

111



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The Telephone Service

- Consistent clinical assessment
- Warm transfer
- Ambulance dispatch
- Appointment booking



Consistent Clinical Assessment

- In the three pilots to date this is NHS Pathways
- 60 hours training
- Period of consolidation
- License requirements
- Dedicated staff



Warm Transfer

- Keeping the caller on the line
- No call backs or only in exceptional circumstances and then called back within 10 minutes
- Increased staffing capacity required by up to 60%

Ambulance Dispatch

- At the point a 999 disposition is reached and agreed a message needs to be sent to the relevant ambulance service dispatch queue
- Assessment system needs to map to ambulance categorisation system i.e. Cat A – 8 or 19 minute, Cat B or Cat C
- National messaging specification written by CfH
- Staff in the 111 service provide pre-arrival advice where required
- Ambulance service don't talk to the patient
- Also need to pass scene safety information to the AT when this is collected



Appointment Booking

- From the initial assessment
- In East Midlands the call is warm transferred to the OOH's provider
- In East of England the appointment is booked within NHS Direct



The Onward Journey

- Over to Alison from NEMS Community Benefit Services Ltd.

Nottingham City '111' Pathfinder

Early Days Experience

GP OOH Provider Perspective



Background - Nottingham City Pathfinder

- Urgent Care focus; links NHS D with NEMS GP and other Nottingham 'urgent care' services
- NEMS & NHSD already contractual partners in GP OOH
- Nottingham City only- 62 practices; 337,000 (48% pop covered)
- NHS Pathways and CMS DOS in use
- Patients ringing surgery number; no change in call volume - yet
- 111 'soft launch' on 11 Nov and 'live launch' on 18 Nov



Caveats

- Very early days (6 weeks)
- Pathways is consistent and uniform - one size fits all
- Provider configuration within health economies is not
- Lessons learned not necessarily transferable to others

Key Steps Along The Way

1. Populating CMS DOS (OOH and local health community)
2. Understanding Pathways; anticipating impact on 'business as usual'
3. Mapping Pathways outcomes to Adastra codes
4. Training needs and training delivery - NHS D and NEMS staff
5. Testing connectivity - telephony, Adastra, DOS
6. Testing 'warm transfer' process
7. Testing, re-testing, making changes
8. Go -live Pathways/DOS 28th September
9. All 62 practices involved by 20th Oct
10. 111 switched on 11 Nov
11. 111 local marketing 18 Nov

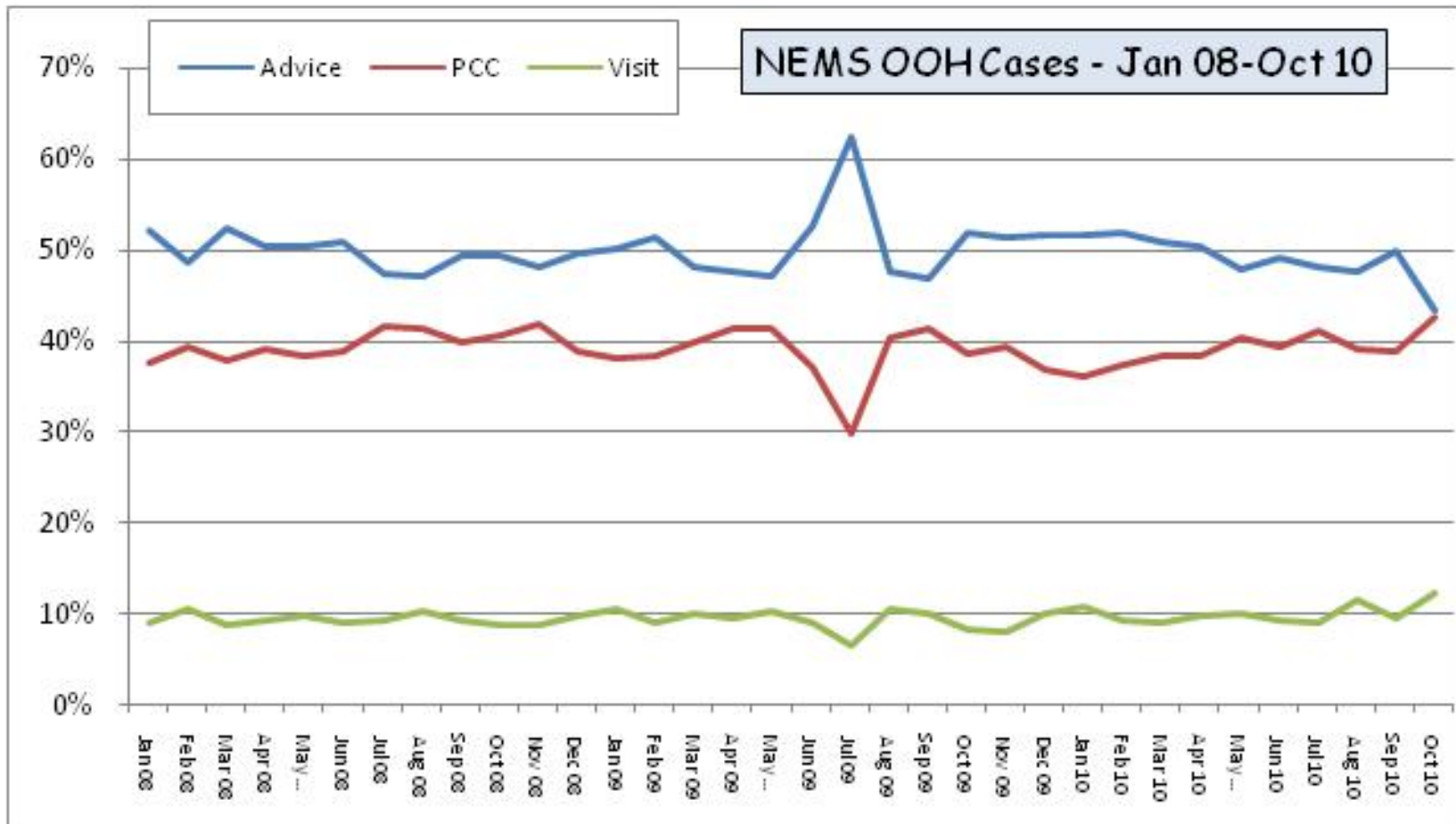
1. Populating DOS

- Scale of the task - do not under-estimate this
- 82 clinical templates
- Knowledge of Pathways - DOS logic is not transparent
- Clinician input- someone 'hands on', with governance role

- Clever- but not sophisticated
- No 'calendar' function
- Not 'time sensitive'
- Save a copy of your completed templates

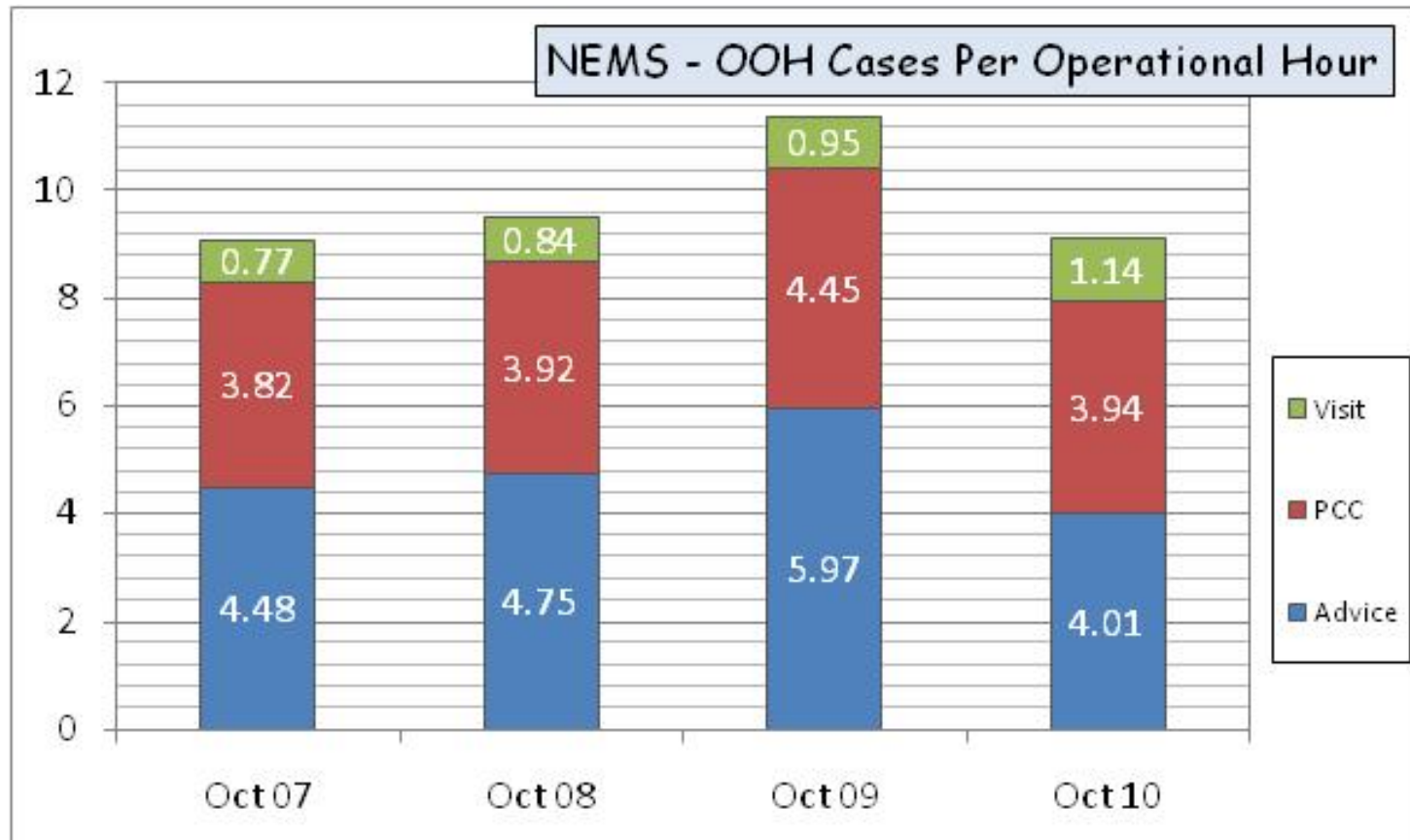
2. Anticipating Impact on Business as Usual [1]

- NEMS has robust data on steady state (2009 - swine flu 'blip')

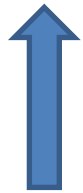


2. Anticipating impact on Business as Usual [2]

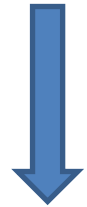
Caveat - early days but - if this is the start of a trend . . .



2. Anticipating Impact on Business as Usual [3]



Face to face contacts at base and at home	Telephone advice consultations
Appointments at our base	Calls ending in self-care advice
Home visits	Urgency
Consultation time (f 2 f)	
Costs – clinicians, drivers, training	
Risk to patient safety	
Difficulty meeting QRs	



3. Mapping Pathways to National QRs for GP OOH

- Pathways not specifically designed for urgent care
- All outcomes have to map to existing NQRs

see in	6 hours	⇒	QR12 less urgent see in 6 hours
see in	12 hours	⇒	
see in	24 hours	⇒	
see in	48 hours	⇒	
see in	3 days	⇒	

speak to in	1 hour	⇒	QR9 less urgent speak to in 1 hour
speak to in	2 hours	⇒	
speak to in	6 hours	⇒	
speak to in	12 hours	⇒	
speak to in	24 hours	⇒	

3. Mapping Pathways to National QRs for GP OOH

- Adds pressure to start of OOH session, weekends and BHs
- Leads to increase in DNAs & dissatisfied patients, especially early hours
- Potential risk to patient safety and provider contracts

The Concept of Relative Urgency

When is urgent not urgent?

Saturday, 23:48

Directed to see a 72 yr old housebound patient with a painless marble sized lump on her leg

Lump there for 2 weeks and the patient wanted to know what it was.

Pathways disposition 'see GP within 24 hrs' = 'see within 6 hrs'

Home visit at 02:00 to give reassurance likely to be a lipoma.

Presented with this call ourselves, we would have managed it with telephone advice.

4. Training and Workforce Issues

- Nurses trained in use of F2F software
- Building up experience of seeing patients at our base
- Extended range of PGDs required
- More non-medical prescribers required
- Rostering to ensure F2F and telephone capability every hour
- Non- GP visiting resource

When Your Turn Comes

Do not under-estimate the time needed to:

- understand and populate DOS
- understand implications of 'mapping' Pathways to OOH outcome codes
- train your staff
- test system connectivity
- identify, report & rectify clinical & operational 'issues'

Or the impact on:

- data quality and 'analysis time'
- reporting GP OOH NQRs
- 'back -end' costs (clinical, analytical, management)
- your OOH contract and staff

Looking to the Future

NHS Pathways	CMS DOS
Pathways mapping to OOH QRs must be rationalised to remove longer timeframes or give OOH providers greater discretion in how these cases are managed	Staff populating clinical templates must understand how NHS Pathways works in some detail
Revisit concept of urgency as a 'constant'	Clinical Templates need to be very much more intuitive / user friendly
Local protocols must be restored - the one size fits all' approach is not workable in the real world of urgent care	Needs to be 'time sensitive'
	Needs a calendar function

Looking to the Future- Provider Safeguards

Provider Safeguards

Overrule a Pathway disposition where a pre-existing management plan is in place (e.g. frequent callers, abusive/violent patients)

Exercise 'duty of care' for clinical governance purposes (e.g. providing telephone clinical assessment for patients refusing 'face to face' or DNAs)

Use local protocols – even if this conflicts with the Pathway outcome

Closing Thoughts

Planning to take 111 calls and provide a GP OOH response?	Just on the receiving end?
Infrastructure for dealing with calls that are 'not yours to deal with'	Will future commissioners use '111' as the front end of GP OOH?
Governance and risk associated with calls that are 'not yours to deal with'	Will you have contract and TUPE issues (call handling staff)?
Complaints	How do you manage costs and performance as a 'back end responder'?
	How will providers report on the National QRs if '111' does the front end?
	How will you handle complaints?