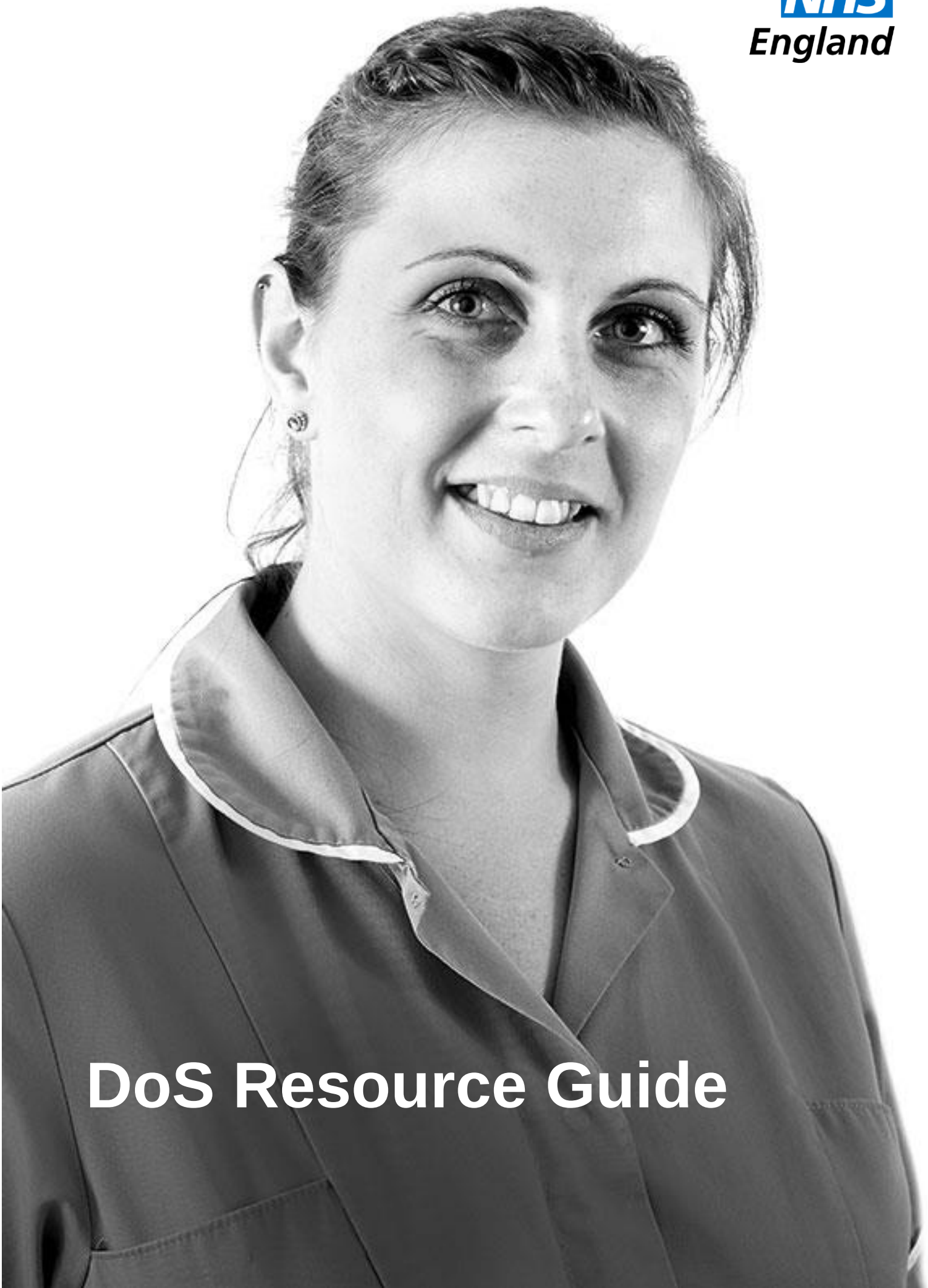
NHS England



DoS Resource Guide

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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	20-05-16	Initial document by NHS Pathways Live Service
0.2	16-07-16	Initial review of document by National DoS Lead
0.3	12-08-16	Discussion with individual DoS regions
0.4	15-11-16	Added per capita ratio, band range, meeting frequency and out-of-hours
0.5	06-01-17	Added reviewers, approvers, number of CCGs, IUC PMOs, section on emergency DoS changes and reviewed actions and recommendations
0.6	20-02-17	Final draft including executive summary for UECR Programme Board
0.7	24-03-17	Confirmation of endorsement from UECRPB; regional scores redacted
0.8	03-06-17	Re-titled DoS Resource Guide as Appendix to IUC Service Specification

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1 Executive Summary

The Directory of Services (DoS) is a critical system, referenced in the Urgent and Emergency Care Route Map[1] (published November 2015), that supports the delivery of the Keogh Urgent and Emergency Care Review.

The data contained within DoS is maintained by DoS Leads: hosted in various types of organisations but the ultimate responsibility of CCGs. There is a varied mix of DoS Lead resourcing across the country, with areas of concern to a lesser or greater degree in each DoS region. NHS Pathways and NHS England have limited visibility of the funding and hosting arrangements for DoS teams or of the staffing levels associated with the role. As a result, there is little confidence in the current situation being fit-for-purpose, and many Regional DoS Leads continue to informally raise concerns with both organisations that their commissioner is not sufficiently committed to the DoS and does not fully understand the full requirements for the role(s).

In order to make the level of resourcing equitable across the country, a ratio measurement is introduced in this paper. Whilst some would consider their WTE to be proportionate with the number of CCGs supported or number of services listed, there is great variation in these throughout England. Population size was therefore selected as the most appropriate denominator to use.

The finding from nine months' consultation with stakeholders surmised in this paper, concludes that DoS resourcing was inadequate to meet the requirements of NHS 111 from 2013, and hasn't kept pace with the evolving needs of the directory. The Urgent and Emergency Care Review Programme Board endorsed the requirements in this paper on 21st February 2017; namely:

- A 'resourcing reset' for commissioners to bring their resource up to standard
- Any resource with sole responsibility for one or more CCGs to be at **AfC band 5 and above**, receiving **strategic direction from AfC band 7 and above** (who does not have local DoS management responsibility)
- Resource in line with the size of the population at a ratio of **at least** 1:450,000
- Recruitment or re-deployment of additional WTE DoS personnel across the country (with each CCG contributing no more than 1 WTE), which will be funded by DoS effecting optimised referrals to lower acuity settings and reducing demand from Integrated Urgent Care to A&E and urgent primary care settings
- Delivery of a regional emergency DoS changes function from 1st April 2017
- Commitment to further develop the DoS maintenance function to remain an integral part of the Integrated Urgent Care system
- Future increases in DoS workloads to be met by process efficiencies, technical enhancements and cross-directory reduction in duplicated efforts, in part delivered by the NHS Digital Access to Service Information (A2Si) Programme.

[1] http://www.nhs.uk/NHSEngland/keogh-review/Documents/1600505%20UEC%20Routemap%20updated%20FV.pdf

2 Introduction

This paper has been produced at the request of the NHS Pathways Programme Board and Integrated Urgent Care (IUC) National Clinical Leads Group to ascertain the status of current regional Directory of Services (DoS) resourcing across the country and identify any remedial action required. It has been prepared with input from the NHS Pathways Live Service team members and the IUC Delivery Team at NHS England.

The term 'Regional DoS Lead' typically refers to between 1 and 4 individuals covering each former Strategic Health Authority (SHA) regional 'footprint' with responsibility for the management and administration of DoS in their area through local DoS Leads, Administrators and Champions. The underlying stocktake to this guidance paper can only ever be a snapshot in time, as resource within DoS regions is an ever-moving picture.

The implementation and support structures and resourcing for DoS in NHS England (the commissioner and therefore, by default, owner of the product and the data population within it), NHS Pathways Live Service (the product vendor within NHS Digital) and SSD (the hosting, support and development arm of NHS Digital) are predicated on having this network of Regional and Local DoS Leads in place across the country. They require the necessary skills and experience to meet the outline job profile, and to be supported by appropriately skilled and experienced local DoS Lead resource to carry out the 'day to day' support and profiling of the DoS.

2.1 Integrated Urgent Care Service Specification

The IUC Commissioning Standards[2] were published in October 2015 to provide guidance on the requirements of the new IUC service, commissioned to enhance the existing service provided by NHS 111. They have since been refreshed to provide clearer requirements to Commissioners, and so will be replaced by the IUC Service Specification in June 2017.

Section 4.4 of the existing IUC Commissioning Standards provided specific instruction relating to DoS resourcing, which served as a baseline for conducting this review and formulating the ongoing requirements:

[Commissioners] should ensure that expert resources are available to engage with all services in order to effectively maintain and update systems providing access to service information.

[Commissioners] should ensure that resources employed to maintain service information are at an equivalent grade to other areas, [have sufficient leadership skills] and are supported by a local governance model with clear reporting structures from the local level through to national reporting and oversight.

[Commissioners] must ensure that adequate resource is allocated to testing of service information returns to the NHS 111 service following profiling changes and/or CDSS upgrades.

The new Service Specification mandates adherence to this paper's findings.

[2] https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf

2.2 Anticipated future requirements for the DoS function

DoS has traditionally served users of NHS Pathways, but in the future is expected to be a source of truth for users throughout urgent and emergency care, primary care and social care. New services are being added to DoS from community, mental health, public health and the third sector to meet the requirements of these new users, as set out in the existing IUC Commissioning Standards:

The Directory of Service (DoS) will hold accurate information across all commissioned acute, primary care and community services and be expanded to include social care.

[Commissioners] need to enable the addition of services from social care, mental health and third-sector services to improve accessibility for patients to these services.

The data is already used to update elements of NHS Choices and sits behind a number of third party applications including patient-facing apps. This growth will only accelerate with the advent of Clinical Assessment Services, Z-Codes profiling and an enhanced application programming interface (API) to DoS data. It therefore follows that with additional services listed and more users, additional resource initially, and then more efficient processes to upload and maintain the data are required.

2.2.1 The consequences of not keeping DoS up-to-date

The potential consequences of an ill-resourced DoS region may include (but not be limited to) the following:

- An increase in referrals to high-cost services by default, such as ED
- Patients referred to inappropriate/out-of-area services for their clinical needs
- Lack of awareness of new services/changes in service details
- Inability to mobilise new services and pilots within the required timescales
- Inability to send electronic patient referrals and post event messages
- Inability to alert service users to changes in capacity demand
- Inability to use new tools such as NHS Service Finder[3] and NHS111 Online
- Ineffective DoS in the new Clinical Assessment Service
- Providers answering out-of-area calls being disadvantaged, as they are unable to access any local solutions and workarounds
- Inadequate training, resulting in a lack of subject matter expertise locally
- Inadequate succession planning, resulting in a gap in provision when staff have an extended period of absence or leave their role
- Inability to retain the specialist skills invested in by the Commissioner
- A lack of confidence in DoS returns and tools (from staff and patients)
- A lack of confidence in NHS 111 and Integrated Urgent Care
- Reputational damage to DoS, NHS 111, IUC and the wider NHS.

2.3 Risk matrix

Reflecting the high-level statements in the existing IUC Commissioning Standards, the state of DoS resource in a region has been objectively risk assessed for the purposes of the initial stocktake in four areas:

[3] Lack of profiled services due to insufficient DoS resource has been cited by users as a preventative factor of the tool's uptake during the extended beta pilot lessons learned events

2.3.1 "Expert resources"

The level of knowledge and expertise is vital for a Regional DoS Lead to provide clear strategic direction to their area, cascade learning to their team, lead projects and understand how to drive the benefits from their DoS to meet the aims of their commissioners and the wider health economy. The role of the 'Regional DoS Lead' as it is currently termed should be dedicated (i.e. no local DoS responsibility), and the value it brings to the wider health economy formally recognised by commissioners.

Given this and the specialised nature of the role, it is therefore prudent for an area to have sufficient succession planning to ensure any new appointment to the Regional DoS Lead role has had reasonable exposure to the DoS and how it functions (e.g. through a provider, commissioner or system supplier).

- **GREEN:** Regional Lead role(s) fully valued by commissioners
- **AMBER:** Regional Lead role(s) not dedicated or formally recognised
- **RED:** Regional Lead role(s) lacking adequate support from commissioners

2.3.2 "Sufficiently leadership skills"

DoS Leads play a key role in effecting referrals across the healthcare system. There is a danger of misunderstanding the role of a Local DoS Lead to be merely a data entry position, whereas a competent Local DoS Lead with sole responsibility for the DoS in one or more CCG(s) will be a decision maker, engaging and building relationships with providers and commissioners on a regular basis. Where staff's duties are not commensurate with their banding, there is concern over retaining expertise.

Based on the findings of this resource stocktake, from 2017/18 commissioners shall employ resource with responsibility for one or more CCG(s) with the leadership skills expected from those at ***AfC band 5 and above****, receiving* ***strategic direction from the leadership skills expected from those at AfC band 7 and above****.*

- **GREEN:** Grade commensurate with duties throughout entire DoS region
- **AMBER:** Individual area of concern relating to commensurate grading
- **RED:** Multiple areas of concern relating to commensurate grading

2.3.3 "Reporting structures"

DoS Leads should have access to clinical, technical and analytical expertise as necessary to undertake their duties. Regional Leads in particular are likely to be involved with clinical governance groups, contracting meetings, conversations relating to new services or service redesign, A&E Delivery Boards, and national conferences, workshops and online forums (although other DoS Leads should be encouraged to attend where appropriate). They should be engaged and proactive, understanding clearly both their commissioners' and the national strategic priorities, and advising on how the DoS can assist in meeting those priorities.

- **GREEN:** DoS Lead and commissioners fully engaged
- **AMBER:** Individual area of concern relating to engagement
- **RED:** Multiple areas of concern relating to engagement

2.3.4 "Adequate resource"

The nature of funding allocation in the NHS means more and more staff working on DoS find themselves currently employed on a fixed term basis. This presents a risk in that there is no guarantee of continuing funding for the role, which could lead to a gap in service provision and a loss of expertise. Also, reflecting on section 1.2 of this paper, the expectation is for the role to become even more fundamental as the number of services listed on DoS grows, as does its user base.

For the purposes of the initial stocktake and in line with the requirement for Local DoS Leads to be at AfC band 5 and above, resource below AfC band 5 has been classed as administrative, referenced and included in headcount, but not included in WTE calculations.

*Based on the findings of this initial resource stocktake, from 2017/18 commissioners shall employ **permanent** resource in line with the size of their population[4] at a ratio of **at least** 1:450,000.*

- **GREEN:** Dedicated resource meets per capita guideline and in place permanently/beyond the financial year
- **AMBER:** Dedicated resource **EITHER** doesn't meet per capita guideline **OR** isn't in place permanently/beyond the financial year (or posts are vacant)
- **RED:** Dedicated resource **BOTH** doesn't meet per capita guideline **AND** isn't in place permanently/beyond the financial year/posts are vacant **OR** WTE to population ratio is less than 1:900,000

2.3.5 Overall RAG rating

A total of the scores allocated for each of the four areas (where red = 10, amber = 20 and green = 30) provides an overall RAG rating for the DoS region. The score for adequacy is double to reflect the importance of a well-resourced DoS team.

Red	Amber	Amber/Green	Green
50-80 Immediate concern that requires addressing urgently	**90-110** Substantial concern that requires addressing soon	**120-130** Minor concern at present or single issue to address	**140-150** Little/no concern at present but continue to monitor

This combined score of out of 150 will contribute to the overall DoS Quality Review[5], undertaken by NHS England, which takes a balanced scorecard approach to objectively measure the overall quality of DoS in any given region with a total score out of 1000.

Note: individual region scores have been redacted from this version of the publication and are available to appropriate recipients by emailing england.dos@nhs.net.

[4] Whilst other factors such as number of CCGs, number of services and local configuration and geography are important, population size was found to be the most consistent factor to consider.
[5] The initial DoS Quality Review is due in June 2017.

3 Emergency DoS changes during the OOH period

In order for DoS to be kept up-to-date 24/7, there must be consideration given to how emergency changes are made during the out-of-hours period, in response to unforeseen circumstances. Given the vast majority of NHS 111 and IUC activity is during the out-of-hours period (particularly weekends), changes identified at these key times should be reflected as soon as possible, to ensure referrals are not made to services unable to receive them.

NHS England has run an 18-month pilot between 1st October 2015-31st March 2017, providing a 24/7 on-call facility for changes to be requested during designated busy periods for those regions without their own facility. Below is a summary of the number and type of calls received.

Period	Profiling change	Profiling error	Technical contingency/ access	Service closed	Capacity update	TOTAL
Winter 2015/16	1	2			9	12
Easter 2016	2	5	2	2	3	14
Bank Holidays 2016		4		1		5
Winter 2016/17	4	6	3	3	6	22

The pilot has found that whilst the volume of requests is relatively low, the types of changes are those that require immediate attention and cannot wait until the next working day. Whilst they are more likely during public holiday periods, the changes may be required at any time throughout the year. Additionally, local knowledge and contacts would be of benefit to the on-call member instead of a national contact.

Therefore, Commissioners shall provide geographical delivery numbers (beginning 01, 02 or 07) to england.dos@nhs.net for this emergency changes function to be delivered within their region across the 24/7 period from 1st April 2017 onwards.

Balancing existing expertise of DoS personnel with training requirements for other staff groups, they may seek to commission an on-call facility from DoS personnel, utilise existing on-call structures (e.g. directors) or 24/7 staff groups (e.g. IUC/999 supervisor desks), or enable direct access by key individual providers.

4 DoS Resource Requirements

- The NHS England national DoS team shall work with stakeholders, including NHS Pathways Live Service, NHS Digital Access To Service Information, NHS England Digital Urgent and Emergency Care, IUC Clinical Leads and IUC Regional PMOs to progress the actions highlighted in this paper
- The NHS England national DoS team shall lead by example and expand in line with the expansion requested of regional DoS teams
- The NHS England national DoS team shall schedule a monthly conference call with each Regional DoS Lead and their Commissioner(s) to discuss resource in their region and the wider DoS Quality Review, and attempt to attend their regional meetings quarterly
- DoS Improvement Funding shall be made available to DoS regions in 2016/17 to address concerns raised by this resource stocktake and the wider DoS Quality Review
- Commissioners shall meet the requirements to have the following DoS resource in place from 2017/18 onwards:
    - A minimum ratio of 1 WTE per 450,000 population AfC band 5 and above:
        - Supplemented by administrative resource below AfC band 5 if necessary (not counting towards the per capita)
        - Receiving strategic direction from AfC band 7 and above who does not have local DoS responsibility.
    - Provision to make emergency demographic and capacity status changes[6] outside of office hours, including (but not limited to):
        - Change in opening hours or contact details e.g. WIC staying open later to relieve pressure on A&E, providing mobile phone back-up if landline has failed
        - Profile errors e.g. test profile set to live, OOH profile not set to open on a bank holiday
        - ITK contingency e.g. routing cases to the back-up server of an OOH provider, technical changes, access issues
        - Services closing temporarily e.g. fire, flood, evacuation
        - Capacity RAG status change e.g. no GP on duty at GP-led health centre, ED department set to amber (with the appropriate authorisation), GP extended hours provider run out of appointments, pharmacy unable to deliver NUMSAS.
- Stakeholders shall work with the NHS England Workforce Development Programme in 2017/18 to define the skills and competencies required of DoS personnel at different AfC bandings, and consider re-titling of the role to more accurately reflect the duties undertaken and value brought to the system
- The underlying stocktake and resource requirements should be continually reviewed to ensure they meet the requirements of the forthcoming financial year, and presented at the DoS Assurance Board, whose remit is to monitor DoS quality across England, preparedness by regions for the implementation of DoS updates and set the strategic direction.

[6] No clinical profile changes should be made during the OOH period