NHS England

Integrated Urgent Care
Key Performance Indicators 2016/17

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Contact Details for further information	Integrated Urgent Care Delivery Team Quarry House Quarry Hill Leeds LS2 7UE Email: england.integratedurgentcare@nhs.net

Document Status

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Integrated Urgent Care

Key Performance Indicators 2016/17

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Contents

1 Executive Summary

1.1 Strategic context

The introduction of Integrated Urgent Care is a direct result of the Urgent and Emergency Care Review (2013) and its proposal for a radical shift in care to a 24/7 functionally integrated access, assessment, advice and treatment service. It is not simply the bolting together of existing services (NHS 111 and GP Out of Hours) but in fact the introduction of a new, functionally integrated service that includes a new clinical advice element: the clinical hub.

New data will be required to measure this Integrated Urgent Care (IUC) service.

1.2 Contents of the paper

The paper starts by describing further the background context and requirement for the new service, and the requirement for data. It goes on in Section 3 to describe the process by which the metrics were developed, and displays a framework which groups the data into tiers of priority.

Section 4 outlines the processes by which data will be collected, including timing and financial implications. Section 5 contains the broad next steps needed to start producing data.

Appendix A gives the specification, sources and accompanying issues for the new Key Performance Indicators (KPIs) that are designed to show whether the service is being delivered successfully. Appendix B lists the full data that will be collected regularly by NHS England, including the KPIs. Appendix C shows how the KPIs supersede existing measures. Appendix D recommends further data items that will assist with monitoring of the service.

1.3 Action required

As detailed within standard contract, providers of IUC services are expected to work with commissioners to supply the new set of KPIs in Appendix A and the additional items in Appendix B.

2 Context

2.1 The Urgent and Emergency Care Review (UECR)

Phase 1 of the UECR was published in November 2013, outlining proposals for a radical shift in care, with more extensive services outside hospital and a change in the way that patients access emergency care. It states that we must help people with urgent care needs to get the right advice in the right place, first time.

The proposal to achieve this was to greatly enhance the NHS 111 service so that it became the smart call to make, and creating a 24 hour, personalised priority contact service. This enhanced service would have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare

professional if that was the most appropriate way to provide the help and advice they need.

Phase 2 of the review proposed a new urgent care service, functionally integrated, centred on a clinical hub, easily accessed, and providing assessment, advice and treatment (Figure 1).

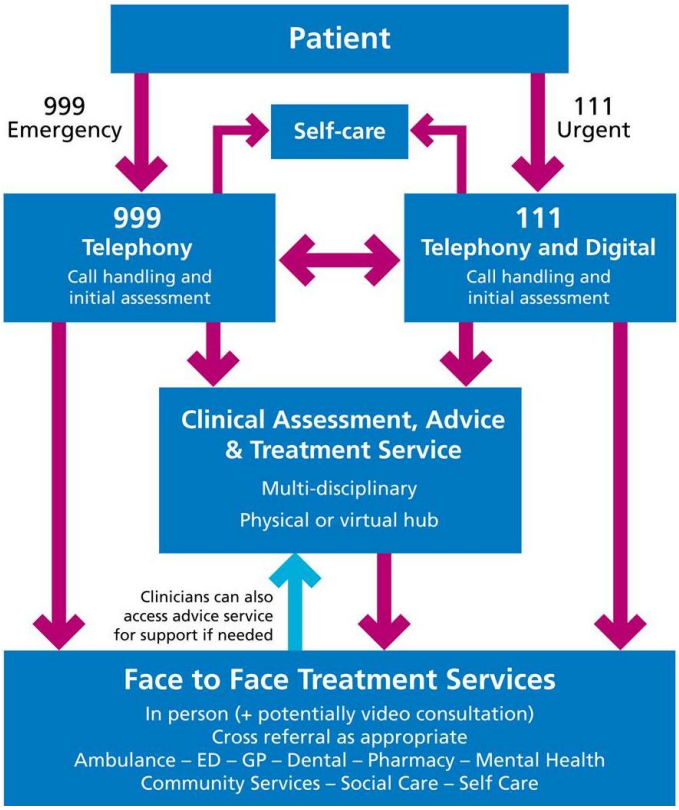

Figure 1: the Integrated Urgent Care service

In order to deliver this new model, new Commissioning Standards will be required to address the separate working arrangements between NHS 111 and out of hours services, and to address the lack of interconnectivity with community services, emergency departments and ambulance services. In addition, it is proposed that new data will be required to measure this Integrated Urgent Care service.

2.2 Reasons to change key performance indicators

Currently in use is a set of limited, time-based targets to measure integrated out of hours services, the National Quality Requirements (NQRs) in the Delivery of Out-of-Hours Services, which were first published in 2004 and updated in 2006 [1].

The introduction of NQRs was a major step forward at the time. However, with a shift in approach for the delivery of Integrated Urgent Care, the existing metrics are arguably no longer fit for purpose, with some of the current NQRs misaligned to

[1] NQRs (2006 update): http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137271

actual working practices. With the introduction of NHS 111 in 2010, the over-reliance on metrics such as calls answered within 60 seconds fails to provide sufficient focus on the experience of callers, or provide any understanding of the patient pathway following the call.

Within urgent and emergency care, a more holistic approach to the measuring of performance for the 'front of house' services is required through a blend of process-driven and outcome-based measures. This would allow a more balanced consideration of how these Integrated Urgent Care services are performing and more accurately reflect the three domains of quality (providing patient safety, effective care, and delivering a positive patient experience).

Given the intent to deliver a 24/7 functionally Integrated Urgent Care service, and the need for commissioners to re-procure services against the new Commissioning Standards, now would be the most practical time to introduce a new set of measures.

3 Development of metrics

3.1 The consultation process

The Integrated Urgent Care Team and the Operational Information for Commissioning Team, both in the Operations and Information Directorate, have conducted an extensive consultation exercise over the past 12 months. This included a series of metrics-specific workshops and regional Urgent and Emergency Care roadshows with providers and commissioners; regular discussion groups with national and regional clinical leads and socialisation with other key internal and external stakeholders including Department of Health (DH), Care Quality Commission (CQC), Monitor and NHS Alliance. This collaborative approach has resulted in the development of a set of high level measures that help define what good looks like for the new Integrated Urgent Care Service.

This exercise reiterated that the existing NHS 111 minimum data set (MDS) and the NQRs were in need of redevelopment using patient-focused measures, and that the quality of the service is broader than simply call answering times and dispositions. Therefore it was proposed that a new additional 'tier' of Key Performance Indicators (KPIs) be created, designed to offer an improved view of the system as a whole (Figure 2).

The existing NHS 111 MDS is to be retained as a source of management information in tier 2 to ensure continued measurement of legacy NHS 111 performance until integrated urgent care services are introduced. A third tier makes recommendations for items to be recorded for every call so that specific requests for data from commissioners can be answered.

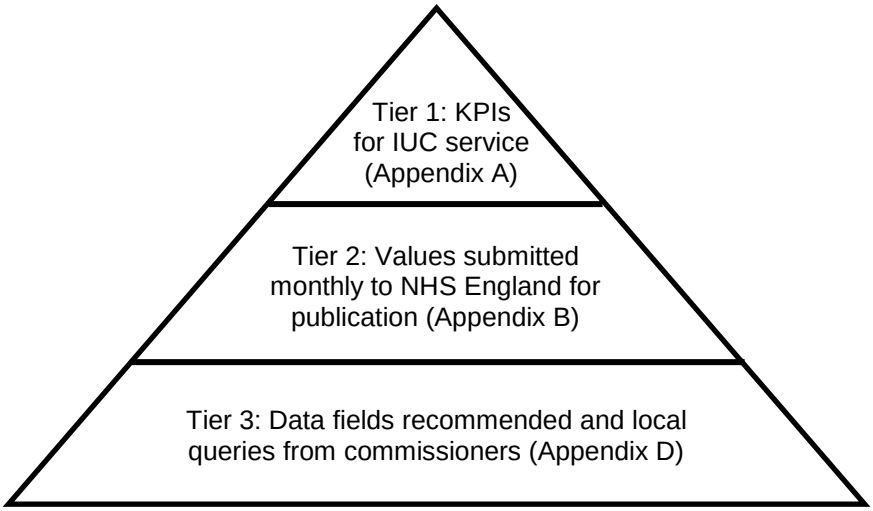

Figure 2: data hierarchy

3.2 Co-ordination with UECR outcomes

The Integrated Urgent Care metrics have been developed to ensure alignment, with the new integrated approach and the wider system outcome measures being developed by the Medical Directorate's UECR Programme. They are categorised where possible into the four service delivery elements of **Access, Assessment, Advice** and **Treatment,** and mapped to the three domains of quality (providing **patient safety, effective care,** and **delivering a positive patient experience**).

4 Impact of Change

The existing NHS 111 MDS is to be retained as a source of management information in 'tier 2' to ensure continued measurement of legacy NHS 111 performance until integrated urgent care services are introduced.

The full set of data in tier 2 that will be collected monthly, including the new KPIs, will ensure consistent comparisons of providers, while they are developing systems to report the new KPIs, and while new Integrated Urgent Care services are being commissioned. Once all providers are supplying the KPIs, we will cease collection of the old indicators that are no longer required.

Commissioners will be expected to share the new metrics with prospective providers during forthcoming re-procurements for Integrated Urgent Care Services, so that necessary arrangements can be made (including any additional contractual costs) to deliver and report against these new measures.

The existing NHS 111 MDS data will continue to be collected in the meantime but the expectation is for all providers to supply the new tier 2 data. Initially, new data items will be collected through a separate process in the Unify2 data collection system, so as not to delay the existing data items for publication.

Some of the KPIs may require changes to providers' management information systems. Whilst we have endeavoured to minimise the impact of any changes by utilising existing data collections, commissioners and providers may wish to take this opportunity to amend their reporting infrastructure. If software development is required, this may have a financial impact. Please see Appendix A for indicative cost implications of data collection on each KPI.

Such changes may result in a financial impact, as would any software development requirements. The latter may be particularly pertinent for the linkage between service data.

5 Next Steps

5.1 Review of metrics

As providers begin to supply the new data items in 2016-17, NHS England will assess the specification with providers and users, and make improvements where necessary to overcome unforeseeable obstacles in definition and collection. This review period with also be used to inform the establishment of the necessary standards within appropriate indicators.

5.2 Timeline

Given that existing NHS 111 and out of hours contract alignment is varied, a defined timeline for implementation and the adherence to the new metrics is not feasible. However, an indication can be seen within the ‘Timing’ element of each metric in Appendix A.

Providers and commissioners will be expected to work collaboratively to ensure they are in a position to report against the new metrics upon the commencement of the new integrated urgent care service. However it is acknowledged that with some new metrics, infrastructure and technological developments may be required beyond the control of the provider and commissioner.

In those cases, development work will be scoped within NHS England in collaboration with other organisations such as NHS Digital. Appendix E offers an indication to the activity to be taken forward by NHS England but is by no means an exhaustive list.

Appendix A: Integrated Urgent Care Key Performance Indicators

This document contains the Key Performance Indicators (KPIs) to judge the performance of Integrated Urgent Care (IUC) providers and commissioners. Later appendices describe the further measures to assess and manage the IUC service as a whole, including those that NHS England will collect regularly.

In 2016-17, as NHS England will start to collect the data described here from IUC and 111 providers, discussions with providers and users may lead to the publication of alterations to this specification.

Table A1: Summary list of KPIs

	Title	Domain	Area	Frequency
1	Calls abandoned after at least 30 seconds	Safety	Access	Monthly
2	Average time to call answer	Patient Experience	Access	Monthly
3	Average time to urgent clinical assessment	Patient Experience	Access	Monthly
4	Face-to-face primary medical care bookings	Patient Experience	Access	Monthly
5	Calls closed as self-care	Patient Experience / Effectiveness	Assessment	Monthly
6	Re-contacts	Safety	Assessment	Monthly
7	Directory of Services catch-all	Effectiveness	Assessment	Monthly
8	Compliance with advice	Patient Experience / Effectiveness	Advice	Monthly
9	Electronic transfer of referral information	Effectiveness	Advice	Monthly
10	Average time to definitive clinical encounter	Effectiveness	Advice	Monthly
11	Serious Incidents	Safety	Whole journey	Monthly
12	End to end reviews	All	Whole journey	Monthly
13	Helpfulness of advice	Patient Experience	Advice	Twice a year
14	Satisfaction	Patient Experience	Advice / Treatment	Twice a year
15	If 111 was not available	Patient Experience / Effectiveness	All	Twice a year

The scope of this document does not include NHS 111 online, or patients entering IUC through unscheduled arrival at a walk-in centre or other location, but where relevant, we will ensure measures of IUC are consistent with measures of those activities.

The KPIs do not include workforce measures, but Appendix D describes how we expect providers to complete standard NHS Digital workforce data collections. Additional measures on staff experience, turnover and absence are being considered for Appendix B.

Access KPIs

	Title	Domain	Area	Frequency	Assesses
1	**Calls abandoned after at least 30 seconds**	Safety	Access	Monthly	Provider

Rationale	Abandoned calls represent an unquantifiable clinical risk since, by definition, the needs of the caller are not established.
Denominator	Count of calls offered, which is equal to calls answered + calls abandoned (whether after more or less than 30 seconds).
Numerator	Count of calls where the caller waited at least 30 seconds after clock start and then abandoned the call before it was answered. Clock start is the end of any introductory message, which should be no more than 30 seconds long. If there is no such message, clock starts at call connect.
Source	Management Information; will need to continue to be compiled by IUC providers.
Standard	Can be set now from existing NHS 111 MDS data.
Cost	No extra cost, data already collected and supplied by providers.
Timing	Regular monthly supply should continue when providers start a new IUC contract.

	Title	Domain	Area	Frequency	Assesses
2	**Average time to call answer**	Patient Experience	Access	Monthly	Provider

Rationale	Every call counts equally for the mean average time to call answer, and as a measure, it keeps the incentive to answer a call that has already waited more than 60 seconds. The length of time before a call is answered is an important contributor to the overall patient experience. Prolonged delays in call answer time result in increasing rates of calls abandoned which generates clinical risk, as described in KPI1.
Denominator	Count of calls answered.
Numerator	Time from clock start (same clock start as KPI1) until the call is put through to a call handler, in seconds. Providers should supply this time aggregated into a total for all calls triaged each month, to avoid transcription errors due to software and time formats. The mean average can then then calculated by dividing by the denominator. All answered calls count; in the extremely unlikely event of a caller genuinely waiting for an hour, for example, that should still contribute to the average time. However, seemingly long wait times that are actually due to data errors, and not genuine, should not be included. Abandoned calls are excluded because otherwise this would overlap with what KPI1 is designed to measure.
Source	Management Information; will need to be compiled by IUC providers.
Standard	Could be set now, once sufficient historical data are requested and received from existing NHS 111 providers.
Notes	Some months are more challenging (such as those with five weekends), but providers should plan for this, ensuring patients receive the same levels of service at all times. Calls answered in 60 seconds is rejected as a measure, because it gives a provider answering 10% of calls after 2 minutes the same performance measure as one answering 10% of calls after 10 minutes. Also, there is no clinical justification for requiring 95%. For consistency, calls answered in 60 seconds will still be collected alongside other data in Appendix B, until all providers are supplying the new KPI2. Longest call time is also rejected as a measure because one long delay early in a month can remove the incentive to answer calls quickly for the rest of the month.
Cost	Negligible extra cost for providers, who should record the call answer time for each call in order to calculate the numerator and denominator.
Timing	Monthly supply expected when providers start a new IUC contract.

	Title	Domain	Area	Frequency	Assesses
3	**Average time to urgent clinical assessment**	Patient Experience	Access	Monthly	Provider

Rationale	Requirement to provide timely patient assessment without delayed call backs within Integrated Urgent Care. As with KPI2, this is a mean average time, which maintains the incentive to respond to calls when they have already waited some time.
Denominator	Count of urgent calls either live transferred to a clinician, or with a request for a call back from a clinician.
Numerator	The waiting time for a clinician in seconds, aggregated across all calls in the denominator. The time will start when the interim disposition is reached; indicating a transfer to a clinician is required. For live transfer, the time ends when the clinician is connected to the caller. For call backs, the time ends when the clinician connects to the number they received to call back on.
Source	Management Information; will need to be compiled by IUC providers.
Standard	Will be set once sufficient reliable data are available from IUC providers.
Cost	Expected to be low, because information is held within providers' management information; the clock start time is already defined in existing MDS item 5.18.
Timing	IUC providers expected to supply monthly; may take them a small number of months to set up reporting systems.

	Title	Domain	Area	Frequency	Assesses
4	**Face-to-face primary medical care bookings**	Patient Experience	Access	Monthly	Provider

Rationale	This will measure the impact of IUC on the wider health care system. It will also measure whether patients have their appointment arranged by the IUC service, so patients do not have to contact a GP practice to organise their own appointment.
Denominator	Count of calls with a final disposition of 'recommended to contact primary medical care'.
Numerator	Count of calls where the IUC service books the patient a face-to-face primary medical care appointment with a clinician who has access to the patient's full medical record.
Source	Management Information; will need to be compiled by IUC providers.

Standard	Will be set once sufficient reliable data are available from IUC providers.
Notes	The numerator will not include where callers choose to book their own appointment. It would be impractical for the IUC service to measure whether such callers do so.
Cost	IUC providers should record these appointments within their management information systems, so the cost for them to report aggregated counts is expected to be low.
Timing	IUC providers expected to supply monthly; may take a small number of months to set up reporting systems.

Assessment KPIs

	Title	Domain	Area	Frequency	Assesses
5	**Calls closed as self-care**	Effectiveness	Assessment	Monthly	Provider
Rationale	UECR requirement for IUC to manage more callers without onward referral, by solving the problem at the time, and not requiring patients to wait and then explain the situation again to another service when that is available.				
Denominator	Count of calls triaged.				
Numerator	Count of calls triaged and closed on the telephone without any face-to-face assessment or onward referral to a service outside IUC. In order to provide context for KPI6, KPI5 will be collected in two parts: (i) calls closed by the initial call handler; and (ii) calls closed by a clinician (either through live transfer or call back).				
Source	Management Information; will need to be compiled by IUC providers.				
Standard	Will be set once sufficient reliable data are available from IUC providers.				
Cost	Small extra cost for providers; this information is already available in existing management information.				
Timing	Regular monthly supply should continue when providers start a new IUC contract				

	Title	Domain	Area	Frequency	Assesses
6	**Re-contacts**	Safety	Assessment	Monthly	Provider

Rationale	To assess the success and safety of advice given and, in particular, to check that the self-care measure (KPI5) is not achieved through inappropriate call closures. Therefore, re-contacts will only be counted for calls closed with self-care. The standard will not be zero, some re-contacts will always be inevitable; but this measure will identify providers with unusually high proportions of re-contacts. Excludes calls from patients with a frequent caller procedure in place, so that the measure is not mostly determined by a small number of patients.
Denominator	Count of calls closed with self-care (the numerator from KPI5).
Numerator	Count of calls closed with self-care, with at least one repeat call to 111 within 72 hours, for the same patient (even if through a different caller and / or from a different telephone). Will exclude calls from patients where there is an agreed frequent caller procedure in place before the call. In the medium-term, when national data allows, numerator will not be limited to re-contact with 111, but will include patients attending A&E, and calls to any existing out of hours GP provider service still in place.
Source	Management Information; will need compiling by IUC providers.
Standard	Will be set once sufficient reliable data are available from IUC providers.
Cost	Low, if this can be derived monthly for all provider areas from the Repeat Caller database. If not, may need small development cost for providers to measure this.
Timing	IUC providers expected to supply monthly; may take them a small number of months to set up reporting systems.

	Title	Domain	Area	Frequency	Assesses
7	**Directory of Service catch-all**	Effectiveness	Assessment	Monthly	Commissioner / System

Rationale	IUC effectiveness is dependent on commissioning of adequate urgent care services and population of the Directory of Service (DoS) with these services, so that the Emergency Department catch-all is not needed.
Denominator	Count of calls where the DoS is opened.
Numerator	Count of calls where the DoS only displays two Emergency Departments with the suffix “(catch all)”.

Source	IUC provider Management Information shared with the NHS Pathways team at NHS Digital.
Standard	Will be set once sufficient reliable data are available.
Cost	Expected to be low, because information is held within providers' management information.
Timing	Providers expected to supply monthly; may take a few months for them to set up a routine to reliably count occurrences.

Advice KPIs

	Title	Domain	Area	Frequency	Assesses
8	**Compliance with advice**	Patient Experience / Effectiveness	Advice	Monthly	System

Rationale	Important to understand compliance with advice given and referrals made, particularly in relation to subsequent unplanned health seeking behaviours. Offers greater insight into actual impact of IUC on A&E rather than reliance on disposition rates.
Denominator	Count of patients with a disposition other than Ambulance or recommendation to attend A&E.
Numerator	Count, within denominator, of patients attending A&E within 24 hours of calling 111.
Source	Matching of NHS 111 call records with Hospital Episode Statistics records.
Standard	Will be set once sufficient reliable data are available from IUC providers.
Notes	The data source requires the matching of IUC record-level data with Hospital Episode Statistics using NHS Number. Providers are likely to need assistance from Commissioning Support Units (CSUs) for this. There is a risk of not counting patients who attend A&E for the same issue more than 24 hours after they called IUC about it; but balanced against this is the risk of counting patients who attend A&E within 24 hours for a different issue. We will also keep in touch with NHS Pathways, who are investigating the feasibility of similar matching across all England, although we do not anticipate outputs from them in 2016-17. The data source is currently unavailable, so in the short-term, this KPI will be measured using the existing NHS 111 survey data. The denominator will be valid responses ("yes, all of it", "yes, some of it" or "No") to "Did you follow the advice given by the 111 service?" The numerator will be responses of "yes, all of it".
Cost	Providers might incur some costs for analytical work, if CSUs are not already undertaking matching work for their IUC provider area. It may be cost-effective if a small number of CSUs provide matched data for a larger number of IUC providers. Also see KPI14 notes relating to the existing NHS 111 survey.

Timing	Matched data is unlikely to be available across all of England in 2016/17. When ready, matched data could be supplied every month, but not to the same timetable as telephony data, due to the need to wait for a consistent England-wide dataset to match to. In the short-term, we still expect survey data every six months.

	Title	Domain	Area	Frequency	Assesses
9	**Electronic transfer of referral information**	Effectiveness	Advice	Monthly	System

Rationale	To support strategic intent within Commissioning Standards to improve referral processes from IUC rather than those between call centre / hub. Currently, very few community voluntary or social care providers have capability to receive electronic information transfer. Nevertheless, we will include them in this measure, because this is the arrangement we want to encourage.
Denominator	Count of calls where DoS is opened.
Numerator	Count of calls where DoS is opened and the details obtained during the call are transferred electronically, securely, and so the subsequent service has them available at the time they continue the assessment and treatment. Secure transmission methods include ITK, point-to-point or nhs.net email, and not fax. Merely sending a post-event message to the GP is not enough to count for this KPI.
Source	Management Information; will need to be compiled by IUC providers.
Standard	Will be set once sufficient reliable data are available.
Cost	Difficult to estimate; providers may incur costs to develop information streams that identify which of many subsequent services are able to receive electronic transfer. Costs will be less if information streams could be at aggregate level; providers may know that for certain subsequent services, all of, or none of, the calls referred will have appropriate electronic transfer.
Timing	Will take providers some time to arrange data flows from their subsequent services. Once data start being produced, additional guidance may be needed to ensure comparability, so data may not be available until 2017.

	Title	Domain	Area	Frequency	Assesses
10	**Average time to definitive clinical encounter**	Effectiveness	Advice	Monthly	System

Rationale	Callers to urgent care services want an answer to their concerns as soon as possible – either in the form of advice and reassurance or the commencement of necessary treatment. This mean average time to receiving an 'answer' across the range of presenting symptoms and final diagnoses is particularly valuable in understanding the patient journey when broken down into such groups.
Denominator	Count of calls triaged.
Numerator	The time from call connect until either (i) call closed with self-care (for calls that count towards KPI5); or (ii) call closed following face-to-face assessment in Integrated Urgent Care; or (iii) call referred outside IUC (such as to service in DoS, A&E or an ambulance service). Timing will not stop when the initial call handler promises a call back from a clinician, nor when such a call back starts. Providers should supply this time aggregated into a total for all calls triaged each month, to avoid transcription errors due to software and time formats. The mean average can then then calculated by dividing by the denominator.
Source	Management Information; will need to be compiled by IUC providers.
Standard	Will be set once sufficient reliable data are available.
Notes	This KPI will only be a total across all symptoms and diagnoses; however, it will standardise reporting, and be useful as a comparison for commissioners to then request the same measure for specific symptoms and diagnoses. In time, given linking of data sources, an option could be to extend this to measure the time until contact starts face-to-face with any subsequent service beyond IUC.
Cost	Difficult to estimate. Providers may incur financial costs from developing existing software in order to capture this metric; analytical work may be needed to ensure consistency of measurement across providers.
Timing	Will be supplied monthly when available, but unlikely that data of sufficient quality will be available in 2016.

Whole journey KPIs

	Title	Domain	Area	Frequency	Assesses
11	**Serious Incidents**	Safety	Whole journey	Monthly	Provider

Rationale	Oversight of IUC incident reporting and learning. The importance and purpose are described in the Foreword to the 2015 Serious Incident Framework at www.england.nhs.uk/patientsafety/serious-incident. The measure is not a simple numerical count, because that would incentivise non-reporting.
Measure	A qualitative, not quantitative, measure: the commissioner must confirm that the provider has a track record of reporting Serious Incidents (SIs), and adequately investigating them, generating effective action plans. For new providers, the commissioner must confirm that the provider is demonstrably encouraging SI reporting and investigation, and has appropriate processes, capacity and capability in place
Source	Email notification by commissioners.
Standard	No standard will be set.
Notes	NHS England will provide guidance to commissioners of IUC services so they are able to assure that SIs are reported and investigated, and the learning is shared, in line with the principles in the IUC Commissioning Standards and Serious Incident Framework above. Assurance can be checked for consistency with the Strategic Executive Information System (STEIS) or National Reporting and Learning System as appropriate.
Cost	Should be low. Providers are already expected to identify, report, investigate, and take action, in response to SIs, and commissioners are already expected to have processes in place to confirm appropriate management of SIs by providers. Perhaps a small additional staff time cost for commissioners to collate evidence from SI reports that demonstrates learning resulting from SIs, or to provide assurances around new providers' systems.
Timing	May take a month or two after each IUC service starts before commissioners confirm to NHS England that the information from providers is satisfactory.

	Title	Domain	Area	Frequency	Assesses
12	**End to end reviews**	All	Whole journey	Monthly	Provider / Commissioner

Rationale	To embed clinical audit of the whole patient journey into the IUC system.
Measure	Confirmation from commissioner that provider has sent qualitative report on end to end reviews. No quantitative measure.
Source	Email notification by commissioners.
Standard	No standard will be set.
Notes	NHS England will provide guidance on how to assure whether commissioners' reports are satisfactory.
Cost	Low extra cost for information collection because providers are already expected to conduct end to end reviews. Perhaps a small staff time cost for providers to produce reports acceptable to commissioners on their learning from such reviews.
Timing	May take some months after each IUC service starts before commissioners confirm to NHS England that the information from providers is in a satisfactory form.

User experience KPIs

	Title	Domain	Area	Frequency	Assesses
13	**Helpfulness of advice**	Patient Experience	Advice	Twice a year	Provider

Denominator	Count of survey responses where "How helpful was the advice given by the 111 service" was answered "Very helpful", "Quite helpful", "Not very helpful", or "Not helpful at all".
Numerator	Count who responded "Very helpful" or "Quite helpful".
Source	NHS 111 patient experience survey.
Standard	No standard, just comparison of improvement over time between providers. Assessment of helpfulness depends upon patient expectations, which are in turn influenced by media and public mood.

Notes	Question asked in most NHS 111 providers' questionnaires historically, but response data not collected by NHS England before 2016.
Cost	Some cost to providers, see KPI14.
Timing	Supply expected to continue every six months, the same as for existing NHS 111 survey data.

	Title	Domain	Area	Frequency	Assesses
14	**Satisfaction**	Patient Experience	Advice / Treatment	Twice a year	Provider
Denominator	Count of survey responses where "Overall, how satisfied or dissatisfied were you with the way the 111 service handled the whole process?" was answered "Very satisfied", "Fairly satisfied", "Neither satisfied nor dissatisfied", "Fairly dissatisfied" or "Very dissatisfied".				
Numerator	Count of survey responses where this question was answered "Very satisfied" or "Fairly satisfied".				
Source	NHS 111 patient experience survey.				
Standard	No standard, just comparison of improvement over time between providers. Satisfaction depends upon patient expectations, which are in turn influenced by media and public mood.				
Notes	Survey will need to be timely and make clear to patients that this refers to the advice from IUC as a whole, including the clinical hub. We will monitor developments in alternative patient experience collection methods (such as text messages); and in the development of outcome measures for the wider Urgent and Emergency Care (UEC) system, to check whether more suitable methods become available for measuring patient experience.				
Cost	Some providers need to increase their sample sizes from the existing survey; cost to them could be a few thousand pounds per year. This would improve data quality for KPI8, 13, 14 and 15. Alternative patient experience data collection methods could cost several thousands of pounds to develop, but may prove more cost-efficient in time than existing surveys.				
Timing	Supply expected to continue every six months, the same as for existing NHS 111 survey data.				

	Title	Domain	Area	Frequency	Assesses
15	**If 111 was not available**	Patient Experience / Effectiveness	All	Twice a year	System

Rationale	To understand how IUC influences health seeking behaviour. Shows how successfully IUC diverts away patients who do not need services but would have used a service had 111 not been available.
Measure	Denominator: count of survey responses with an answer to “If the 111 service had not been available...” Numerator: count of survey responses that answered “I would not have contacted anyone else”. Then, subtract the proportion above, from the proportion of calls triaged that were not recommended on to other services.
Source	NHS 111 patient experience survey.
Standard	No standard, just comparison of improvement over time between providers. This measure depends upon the categories of patients that choose to call 111.
Notes	Publicity and signposting may increase calls to 111 from low acuity callers, decreasing this measure; so this is more a measure of the system as a whole, rather than individual providers.
Cost	Some cost to providers – see KPI14.
Timing	Supply expected to continue every six months, the same as for existing NHS 111 survey data.

Development KPIs

To understand the impact of Integrated Urgent Care on the wider Urgent and Emergency Care system, we will investigate ways of producing the following indicators. They will require matching of records to sources that are not consistently available across England, so will take need development time.

	Title	Domain	Area	Frequency	Assesses
	Ambulance dispatches	Effectiveness	Assessment	Monthly	Provider

Rationale	To assess unnecessary ambulance requests. The four hour limit is to avoid matching to ambulance dispatches from later ambulance requests not via 111.
Denominator	Count of calls with an ambulance disposition.

Numerator	Count of calls with an ambulance disposition where the patient had an ambulance dispatched within four hours.
Source	Secure matching of IUC call records to Ambulance Service records.
Standard	Will be set once sufficient reliable data are available from IUC providers.
Cost	Providers might incur some costs for analytical work, if CSUs are not already undertaking matching work for their IUC provider area. It may be cost-effective if a small number of CSUs provide matched data for a larger number of IUC providers.
Timing	Not possible until records including NHS Number are available from Ambulance Services. When ready, could be supplied every month, but not to the same timetable as telephony data, due to the need to wait for availability of records to match to.

	Title	Domain	Area	Frequency	Assesses
	Compliance with advice – Primary Care	Patient Experience / Effectiveness	Advice	Monthly	System

Rationale	To understand compliance with advice given and referrals made, particularly in relation to subsequent unplanned health seeking behaviours. Offers insight into actual impact of IUC on primary care, rather than merely disposition data.
Denominator	Count of patients booked into a face to face primary care appointment by the IUC.
Numerator	Count, within denominator, of patients attending face to face primary care appointment.
Source	Possibilities for matching data or other sources to be investigated.
Standard	Will be set once sufficient reliable data are available.
Notes	One option could be matching of IUC record-level data with GP booking records if these were available and included NHS Number. A solution could involve providers of software for practices. Such matching would need assistance from Commissioning Support Units (CSUs). Matching would risk not counting patients who attend a general practice surgery for the same issue more than 24 hours after they called IUC about it; but balanced against this is the risk of counting patients who attend general practice within 24 hours for a different issue.
Cost	Providers might incur some costs for analytical work, if CSUs are not already undertaking matching work for their IUC provider area. It may be cost-effective if a small number of CSUs provide matched data for a larger number of IUC providers.
Timing	Matched data is unlikely to be available across all of England in 2016/17. When ready, could be supplied every month, but not to the same timetable as telephony data, due to the need to wait for a consistent England-wide dataset to match to.

Appendix B: NHS England regular data collection

NHS England will collect, via the Unify2 web portal, the data required for the KPIs above, along with the data items in the existing NHS 111 Minimum Data Set (MDS), and some new items not contributing to KPIs but essential for regular monitoring of the Integrated Urgent Care system.

Table B1 Call data collected every month

KPI	MDS ref.	Description
	4.2	Resident population. To ensure consistency, now calculated by NHS England from Office for National Statistics (ONS) CCG population estimates and population projections. This will be removed from the Unify2 collection so that ONS population revisions can be used in publications without requiring revisions to Unify2 data.
2	New item	Total call answer time for the month in seconds
4	New item	Count of calls where the IUC service books a face-to-face primary medical care appointment
5	New item	Calls triaged and closed on the initial telephone call by a call handler, without clinical input
5	New item	Calls triaged and closed by an IUC clinician without face-to-face assessment or onward referral outside IUC
6	New item	Count of calls with at least one re-contact for same patient and condition
7	New item	Count of calls where the DoS is opened
7	New item	Count of calls where the DoS only displays two A&Es and “(catch all)”
8	New item	Count of patients attending A&E within 24 hours of a call
8	New item	Count of patients attending A&E within 24 hours of a call that had a disposition other than 5.23 and 5.24
9	New item	Count of referrals outside the clinical hub
9	New item	Count of referrals with electronic data transfer
10	New item	Total time to definitive clinical encounter
1	5.3	Count of calls offered
	5.4	Count of calls offered where 111 dialled
	5.5	Count of calls offered where other number dialled
1	5.6	Count of calls abandoned after 30 seconds waiting time
	5.7	Count of calls answered
	5.8	Count of calls answered where 111 dialled
	5.9	Count of calls answered where other number dialled
	5.10	Count of calls answered within 60 seconds
	5.11	Count of calls where NHS Pathways used to triage
	5.12	Count of calls not triaged: caller terminated call
	5.13	Count of calls not triaged: caller referred, no triage
	5.14	Count of calls not triaged: caller given health info
	5.15	Count of calls not triaged: other reason
	New item	Calls matched to Patient Demographic System
	5.16	Count of calls transferred to clinician / clinical hub
	5.17	Count of calls live transferred to clinician / clinical hub
	New item	Count of calls answered by a clinician rather than a call handler
	New item	Calls routed elsewhere through IVR
	New item	Count of calls transferred in to clinical hub from 999
	New item	Count of calls where an external clinician contacted the clinical hub

KPI	MDS ref.	Description
	New item	Count of episodes assisted by clinical hub after unscheduled arrival of patient (such as via minor injuries unit or walk-in centre)
	5.18	Mean average NHS 111 live transfer time
	5.19	Count of calls where person offered call back
	5.20	Count of call backs within 10 minutes
3	New item	Count of urgent calls where person offered call back
3	New item	Total waiting time across all urgent calls for call back from clinician
	5.21	Mean average episode length in seconds
	5.23	Count of dispositions of ambulance dispatch
	5.24	Count of dispositions of recommended to attend A&E
	5.25	Count of dispositions of recommended primary or community care
	5.25a	Count of dispositions of recommended to contact primary or community care
	5.25b	Count of dispositions of recommended to speak to primary or community care
	5.25c	Count of dispositions of recommended to dental / pharmacy
4	New item	Count of dispositions of recommended to contact primary medical care
	New item	Count of dispositions of recommended to contact community care
	New item	Count of dispositions of recommended to dental
	New item	Count of dispositions of recommended to pharmacy
	5.26	Count of dispositions of recommended to attend other service
	5.27	Count of dispositions of not recommended to attend other service
	5.27a	Count of dispositions of given health information
	5.27b	Count of dispositions of home care recommend
	5.27c	Count of dispositions of non-clinical
	New item	Count of calls where the first choice DoS service was rejected. Will assess need to prevent illegitimate rejections, and improve DoS profiling / ranking, using a denominator of 5.24+5.25+5.26.
	6.2	Handling time worked by call handlers in minutes
	6.3	Handling time worked by clinical staff in minutes

Table B2 Survey data, initially collected every six months

KPI	MDS ref.	Description
	7.2	Count of survey responses
14	7.3	Count of survey responses very satisfied (with 111 experience)
14	7.4	Count of survey responses fairly satisfied
14	7.5	Count of survey responses neither satisfied nor dissatisfied
14	New item	Count of survey responses fairly dissatisfied
14	New item	Count of survey responses very dissatisfied
14	7.7	Count of survey responses with no view on satisfaction
8	7.8	Count of survey responses fully complied with advice
8	7.9	Count of survey responses partially complied with advice
8	7.10	Count of survey responses didn't comply with advice
8	7.11	Count of survey responses with no view on compliance with advice
13	New item	Count of survey responses where advice was very helpful
13	New item	Count of survey responses where advice was quite helpful
13	New item	Count of survey responses where advice was not very helpful
13	New item	Count of survey responses where advice was not helpful at all
13	New item	Count of survey responses with no view on helpfulness of advice

KPI	MDS ref.	Description
	7.12	Count of survey responses where problem has resolved
	7.13	Count of survey responses where problem has improved
	7.14	Count of survey responses where problem remained the same
	7.15	Count of survey responses where problem got worse
	7.16	Count of survey responses with no view on change in problem
15	7.17	Count of survey responses that, without 111, would have used ambulance
	Of which	
	7.18	Subsequently used ambulance service
	7.19	Subsequently used A&E service
	7.20	Subsequently used a primary care service
	7.21	Subsequently used another service
	New item	Subsequently used no service
15	7.22	Count of survey responses that, without 111, would have used A&E
	Of which	
	7.23	Subsequently used ambulance service
	7.24	Subsequently used A&E service
	7.25	Subsequently used a primary care service
	7.26	Subsequently used another service
	New item	Subsequently used no service
15	7.27	Count of survey responses that, without 111, would have used primary care
	Of which	
	7.28	Subsequently used ambulance service
	7.29	Subsequently used A&E service
	7.30	Subsequently used a primary care service
	7.31	Subsequently used another service
	New item	Subsequently used no service
15	7.32	Count of survey responses that, without 111, would have used other service
	Of which	
	7.33	Subsequently used ambulance service
	7.34	Subsequently used A&E service
	7.35	Subsequently used a primary care service
	7.36	Subsequently used another service
	New item	Subsequently used no service
15	7.37	Count of survey responses that, without 111, would have used no service
	Of which	
	7.38	Subsequently used ambulance service
	7.39	Subsequently used A&E service
	7.40	Subsequently used a primary care service
	7.41	Subsequently used another service
	New item	Subsequently used no service
	New item	Count of non-response to question on service use without 111

KPIs 11 and 12 require that each month, providers will report qualitatively, rather than quantitatively through the Unify2 system.

Additional measures on workforce are being considered for regular collection as part of Tier 2, such as staff experience, turnover and absence; and where possible, consistent with workforce data on other NHS areas. As a minimum, providers will be expected to complete the standard NHS Digital workforce data collections described in Appendix D.

NHS England also requires the cost of contracts, when signed by commissioners, in order to assess cost per call and value for money. This information will not need to be collected repeatedly, but only once per contract (for contracts which are not fixed amounts, information will need to include how the cost is calculated). Contract costs will not be published.

Appendix C: Superseded National Quality Requirements

The Key Performance Indicators (KPIs) and the data in Tiers 2 and 3 will provide all that is needed to assess overall performance of the Integrated Urgent Care system, so the National Quality Requirements in the Delivery of Out-of-Hours Services will not be needed to assess Integrated Urgent Care providers.

2006 NQRs	Superseding Integrated Urgent Care KPIs
8. Initial Telephone Call Engaged and abandoned calls	KPI1 measures abandoned calls. KPI2 measures average call answer time. Engaged calls do not apply to Integrated Urgent Care telephony systems. In rare circumstances, callers may receive a technical difficulty message instead of being put through to a call handler. These are described further in Appendix D.
Time taken for the call to be answered by a person	
9. and 10. Clinical Assessment Identification of immediate life threatening conditions	Not routinely reported but providers should continue to record the time data supplied to NHS Pathways for call connect, and for the transfer of the request for a Red ambulance to the dispatch desk.
Start definitive clinical assessment for urgent calls within 20 minutes, and for all other calls within 60 minutes.	KPI3 measures time to the start of clinical assessment and KPI10 measures average time for definitive clinical encounter.
At the end of the assessment, patient clear about outcome and timescale.	KPI8 measures compliance with advice.
11. Patients treated by the clinician best equipped to meet their needs and in the most appropriate location.	KPI14 measures helpfulness of advice. KPI15 measures satisfaction.
12. Face-to-face consultations started in: • Emergency: Within 1 hour. • Urgent: Within 2 hours. • Less urgent: Within 6 hours.	KPI10 measures average time for definitive clinical encounter.
13. Patients unable to communicate effectively in English Interpretation service in 15 minutes; provision for impaired hearing / sight	Not a KPI, but should be collected within the list in Appendix D for reporting upon request of local commissioners.

Appendix D: Related data

Aside from the KPIs and the rest of the monthly collection, commissioners and NHS England will need other management information for various purposes.

1. Workforce data

Integrated Urgent Care Providers are expected to comply with the NHS Digital workforce Minimum Data Set collection. If a provider does not use the Electronic Staff Record system (from which the NHS Digital will be able to directly extract the data), then the provider should supply workforce information, every six months, through the NHS Digital secure internet data collection system. Access and other instructions are available from workforce.standards@nhs.net.

Some workforce data is already available for Ambulance Service staff at http://content.digital.nhs.uk/searchcatalogue?productid=21281: Table 2 in "Organisation tables" shows total full-time equivalent staff numbers split by staff group.

In 2015-16 NHS England proposed to NHS Digital improved categories for this publication for the types of employees in Ambulance Services. However, NHS Digital will not be able to publish data for these improved categories before 2017.

For the independent sector, NHS Digital only publish such data aggregated across organisations, and will only share such data for an individual organisation if that organisation provides explicit approval to NHS Digital.

Consequently, and as noted in Appendix B, measures of staff turnover and absence are being considered for inclusion in Tier 2. Such measures are not KPIs, determining success or otherwise of the service, but are useful context and can provide early warnings of developing problems with a service.

2. Patient experience data

As described in KPI14 in Appendix A, the existing NHS 111 survey will continue for now, and guidance will be issued to improve its quality. NHS England will assess how best to collect patient experience for Integrated Urgent Care and the wider urgent and emergency care system in future.

Valuable intelligence could be generated by matching survey responses to individual call records. However, this will require Information Governance approval, and an assessment of any impact on response rates and the likely successful matching rates.

Whether matching is used or not, the following contextual information would enhance patients' responses to existing survey questions:

- Clinical Commissioning Group (CCG) of residence
- Date of initial contact with Integrated Urgent Care
- Date survey sent to respondent
- Survey mode (postal, website, telephone, on-site paper, on-site electronic)
- Date of receipt of completed survey

There is a page of the existing GP Patient Survey (GPPS) questionnaire for respondents who "wanted a GP but your surgery was closed". The routine publication of GPPS results will display answers to these questions for all CCGs, providing useful context, but these results will not be KPIs. The relevant questions asked in 2015 were:

- Q41. Considering all of the services you contacted, which of the following happened on that occasion?
- Q42. How do you feel about how quickly you received care or advice on that occasion?
- Q43. Considering all of the people that you saw or spoke to on that occasion, did you have confidence and trust in them?
- Q44. Overall, how would you describe your last experience of NHS services when you wanted to see a GP but your GP surgery was closed?

3. Technical difficulties

On rare occasions, for reasons that may or may not be within providers' control (extreme weather, insufficient telephony capacity), callers receive an automated message quoting technical difficulties, and are not connected to an NHS 111 call handler. Providers cannot count these because such calls do not reach each provider's Automated Call Distributor (ACD).

NHS England already receives regular alerts when this process is engaged, and providers are also able to receive such alerts. NHS England will annotate data where these difficulties mean abandoned call data do not reflect callers' experiences.

4. Call-level data, to be recorded for every episode

The list below contains variables that we expect will need recording for each incident. These do not necessarily mean that data will need to be reported for each of these variables. For example, we expect providers to record callers' ages, but we do not expect providers to routinely report the count of callers of any particular age.

The Data Services for Commissioners (DSfC) programme [2] will recommend specifications for data fields for use by Data Services for Commissioners Regional Offices (DSCROs), including core data items that enable linkage of data sets.

Some DSCROs have already made progress in data linkage, such as assessing whether patients who call 111 subsequently arrive at Emergency Departments; or whether ambulance requests in non-life-threatening circumstances are re-triaged by Ambulance Services. It may take time and analytical resources for such matching to generate comparable data across England.

The DSfC list of data fields for Integrated Urgent Care is still being developed in early 2016 but currently contains the following items:

4a Timestamps

Dates should include the year, month, and date; and times should include the hour, minute, and second. Some of the following will not be relevant for every call and so

[2] DSfC programme: http://digital.nhs.uk/dataservicesforcommissioners

can be left empty. Many are already recorded for NHS 111 calls and shared with the NHS Digital NHS Pathways team.

1. Date/time 111 call reaches provider's telephone switch
2. Date / time call answered
3. Time triage starts
4. Date / time interim disposition (Dx) reached
5. Date / time caller put through to clinician
6. Date / time triage ends (final disposition agreed)
7. Date / time call ends
8. Date / time clinician call back starts
9. Date / time clinician call back ends
10. Date / time contact starts with provider selected from DoS

4b Demographics of patient

11. Date of birth
12. Age at call date
13. Name
14. Usual address
15. Person stated gender
16. Ethnicity
17. Preferred language (includes sign language)
18. Whether caller is patient
19. Registered GP practice (determines CCG of registration)
20. Usual postcode (determines CCG of residence) [3]
21. Symptom group
22. Symptom discriminator[4]
23. Trauma flag
24. Age group (for callers wishing to remain anonymous and not giving age)

4c Other variables not involving Directory of Services

25. Case number generated by the call handling system
26. NHS number
27. NHS number status indicator code (such as trace conflict)
28. Withheld identity reason
29. Incident location co-ordinates
30. Activity identifier
31. Local patient identifier (for matching without revealing NHS number)
32. Source of call (111 / 999 / clinician...)
33. NHS 111 area code
34. Organisation code of Integrated Urgent Care provider
35. Organisation code of commissioner of the service
36. Organisation code of commissioner derived from patient's home postcode
37. Organisation code of commissioner of patient's registered GP practice
38. Provider site code

[3] The patient's home postcode can be converted using the free ONS Postcode Directory to Lower layer Super Output Area (LSOA), and from there into income deprivation score using the free www.gov.uk/government/collections/english-indices-of-deprivation.
[4] Z code or link to Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT).

39. User ID of call handler
40. Skill set of system user
41. Repeat caller flag
42. Special Patient Note (SPN) flag
43. Reason for not triaging
44. Triage Dx code generated by Pathways
45. Triage Dx group (Ambulance, A&E etc)
46. Final Dx code agreed with caller
47. Final Dx group
48. Flag for triage disposition overridden
49. Reason for Dx override
50. Cx keywords (care advice standard scripts reviewed with patient)
51. Whether a prescription was issued
52. Whether patient's registered GP practice received a post-event message

4d Directory of Services (DoS) data

53. Whether initial service supplied by DoS was rejected by caller
54. Reason for rejection of initial service from DoS
55. Service from DoS: Unique identifier
56. Service from DoS: Service type
57. Service from DoS: Description of service
58. Order of services presented in NHS Pathways
59. Description of Gap service (service not shown by DoS)
60. Type of Gap service (service not shown by DoS)
61. Reason for service not shown by DoS
62. Whether DoS displays two Emergency Departments and "(catch all)"
63. Whether service receives appropriate call details electronically

Appendix E: Timetable

Activity	Timeframe
Establish the benchmark levels within the indicators that allows appropriate performance management	
Evaluate existing performance data to establish indicative target levels based on the current average performance. Agree new standards in discussion with Commissioners and Providers (allowing flexibility for future amendment).	3-6 months
Test new metrics' reporting with early implementers to establish baseline data to guide a decision on continuation of initial standards for further rollout.	6-12 months
Infrastructure to ensure data collection	
Guidance on technological requirements in collaboration with Digital Urgent Care team	3-6 months
Implementation of technological requirements and processes including data matching	6-12 months
Refinement of patient experience KPIs and collection methods	
Guidance on improvements to existing 111 patient survey	3-6 months
Work with Medical Directorate on options for measuring patient experience across Urgent and Emergency Care, and impact upon existing survey redevelopment	12 months