce risk / harm to patients.	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
LQR 26	Patients will be proactively involved in service continuous improvement both performance and quality through focus groups, surveys and feedback.		Quarterly report	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 27	Patient satisfaction surveys will be undertaken: The equivalent of 200 patients per month will be sent the questionnaire including friends and family test (FFT)	25%	Numerator: Total number of callers to 111 invited to fill out patient satisfaction questionnaire Denominator: Total number of callers to 111	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	

LQR 28	An increasing number of patients who describe the quality of service received as "Good" or "Very good"	85%	% of patients who describe the quality of service received as "Good" or "Very good"	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 29	Patients are treated as individuals in accordance with their needs and in a way that is free from discrimination		Patient survey, Equalities reporting	Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Quarterly	
LQR 30	Responsive to feedback and can demonstrate learning from it including serious incidents, complaints and health professional feedback.	90%	Percentage of complaints resolved first time Percentage of patients not satisfied with response including PHSO reports	Standard contract performance measures Local Improvement Plan (with agreed trajectory / tailored timeframe for completion)	Monthly	
			Quarterly report			