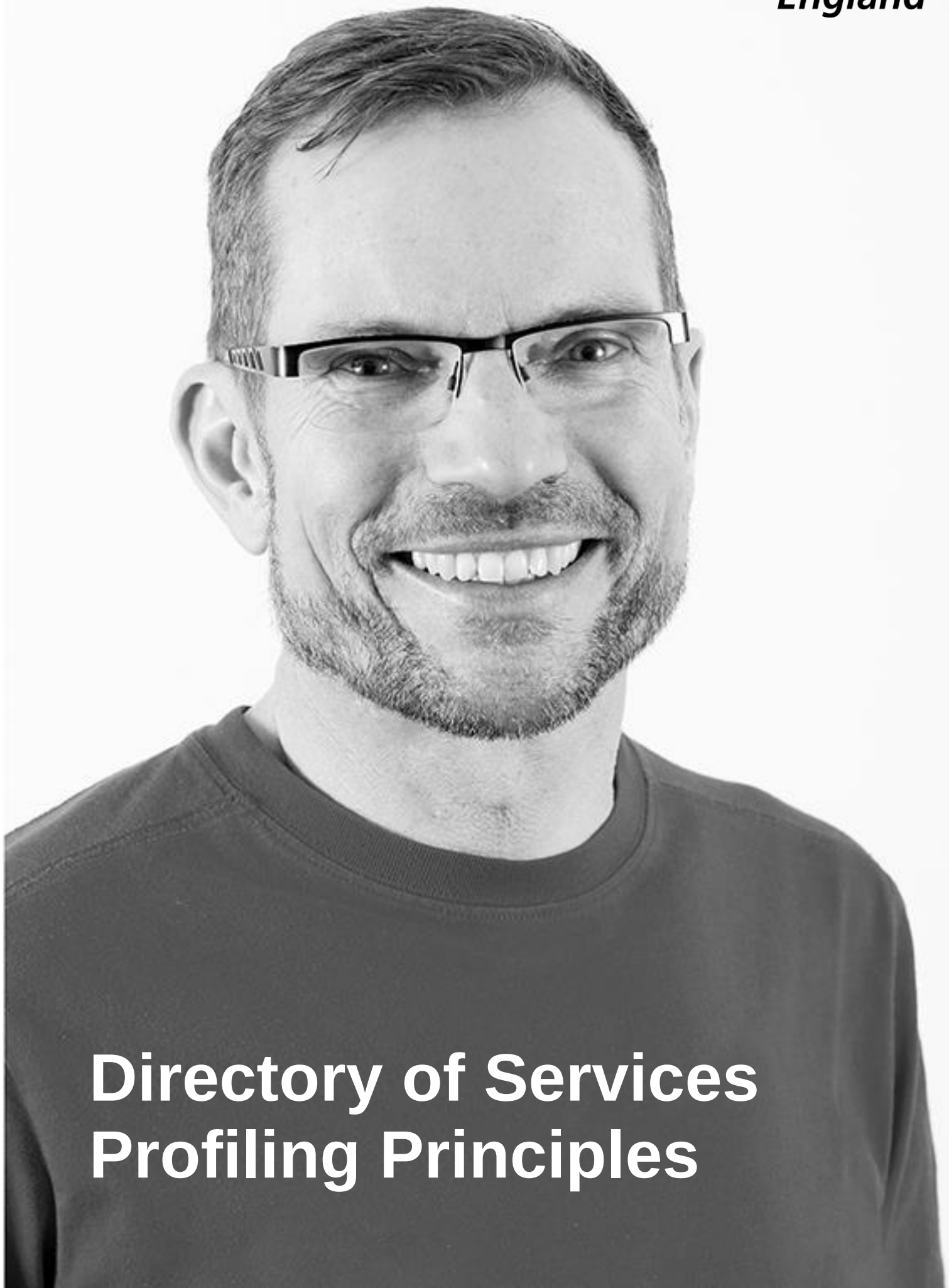
NHS England



Directory of Services Profiling Principles

Directory of Services Profiling Principles

Best practice guidance for DoS Leads and DoS teams in England

Version number: 0.4

First published:

Updated: N/A

Prepared by: David Murphy, National DoS Lead, Urgent and Emergency Care Delivery Team

Classification: OFFICIAL-SENSITIVE: PERSONAL

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Revision history

Version	Date	Summary of changes
0.1	03-02-16	Initial document
0.2	26-07-16	Updated following review by DoS Leads and Clinical Leads
0.3	10-08-16	Expansion of mental health principles and addition of search appendix
0.4	06-09-16	Clarification of principle regarding GP in-hours cover

Contents

1 Introduction

1.1 Purpose

The aim of this document is to provide better consistency in the integrity of the data entered by Directory of Service (DoS) regions, and form part of the wider DoS Quality Review undertaken by the National DoS Lead(s). Following the principles set out will provide a more cohesive approach to DoS profiling across the country.

1.2 Context

The DoS is a national database of NHS services. It was initially set-up to support users of NHS Pathways (NHSP): Clinical Decision Support Software (CDSS) used primarily in calls made to 111 but also to 999. It supports clinicians and non-clinicians in being able to make safe and effective referrals following a telephone assessment of a patient's symptoms.

Population and live maintenance of the data within DoS is the ultimate responsibility of the Clinical Commissioning Group (CCG). This entering and editing of the data is referred to as 'profiling', as each entry in the database is a DoS profile comprising of details of the service it relates to. Each provider listed is responsible for ensuring the details listed about their service(s) are an accurate reflection of what they are commissioned to provide. This profiling is completed by DoS Leads and DoS teams employed by one of the following:

- Individual CCG
- Lead CCG on behalf of a number of associate CCGs
- Commissioning Support Unit (CSU) on behalf of the CCG(s)
- NHS provider on behalf of the CCG(s) e.g. ambulance service.

In preparation for the go-live of NHS111 services across the country in April 2013, an assurance process was completed by NHS England to ensure the data within DoS was fit-for-purpose. Since then, a number of improvements have been made; not only to the infrastructure of the database, but in the approach to profiling itself. The assurance process hasn't been repeated to reflect these changes.

Whilst it is recognised that DoS profiling should reflect local requirements, there are some best practice guidelines which should be adopted by DoS Leads and DoS teams throughout the country. Doing so has the following benefits:

- Assists local teams in optimising their DoS to meet strategic aims
- Prevents border issues where unsuitable services from a neighbouring CCG are presented as an option to a patient
- Provides an ongoing framework to measure the quality of DoS profiling against
- Gives guidance on the preferred approach to profiling for those new to DoS or with less experience of how it works

Where a 'profiling principle' has not been adopted by a CCG or an area, it is expected there will be reasonable justification as to why this principle is not suitable for them. It is anticipated that this will be an iterative document that reflects future changes in the DoS infrastructure, which may require adaptation of profiling activities. Most principles in this document should be achievable now, however some may be aspirational due to current resource or infrastructure challenges.

2 Database structure and set-up

2.1 Ranking strategy

There are currently five ranking categories in DoS. These enable commissioners to decide which team types they would like patients referred to following an NHS Pathways assessment. Services ranked 'highest' will return above services ranked 'high' and so on. Further granularity is due to become possible in 2017; however the principles to be applied remain the same.

- It is only necessary to place team types in separate ranking categories where they may contain services that return for same Pathways outcome e.g. the ranking of dental services and primary care services could be considered in isolation of each other, as long as there is no overlap in clinical profiling.
- Ranking should be agreed by the nominated lead for the CCG.
- Review at least once a year, or when a new team type is added.

2.1.1 Highest

- Team types in this category are likely to be specialist/community services which are lower cost to provide and delivered virtually or close to/within the patient's home.
- Team types in this category are likely to either:
  - Be restricted to a GP surgery(s) (or in future geographical area); and/or
  - Have a smaller group of symptom groups (SGs) and symptom discriminators (SDs) mapped to them for specific clinical presentations.

2.1.2 High

- Team types in this category are likely to include generalist in-hours primary care services. This is to ensure in-hours services are returned in preference to out-of-hours services.

2.1.3 Normal

- Team types in this category are likely to include generalist out-of-hours primary care services. This is to ensure in-hours services are returned in preference to out-of-hours services.

2.1.4 Low

- Team types in this category are likely to include generalist emergency care services (including ED) which are higher cost to provide and delivered at a distance from the patient's home. This is to ensure primary care services are returned in preference to emergency care services.

2.1.5 Lowest

- Team types in this category are likely to be those which are either not commissioned within the CCG geography, or if there is a service commissioned by a neighbouring CCG's geography it is unlikely a patient would be referred to it. This is to ensure in-area services are returned in preference to out-of-area services.

2.2 Hierarchy

There are seven hierarchy levels that DoS profiles can be filed under.

2.2.1 Level 1

- Level 1 of a DoS profile should be the DoS region where the service geographically primarily resides or provides services for. It enables DoS profiling/permissions to be managed/audited at region level, and for a DoS region's DoS profiles to be easily exported for use in other applications.

2.2.2 Level 2

- Level 2 of a DoS profile should be the grouping of CCGs that are maintained by an individual DoS Lead or DoS team (e.g. Norfolk, Surrey etc.). Depending on the structure of DoS resourcing, this may align with the system resilience group (SRG), STP (strategic transformation plan) footprint, urgent and emergency care (UEC) network or otherwise. This profile would be purely administrative and set in the organisational cluster team type. It enables DoS profiling/permissions to be managed and audited at DoS Lead/team level, and for a DoS Lead/team's DoS profiles to be easily exported for use in other applications.
- Where an organisational cluster contains a sole CCG, it should still be set up to ensure all CCG profiles are at Level 3.

2.2.3 Level 3

- Level 3 of a DoS profile should be the CCG where the service geographically primarily resides or provides services for. It may be the CCG that has commissioned the service, or the lead CCG that has commissioned the service should it be co-commissioned. This is the level where the ranking strategy should sit. It enables DoS profiling/permissions to be managed and audited at CCG level, and for a CCG's DoS profiles to be easily exported for use in other applications. It also means that an individual CCG and all the DoS profiles underneath that they are responsible for can be moved between organisational clusters and DoS regions easily.

2.2.4 Level 4

- Level 4 of a DoS profile should be the provider/contractor of a service. In many cases, this will be the active DoS profile that is searched by the end user. In some cases, where one provider/contractor provides a number of services within the CCG (e.g. Boots pharmacies) it may be a parent profile which allows permissions for the services underneath to be easily assigned.

2.2.5 Level 5

- For providers/contractors that have multiple services within a CCG, Level 5 of a DoS profile will be the active DoS profile that is searched by the end user. Otherwise it will not be used.

2.2.6 Levels 6-7

- Levels 6-7 of a DoS profile are due to be removed and should not be used.

2.3 Search distance

The DoS in NHS Pathways has a default search distance of 60km north/south and east/west from the patient's current location. In most cases, particularly urban areas, this is too far and presents options to a Pathways call handler beyond where the patient would reasonably be expected to travel. Some system suppliers have the functionality to change this default distance at either postcode or postcode district level (or both), and in the future DoS itself will. It may be this default search distance could have uses beyond NHS Pathways in the future.

2.3.1 Suggested methodology to determine search distance

- Identify the furthest apart geographical services that a patient would be required to travel to. For most areas, this will be an ED with a full eye casualty (e.g. all Sussex patients would need to be able to travel to Brighton Eye Hospital, all London patients would need to be able to travel to Moorfields Eye Hospital). The rationale is that any service a patient may be referred to would not be further away than the second furthest of these services.
- Disregard any services where the location is notional (e.g. GP OOH), as further profiles with notional addresses could be added to accommodate any reduction in search distance (potentially subject to time/cost implication of configuring of ITK messaging); however be sure to identify any requirements for this during scenario testing and before implementing the new distances.
- Identify a central postcode within each postcode district. These will typically be **** 1AA for the Royal Mail address. The number 1 may be 0, 4 or different in some areas. A postcode table or the postcode search on www.royalmail.com/find-a-postcode will help you identify these. If resource allows, it may be possible to specify search distances at a more granular level. However, providing search distances at postcode district level initially will help ensure that almost all new postcodes are accounted for without further work.
- Use service search on the DoS website to measure the distance from each identified postcode to the second furthest identified service. This is effectively your scenario testing as you are ensuring that the reduction in search distance will not prevent required services from returning. Note that the results here are shown in miles and may need converting to kilometres, depending on your host system.
- Add an envelope to this distance to account for the width and breadth of the postcode district. This will vary depending on the size of the district. You may need to round up to a full kilometre, depending on your host system.
- Ensure your process has sign-off from your local clinical governance group.
- Provide the host system with the values to update their mapping table in the format they require, and monitor for any detrimental impact on DoS results once implemented.

3 Individual profile set-up

3.1 Duplicate profiles

- Only duplicate profiles when necessary to reduce administrative burden.
- There should only be a requirement to duplicate DoS profiles where the service has either:
  - geographical coverage beyond the search radius, for example GP OOH service covering a number of CCGs
  - a change in clinical offering during the opening hours, for example nurse-led WIC, GP-led WIC and X-ray at WIC
  - a GP Choice offering in addition to its GP in-hours service; and/or
  - a different naming, ranking, referral method or disposition instruction requirement
- When duplicating profiles, consideration should be given as to whether each of the supplementary profiles requires matching referral roles.
- If a number of services are commissioned from the one provider, and demographic details are the same (including team type, location, opening hours and referral method), these are possible to incorporate on the same DoS profile.

3.2 Service status

There are seven service statuses that DoS profiles can be set to:

3.2.1 Commissioning

- Commissioning should be for new DoS profiles that are in the process of being set-up. This is likely to be for new services, services being modelled, or services that are moving to a new provider.

3.2.2 Pending

- Pending should be for new DoS profiles that have been set-up, and are now awaiting sign-off (as per the local governance process) to be made active.

3.2.3 Active

- Active should be for any DoS profile that has been signed-off (as per the local governance process) and is now ready and available to be searched by DoS users. Most DoS profiles should be set with this service status.

3.2.4 Suspended

- Suspended should be for any DoS profile where the service is unavailable for a period of time or until further notice, but is likely to be available again in the future.

3.2.5 Closed

- Closed should be for any DoS profile where the service is no longer available, but the profile may be required in the future (for example a pop-up clinic for the winter period which may be re-commissioned the following year, or a service moving to a new provider in the future)
- When some services close (particularly services patients are registered to), it may be necessary to keep the profile active for a period of time with information about what alternative services patients should be accessing.

3.2.6 Retired

- Retired should be for any DoS profile where the service is no longer available, and there is no future use for the profile. These profiles are purged on a periodic basis by the NHS Pathways team when also moved to the retired team type, so if there is any doubt as to whether the profile is needed again, it should not be set as retired.

3.2.7 Template

- Template should be for any DoS profile which is used to populate other DoS profiles with profile information either in-part or in-full. It can also be to hold back-up profiles for key services. It is used for administrative purposes.

3.3 Naming convention

- The service name should be prefixed with an abbreviation of the service type. In most (but not all) cases this will match the team type that the service has been profiled as. The service name should be suffixed with the location of the service or the geographical area it covers. Naming convention should follow the principles set out in the NHS111 Lessons Learned document from 2013.Naming convention should be similar to neighbouring DoS regions to ensure consistency for calls to NHS111 received out-of-area.

3.4 Search algorithm

The embedded document explains in more detail how the search algorithm works.

Search Algorithm Hot Topic.docx

4 Team types

4.1 Emergency department (ED)

Services in this team type will be used for catch all events; that is when there are not at least two services which meet the patient's requirements, then the first two services in the ED team type will present with the suffix '(CATCH ALL)' regardless of the clinical profile, capacity status or search distance. For this reason, emergency department profiles which are not able to deal with a wide range of ages or symptoms should not be placed in this team type:

- Eye hospitals should be placed in the eye casualty team type and paediatric units should be placed in the speciality ED team type
- Services in the ED team type should not include any primary care level symptom discriminators in the clinical profile
- Services in the ED team type should not be restricted to any GP surgery.

4.2 Dental care services

There are three team types for dental services:

4.2.1 Dental services

- This team type should contain in-hours dental practices, as listed in the Business Services Authority database.
- They should be ranked higher than the dental emergency team type.
- NHS dental practices are commissioned to provide urgent access slots. Unavailability of these slots should be managed using the capacity status functionality, and not by removing disposition codes from the clinical profile.

4.2.2 Dental emergency

- This team type should contain dental helplines, dental assessment and triage services, and urgent and emergency unscheduled dental care services
- They should be ranked lower than the dental services team type
- They may be open during the in-hours period and/or the OOH period.

4.2.3 Domiciliary dental

- This team type should contain dental services that are able to provide assessment and/or treatment in a patient's home.

4.3 Pharmaceutical services

There are four team types for pharmacy services:

- Services which are typically open during the in-hours period should be included in the pharmacy team type
- Services whose opening hours span into the out-of-hours period should be included in the pharmacy extended hours team type. This is to enable these services to return in the evening, even if an in-hours pharmacy is open within the disposition timeframe the following morning
- Additional services commissioned from pharmacies can be cross-referenced against the PSNC database (http://psnc.org.uk/services-commissioning/services-database/). They should be included in separate profiles in the urgent repeat medicines or minor ailments service team types (if relevant), ensuring no clinical codes overlap between the different profiles.

4.4 Mental Health

The recommendations from the 2015 paper “MH DoS profiling for commissioners and providers guidance” should be followed:

- Mental health teams aiming to divert patients with suicide ideation away from Emergency Departments should add the relevant ED disposition codes to their own service profiles, to ensure patients are not inappropriately referred to ED (if the service is able to deal with the patient in the relevant timeframe)
- Mental health teams aiming to divert patients with low level depression away from general practice should add the relevant PC disposition codes to their own service profiles to ensure patients are not inappropriately referred to GP practices (if the service is able to deal with the patient in the relevant timeframe)
- All services that form part of the Mental Health Crisis Care pathway should be included on the DoS
- All Section 136 / Health Based Places of Safety should be profiled on the DoS to help ensure that people (particularly children and young people) are not held/assessed in police cells
- Ensure that Crisis Support services are able to receive referrals directly from NHS111
- Ensure that any third sector organisations that can provide support to patients in crisis are profiled on the DoS.

4.5 General practice in-hours services

There are three team types in DoS which cater for in-hours GP services.

4.5.1 GP in-hours

- DoS profiles in this team type should only cover the core contract hours of 8.00am to 6.30pm Monday to Friday. Otherwise GP in-hours profiles will return inappropriately for patients out of the area in the out-of-hours period.
- Where a surgery is not open for the entirety of the core contract hours, there should be clear signposting to the alternative cover provided. This is sometimes referred to as marginal cover (e.g. 8.00-8.30am or 6.00-6.30pm). This signposting may be on the GP answerphone message or in the DoS disposition instructions.
- Where a branch surgery or a group of surgeries are closed for part of the day (e.g. for training) and cover provided by the group practice or another provider(s), the GP in-hours profiles should have their opening times amended to show they are closed. There should be a separate, dedicated DoS profile set to open for the covering service, which will have the same team type as the covering service (e.g. OOH) to ensure search distances work as they should. The changing of times on the DoS profiles should be achieved using the exception dates functionality unless the closure is a weekly event.
- The GP in-hours profile should not be restricted, as surgeries have a requirement to accept referrals for temporary residents.
- The GP in-hours team type should be ranked higher than the GP OOH team type, to ensure that the GP surgery is offered to a patient in preference to the out-of-hours service if both are open during the disposition timeframe.

4.5.2 GP extended hours

- Any hours that a GP practice is able to accept new referrals outside of the core contract hours should be covered on a GP extended hours profile.
- The GP extended hours profile should be restricted to patients registered at that surgery or a number of local surgeries. Otherwise GP extended hours profiles will return inappropriately for patients out of the area during the out-of-hours period. If this restriction is not possible, the team type should be changed to WIC.
- The GP extended hours team type should be ranked higher than the GP OOH team type, to ensure that the GP extended hours service is offered to a patient in preference to the out-of-hours service if both are open during the disposition timeframe.
- Consideration should be given to the GP extended hours service being able to either update their capacity on DoS, or make onward referral to the GP OOH service, should they run out of appointments whilst showing as open on DoS.

4.5.3 GP Choice

The team type of the existing in-hours DoS profile should not be changed to GP Choice, as this will prevent the “(Home GP)” suffix being displayed correctly, and cause issues with reporting volumes of GP Choice referrals.

- Surgeries offering services to GP Choice patients should have their DoS profile duplicated in the GP Choice team type
- The GP Choice team type may be ranked lower than GP in-hours to reflect the fact it is only an available choice for a small cohort of patients.

5 Governance

5.1 Commissioned services

DoS Leads and teams may or may not be clinicians. As the clinical profile will inform referral decisions for non-clinical users of NHS Pathways, clinical oversight is essential to ensure it is safe. The following principles are to inform regional governance procedures and do not supersede them.

- Any health services or healthcare-relevant social care services commissioned by NHS England, Clinical Commissioning Groups or the local authority or any other relevant body should be included in DoS
- The nominated operational lead and contracting manager responsible for the service(s) should both have visibility of any demographic/administrative changes
- In certain circumstances if the permissions allow and appropriate safeguards, reporting and procedures are in place, it is possible for administrative changes to be made or proposed by the providers directly, or a provider answering 111 calls
- Care should be taken when amending opening hours that these are in line with the commissioned opening hours for the service
- Any clinical changes to NHSP codes should be agreed by the nominated clinical lead for the service(s) prior to being implemented
- If a service is unable to accept new clinical codes designated for their team type, they should be asked to advise where the code should be mapped to instead, understanding that if the code is not mapped it will result in a catch all event which should be avoided at all costs
- Any clinical changes should be confirmed by the nominated clinical lead for the commissioner prior to being implemented; however removal of clinical codes can be agreed by the commissioner without consent of the provider
- The regional clinical governance lead (or their nominee) should have an overview of clinical changes being applied and review any exceptions prior to being implemented
- The DoS Lead should make use of call routes (including Pathways Web), predicted volumes from beta testing (when available), descriptions for symptom discriminators (when available) and NHSP clinical queries calls to assist the clinical representatives in understanding the context and impact of any new clinical codes
- Clinical changes to type one services (dental practices, GP practices, opticians and pharmacies) can be agreed ‘in bulk’, as the core profile should be the same across all services, and agreement by individual services would be untenable
- Clinical profiles should be regularly compared against the national template and the profiles of neighbouring services in the same team type, to ensure consistency and avoid missing codes
- Clinical codes may potentially be removed from lower ranked services to encourage selection of higher ranked services. However, consideration should be given to what would happen should the higher ranked service become temporarily unavailable during the 24-hour period (e.g. red capacity status) to avoid a catch all event
- Z codes are searched for by clinical users only. Whilst that means these changes can potentially be applied without the prior agreement of the clinical representatives, best practice would be to follow the same governance framework as for NHSP codes

- Clinical DoS Leads may have devolved responsibility to undertake the clinical sign-off on behalf of the commissioner
- Overall responsibility for the content of DoS, and the appropriate governance being applied, sits with the assigned DoS Lead and DoS teams.

5.2 Non-commissioned services

- In the absence of a formal commissioner, the local clinical governance lead or their delegate is able to provide sign-off for any clinical changes.

5.2.1 National services

Some services are delivered nationally. Whilst there is a desire for local areas to be able to access them on DoS, the responsibility for profiling the services doesn't immediately sit with regional teams.

- National bodies may have local teams which can be profiled on the DoS (as per sections 5.1 or 5.2)
- Regions wishing to profile national services may do so (as per sections 5.1 or 5.2) and then submit the profile(s) to the National DoS Lead(s) who will maintain a register of services profiled
- Other regions will be able to access the register of national services profiled to help inform their local profiling; however where profiles are duplicated to cover additional geography, the governance arrangements will sit with the DoS region where the profile resides.

5.3 Capacity status

It is vitally important that DoS profiles accurately reflect the capacity of services that are open to receive referrals. This is achieved using the capacity status tab, where services can be set to green, amber or red. This is different to the capacity grid functionality within DoS and there is not necessarily a direct correlation between the two.

5.3.1 Definitions

- **Green** – a service has high capacity. The service is able to accept referrals and likely to meet any disposition timeframe
- **Amber** – a service has limited capacity. The service is able to accept referrals but they are busy and may not be able to meet the disposition timeframe. Alternative services should be considered where possible
- **Red** – a service has no capacity. The service is not able to accept referrals or has run out of appointments. Services will not present as an option (apart from an emergency department in a catch all event).

5.3.2 Updating the capacity status

- Any service should have the facility to have their capacity status updated to amber if needed without delay across the 24/7 period. Failure to do this would result in patients potentially being misled that a service isn't busy when it is. This may be by using their access permissions or accessing a managed phone line.
- Services that are deemed to be 'supplementary' should have the facility to have their capacity status updated to red across the 24/7 period. Supplementary services are likely to cover a smaller geography and be ranked in the higher categories, and have most if not all of their clinical profile form part of another service available to the patient (e.g. MIU, UCC or WIC would typically have a sub-set of the GP clinical codes). The exact services or service types are for local determination. Failure to do this would result in patients potentially being directed to a service which is unable to accept the referral.
- Services that are deemed to be 'core' should only be updated to red with sufficiently senior approval i.e. only in case of a major incident as part of established protocols. Approval is likely to come from an on-call director for the commissioning organisation. Escalation procedures should allow for this approval to be granted in a timely manner and the change to be made to DoS across the 24/7 period
- Triggers for changing the capacity status to amber or red should be in the escalation procedures for individual services
- Changes could be made by DoS Leads, on-call teams and/or provider organisations with appropriate training and access permissions to ensure 24/7 cover
- An audit trail of any changes must be kept and commissioners of services alerted retrospectively to the changes made.

6 Weighting and scoring

The principles outlined in this document focus on how profiling activities should be undertaken by regional DoS teams, and has been produced after extensive consultation with DoS Leads and Clinical Leads nationally. Adherence to the principles will form part of the over-arching Quality Review process, which in turn feeds into the quarterly DoS Assurance Board and Integrated Urgent Care Checklist return to NHS England.

For each profiling principle in sections 2-4 of this document, there are four outcomes that can be attributed for a DoS region:

- Principle met in full – 2 marks
- Principle not met (with local mitigation) – 2 marks
- Principle met in part – 1 mark and recommendations for improvement given
- Principle not met – 0 marks and recommendations for improvement given

Section 3.2 has ¼ the weighting of other sections in this document. Section 5.1 has double the weighting of other sections in this document. The total score is 200.

6.1.1 Evidence gathering

Evidencing compliance with the profiling principles will be achieved using a variety of methods. This exercise should be completed in partnership by the regional DoS Lead and National DoS Lead.

The following table sets out the total marks available for each section of this document and the evidence required in order to ascertain whether or not the principles have been met. It is expected the Regional DoS Lead will repeat the exercise with their local DoS Leads to understand any variation within their region.

Section	Description	Marks	Evidenced by
2.1	Ranking strategy	18	Review of ranking strategy
2.2	Hierarchy	14	Service status report
2.3	Search distance	14	Discussion with regional team
3.1	Duplicate profiles	8	Review of duplicate profiles
3.2	Service status	4	Service status report
3.3	Naming convention	2	Service status report
	SUB-TOTAL	60	
4.1	Emergency departments	6	Review of ED profiles
4.2	Dental care services	14	Review of dental profiles
4.3	Pharmaceutical services	6	Review of pharmacy profiles
4.4	General practice in-hours	22	Review of GP profiles
4.5	Mental health	12	Review of mental health profiles
	SUB-TOTAL	60	
5.1	Governance (comm'd)	60	Regional governance procedure
5.2	Governance (non)	8	Regional governance procedure
5.3	Capacity status	12	Regional governance procedure
	SUB-TOTAL	80	
	TOTAL MARKS	**200**	