Professional Record Standards Body

Better records for better care

111 REFERRAL INFORMATION STANDARD

FINAL REPORT V1.1

April 2023

Acknowledgements

The Professional Record Standards Body
The independent Professional Record Standards Body (PRSB) was registered as a community interest company in May 2013 to oversee the further development and sustainability of professional record standards. Its stated purpose in its Articles of Association is: “to ensure that the requirements of those who provide and receive care can be fully expressed in the structure and content of health and social care records”. Establishment of the PRSB was recommended in a Department of Health Information Directorate working group report in 2012.

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Community Interest Company No 8540834

Document Management

Revision History

Version	Date	Summary of Changes
0.1	16.02.2022	Initial report
0.2	21.2.2022	After initial review
0.3	11.03.2022	Further team review
0.4	16.03.2022	New version to clear comments and track changes
0.5	16.03.2022	Headings reformatted
0.6	17.03.2022	Updates after full team review
0.7	31.03.2022	Updates following BaRS and assurance committee review
1.0	11.04.2022	First release after BaRS and assurance committee approval
1.1	11.04.2023	Updated to change GP to general practice for clarity

Reviewers

Reviewer name	Title / Responsibility	Date	Version
Martin Orton	PRSB Project Manager	11.03.2022	0.2
James Ray	Clinical Lead (ED)	16.02.2022	0.5
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Approved by

Name	Date	Version
PRSB Assurance Committee	21.03.2022	0.6
Booking and Referral Standard (BaRS) Product Board	04.04.2022	0.6

Glossary of Terms

Term / Abbreviation	What it stands for
The PRSB	**The Professional Records Standard Body** are a unique collaboration of groups representing those who receive and provide health and social care across the UK, as well as those providing the IT systems that support care.
The PRSB CTOP	**PRSB clinical and technical operations panel**
NHS E & I	**NHS England & Improvement** - NHS England and NHS Improvement have worked together as a single organisation since 1 April 2019, to help improve care for persons and provide leadership and support to the wider NHS.

NHS D	**NHS Digital** – Formally the Health and Social Care Information Centre (HSCIC) was formed in 2013 as the primary delivery organisation taking charge of information, data and IT systems for commissioners and clinicians in health and social care across England NHS X and NHS D have integrated with the Transformation Directorate at NHS England.
NHS X	**NHS X** – Lead the digital transformation arm of the NHS setting standards and policy, supporting the digitisation of health and care organisations 2019 – 2022. After three years leading the digital transformation of health and social care as NHSX, NHS X and NHS D have integrated with the Transformation Directorate at NHS England.
NHS 111	**NHS 111** - is an NHS service which makes it easier and quicker for persons to get the right advice or treatment they need, be that for their physical or mental health. 24 hours a day, 7 days a week. To get help from NHS 111, you can: • Go online to 111.nhs.uk (for assessment of people aged 5 and over only). • Call 111 for free from a landline or mobile phone.
NHS 24	**NHS 24 – Scotland 111 service -** provides urgent care and advice when your general practice, pharmacy or dental practice is closed
111 Online	**111 Online -** is a fast and convenient alternative to the 111-phone service and provides an option for people who want to access 111 digitally. It is one of several digital NHS services that are empowering people to manage their own health and care. Where enabled 111 offers the ability for the person to book direct into ED
111 CAS	**111 Clinical Assessment Service -** Through a single Clinical Assessment Service (CAS), healthcare professionals working outside of a hospital setting, staff within care homes, paramedics and other community-based clinicians will be able to make the best possible decision about how to support people closer to home, potentially avoiding unnecessary trips to A&E.
COVID 19	**COVID-19** is a new form of coronavirus known as SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2). It was first reported in December 2019
PEM For Information	**Post Event Message –** A message that is sent back to the registered general practice informing them of the encounter with 111
PEM For Action	**Post Event Message –** A general practice Referral message from 111 which is sent to the general practice when action is required from the general practice. This is the current name and applies to the currently flowing ITK messages. In future this will be called a 111 referral. 111 sends a referral (PEM for action currently) when booking direct in to general practice appointments in England.

Repeat Caller	Identifies repeat caller that calls the 111 service on multiple occasions over a short period of time (in response to the section 28 of the coroners ruling in the Penny Campbell case).
Royal Colleges	The organisations that provide oversight and governance to the medical professions and provide endorsement to PRSB standards
BDA	British Dental Association
OCDO	**Office of the Chief Dental Officer**
RPS	**Royal Pharmaceutical Society**
BPS	**British Psychological Society**
NHS BaRS	**Booking and Referrals Standard** - The Booking and Referral standard is an interoperability standard for healthcare IT systems that enables booking and referral information to be sent between NHS service providers quickly, safely and in a format that is useful to clinicians. It will eventually be available in all care settings.
AACE	**Association of Ambulance Chief Executives - includes:** • The National Ambulance Service Medical Directors (NASMeD) • National Ambulance Service Directors of Operations (NDOG) • National Digital Leaders Group (NDLG)
CDSS	**Clinical Decision Support Systems**
NHS Pathways	**NHS Pathways** - NHS owned algorithmic clinical assessment tool
NHS Pathways Outcome codes **SG, SD & DX Codes**	**SG – Symptom Group – Presenting Need / Issue** **SD – Symptom Discriminator – Severity, Clinical need** **DX – Disposition Code – Urgency**
AMPDS	**Advanced Medical Priority Dispatch** System (AMPDS) is a unified system used to dispatch appropriate aid to medical emergencies including systematized caller interrogation and pre-arrival instructions
DOS	**The Directory of Services (DoS)** is a central directory that is integrated with NHS Pathways and is automatically accessed if the patient does not require an ambulance or by any attending clinician in the urgent and emergency care services.
PODAC Program	**Pharmacy, Optometry, Dentistry, Ambulance and Community -** national Digital PODAC programme to improve digitisation and productivity using digital technology across PODAC sectors.
ECDS	**The Emergency Care Data Set (ECDS)** is the national data set for urgent and emergency care. It replaced Accident and Emergency Commissioning Data Set
ED	**Emergency Department** (also known as A&E)

111 – ED Pilot	A First of Type use case using the 111 Referral standard
FoT	**First of Type**
ITK Message	**Interoperability** Toolkit - provides specifications for electronic messaging between systems, supported by an accreditation for suppliers who build solutions that adhere to these specifications.
SNOMED CT	**Systematized Nomenclature of Medicine Clinical Terms** is a structured clinical vocabulary for use in an electronic health record. It is the most comprehensive and precise clinical health terminology product in the world.
Fast Healthcare Interoperability Resources (FHIR)	**FHIR** is a Health Level Seven International (HL7®) **standard** for exchanging healthcare information electronically. ... **FHIR** combines the best features of previous **standards** into a common specification, while being flexible enough to meet needs of a wide variety of use cases within the healthcare ecosystem.
IUC Specification	**Integrated Urgent Care Service Specification**
Use Case	A methodology used in system analysis to identify, clarify, and organise system requirements
NHS appointment booking standard	The NHS appointment **booking standard** is an open **standard** supporting **booking** across many **care** settings. It utilises the **Care Connect** FHIR messaging **standard** and is being published in the form of a website
API	**Application Programming Interface**, which is a software intermediary that allows two applications to talk to each other. Each time you use an app like Facebook, send an instant message, or check the weather on your phone, you're using an API.
Clinical Document Architecture (CDA)	The **HL7** Version 3 Clinical Document Architecture (**CDA**®) is a document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange between healthcare providers and people.

Planned Review Date and Route for User Feedback

The next maintenance review of this document is planned for a 3 year period, subject to agreement with NHS X as the commissioning body.

Please direct any comments or enquiries related to the project report and implementation of the standard to support@theprsb.org

Contents

1 Executive Summary

It is well known that the NHS services across the UK are under real pressure with demand outstripping supply. The pressure has recently been exacerbated by the pandemic but also exacerbated by patients not being seen in the services appropriate for their needs. Across the UK, 111 services are becoming the first point of contact for urgent care with the aim to direct patients to the most appropriate service for their needs.

England's NHS Long Term Plan sets out to ensure patients get the care they need, fast, and to relieve pressure on A&Es through referring patients to the most appropriate service, which could include urgent treatment centres, same day access services, general practice primary care based services, or other services such as community, mental health, community pharmacy, dentistry or optometry. In some cases the 111 services would have the ability to book slots or appointments with the receiving service.

Currently in England, a 111 report can flow to the receiving organisation using an Interoperability Tool Kit (ITK) message. This report is based on the summary of decision points from the triage algorithm and reads poorly by clinicians on the receiving end – it lacks clinical value by not using a language that clinicians are trained to use. The same ITK message is used to inform the person's general practice of the 111 encounters, this is known as a post event message (PEM) or 111 report for information.

The NHS bookings and referral standard programme (BaRS) is working to develop both a booking and referral standard for 111 referrals to support the needs and policy, and which can be implemented using FHIR (Fast Healthcare Interoperability Resources) technology which is the current NHS standard and being widely adopted across health and care. The PRSB is providing the 111 referral content standard.

PRSB have developed the 111 referral standard to provide clear, concise and effective information for the 111 referral along with a post event message (PEM), a subset of the referral, to inform the person's general practice.

The standard will provide clear, easy to use information that can be shared with the receiving clinician or professional so they can provide appropriate, efficient, effective, and safe treatment to the person. It allows for the sharing of the clear reason for the referral to allow a safe transfer of care. The presenting need (as identified by the person), the chief complaint (identified either through the triage process or by a clinician) and the chief clinical concern or a diagnosis where there has been assessment by a clinician. The standard will give people confidence that information they provide is passed on to next stage in their journey so they don't have to repeat it all each time.

1.1 Development methodology

The 111 Referral standard has been developed over a four-year period through several commissions and phases, as summarised below, and in accordance with the proven, established, and trusted PRSB methodology involving UK wide consultation.

In 2018 PRSB were commissioned by NHSE to set out the high-level information requirements for a 111 clinical assessment service. The work included research and evidence gathering of existing guidance, current practice (examples of current records and communications, output from clinical decision support systems), and relevant related projects and standards. Draft requirements were developed from this and then refined

through a multi-disciplinary workshop with health and care professionals, patients and system suppliers.

Urgent care workflow report and requirements are referenced in Appendix 1

In 2021, PRSB conducted discovery work to validate the previous high-level requirements from 2018 and recommend the work needed to develop a 111 referral standard. This work:

- Validated the 2018 requirements with the addition of a few data items
- Concluded that the proposed standard could work for 111 referrals from call handlers and 111 online, although some information would only be available where there was contact with a clinician.
- Concluded that a general practice post event message (PEM) should be developed alongside the 111 referral standard as it is expected to be subset of the referral information and consultation will involve many of the same stakeholders.

The discovery phase report is referenced in Appendix 2

In August 2021 a short commission delivered a draft information model from the outputs of the discovery work to support pilots for BaRS for 111 to emergency departments (ED). The 111 referral information model V0.2 was provided for this purpose, validated by the same project team from the discovery work, working with NHS Digital and NHSX and using existing PRSB standards components wherever possible for consistency with other standards and FHIR profiles.

Starting in October 2021 PRSB completed the development through;

- Wide consultation through a survey for users of services, senders and receivers of 111 referrals to gain consensus and support for the standard and test it across the many different destination communities including with IT providers and system suppliers. This was followed up with specific engagement with areas with lower numbers of survey responses (dentistry, optometry, mental health and community pharmacy) to verify the draft 111 referral standard was suitable for those areas.
- Verifying that 999 services could provide the essential information of a 111 referral and therefore be included into scope of the standard.
- Engagement with GPs through interviews and focus groups to define the general practice PEM.
- Further work is delayed to May/June 2022 to gather and analyse feedback from the 111 to ED pilots and update the standard as appropriate.

1.2 Summary of findings

- The survey responses and discussions with individual sector focus groups confirmed that the UK wide 111 Referral standard will provide the information required for a clear and informative 111 Referral to any organisation or services the person may go to next following an encounter with 111.
- There is variance across the UK with the Clinical Decision Support Systems (CDSS) used by the 111 services, resulting in differences in the content , structure and workflow of the 111 reports. All UK Countries are keen to standardise the information and information flows.
- All aspects of the 111 Referral consultation, involving general practice, (the survey, GP focus groups & interviews) reported that the existing 111 reports were difficult to read due to the inclusion of the NHS Pathways negative responses and the overall format pushing the important information to the bottom of the 111 report. Discussions with the JGPIT Committee and other GPs representatives confirmed that a subset of the 111 Referral could be used to create a much improved general practice PEM .

There is widespread support for the general practice PEM to be updated as soon as possible.

- The comparison of the 999 data set with the 111 Referral standard confirmed that the 999 services data set can be used to populate the 111 Referral standard. This will support the sending of referrals that do not require the 999 services to 111, but where the 999 service refers directly to other services in the same way as 111 services.
- There are technical developments underway to improve interoperability and information flows across the wider health and care system. These being the implementation of SNOMED by the Clinical Decision Support supplier systems and the ability of sending and receiving systems to send and receive messages via FIHR messaging, the 111 referral standard has been developed with the future in mind but will need updating alongside the system technical developments as required.

1.3 111 Referral Standard

The table below provides a high-level view of the standard. The blue shaded sections are the sections included in the general practice post event message (PEM).

The full standard is referenced in Appendix 8.

Section Name	Conformance - Mandatory, Required, Optional	Description
Person demographics	Mandatory	The person's details and contact information.
Caller Details	Required	Name of caller, relationship, telephone number and preferred contact method. For use where the caller isn't the person needing care or advice,
GP practice details	Required	Details of the person's GP practice.
Dental Practice details	Required	Details of the person's usual dental practice.
Individual requirements	Required	Note that the Individual requirements section includes reasonable adjustment and specific elements for accessible information requirements to support communication.
Safeguarding	Required	Any safeguarding concerns identified
RIsks	Required	Any risks identified, includes risks to self or to others
Consent for information sharing	Required	This is a record of consent for information sharing under the common law duty of confidentiality. Where consent has not been obtained or sought, the reason why should be provided. Include best interests decision where person lacks capacity.
Referral details	Mandatory	Details of the referral; from where and to where and any person input into the selection. Also urgency of referral, which where the Pathways triage is used is derived from the DX code resulting from the triage process.
Presenting Complaints or issues	Mandatory	Presenting complaints or issues and the Chief Compliant which is manadatory. Where the Pathways triage is used the Chief Complaint is derived from the symtom group (SD) or sympton discriminator (SG) code resulting from the triage process.
Problem	Required	Provides either a diagnosis or the chief clinical concern. These are only likely to be available where there has been a clinical assessment.
Clinical Summary	Required	A summary of the person's contact such as reason for attendance, chief clinical concern or diagnosis and actions taken or required. Only likely to be available where there has been a clinical assessment.
Social Context	Required	The social setting in which the person lives, such as their household (e.g. lives alone), occupational history, and lifestyle factors.
Allergies and adverse reactions	Required	This is for person reported allergies or adverse reactions which may not be on the persons electronic health record. It is NOT to transfer the person's recorded allergies which the receiver can look up (e.g. via SCR, GP Record or shared care record).
Medications and medical devices	Required	This is for person reported medications and medical devices which may not be on the person's electronic health record. It is NOT to transfer the person's prescribed medications which the receiver can look up (e..g via SCR, GP Record or shared care record). The full section has been kept for consistency even if only some of the elements are needed for this use case. This is important for example if the person is taking over the counter medications (e.g St John's Wort) bought online or other medications which are not on the person's record such as mental health medications.
Plan and requested actions	Required	The details of any actions or plans for the person (or carer) or the receiving professional.
Person and carer concerns expectations and wishes	Required	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/ representative on behalf of the patient).Where the person lacks capacity this may include their representative's concerns, expectations or wishes.

1.4 Recommendations

The following recommendations are made to support implementation, adoption and achieving the full benefits of the engagement and the standard:

1. 111 services should work towards using SNOMED CT for coding the outputs. SNOMED CT is the NHS's chosen standard for clinical terminology, and there are many advantages to using coded data at both the sending and receiving ends of the referral. The use of SNOMED CT is increasing across the NHS, is specified and used in the developing UK Core FHIR specifications and standards, for other transfers of care standards and used extensively in emergency departments and urgent care driven in part by the use of the emergency care dataset (ECDS) which uses SNOMED CT.
2. Consider if 111 call handlers in England are able to provide a summary for onward referrals as happens with NHS24 in Scotland.
3. Implementation of the general practice PEM should be combined with the implementing the 111 referral to general practices. Consider the workflow and handling in the general practice system to ensure the PEM is distinguished from the referral and both are handled in appropriate ways.
4. Consideration should be given to format and layout of the PEM to ensure it meets the requirements of 111 services and general practice services.
5. The current 111 report or ITK message could be edited to remove the negative responses to the pathways clinical triage, and instead clearly show the resulting disposition (symptom group and symptom discriminator) codes and urgency (DX codes). This would make the current 111 report useful and useable to both receivers of 111 referrals and to general practices receiving the "For Information" 111 report (or PEM).
6. In parallel with the recommendation 5 above, engagement with both general practice system suppliers and general practices could explain the difference between the current 111 report "For Action" (or 111 referral) from the 111 report "For Information" (or PEM) so they can be easily distinguished and handled in the appropriate ways. This could change the use of these current messages to be useful and effective, rather than difficult or ignored.
7. Revise the general practice PEM 'never send list' based on feedback from our GP consultation and further engagement with GPs. There are a number of never send conditions where the feedback indicated that GPs would like to receive the PEM.
8. Consider the existing service data sets; ECDS, Ambulance, Integrated Urgent Care when 111 moves to using SNOMED CT, to ensure the codes selected at 111 call handler and /or CAS level will be received and align with these already defined data sets.
9. Pilot and test the BaRS including the 111 referral standard in the other destination areas beyond 111 to ED, as is being planned in the BaRS programme.
10. Primary care systems should be able to handle qualifiers (e.g. a *suspected* diagnosis) so these functions in SNOMED CT can be used safely all across health and care. This is recognised as being beyond the 111 Referral standard and BaRS, but needs to be addressed, particularly as general practice systems move to being able to receive structured coded messages.

1.5 Conclusion

In conclusion,

- The 111 referral standard has been developed through UK wide consultation and consensus.
- The BaRS team are currently piloting the draft standard for 111 to ED as a First of Type. Learning from this implementation will be used to update the standard and inform further pathways going forward.
- The general practice PEM is a subset of the 111 Referral standard as agreed as part of the consultation.

This Final report is the accumulation of the work carried out to produce the 111 Referral standard and describes the activities undertaken. Following approval of the standard and this final report by the BaRS product board and the PRSB assurance committee, endorsement will be sought from the relevant professional bodies and other key stakeholders.

Once the standard is endorsed and the initial 111 to ED pilot completed, PRSB will support the BaRS programme with approval of an Information Standards Notice (ISN) to give the standard a formal and legal basis.

2 Introduction

2.1 Background and Context

The need for effective referral information for a person referred on from 111 services was identified as 111 services become more frequently used. In 2018, PRSB, commissioned by NHS England produced a report on urgent care information flows which set out the high-level requirements for a referral from a 111 clinical assessment service (CAS).

For several years, there has been focus on improving urgent and emergency services, primarily getting individuals to the most appropriate service for their needs., The COVID-19 pandemic raised the profile of this requirement. Revised schemes have been introduced over the past 2 years including bookings from 111 direct into Emergency Department (ED) systems listing arrival time slots so ED can manage arrival flows.

Currently in England, a 111 report can flow to the receiving organisation using an Interoperability Tool Kit (ITK) message. This report is based on the summary of decision points from the Pathways triage algorithm and reads poorly by clinicians on the receiving end – it lacks clinical value by not using a language that clinicians are trained to use. The same ITK message is used to inform the person's general practice of the 111 encounters, this is known as a PEM – for information.

A newer interoperability standard known as FHIR (Fast Healthcare Interoperability Resource) is now being adopted by many clinical IT systems which offers potential for an improved message sharing capability including urgent and emergency care systems and across the UK.

A need was identified for a new 111 referral standard, which can be implemented in FHIR and can provide clear and concise referral information to all receiving organisations (including ED, pharmacy, dentistry, optometry, mental health, community, and general practices). PRSB have been tasked with standardising the information captured and shared in the 111 report following a person encounter with the 111 service. The new 111 referral standard was commissioned by NHSX as part of the NHS Booking and Referral standard (BaRS) programme. The long-term aim is for this standard to be part of a future standard or set of standards for referrals from any source to any destination.

NHS Digital's Booking and Referrals Service (BaRS) are carrying out a First of Type (FoT) pilot for the 111 to ED referral and developing the FiHR messaging to support the draft PRSB 111 referral standard.

PRSB have produced the 111 referral standard following a UK wide full consultation.

2.2 Previous stages of work contributing to the standard

2.2.1 2018 High level information requirements

In 2018 PRSB were commissioned by NHSE to set out the high-level information requirements for a 111 clinical assessment service. The work included research and evidence gathering of existing guidance, current practice (examples of current records and communications, output from clinical decision support systems), and relevant related projects and standards. Draft requirements were developed from this and then refined through a multi-disciplinary workshop with health and care professionals, patients and system suppliers.

The report and requirements are referenced in Appendix 1

2.2.2 2021 Discovery work

In 2021, PRSB conducted discovery work to validate the previous high-level requirements from 2018 and recommend the work needed to develop a 111 referral standard. This work;

- Validated the 2018 requirements with the addition of a few data items
- Concluded that the proposed standard could work for 111 referrals from call handlers and 111 online, although some information would only be available where there was contact with a clinician.
- Concluded that a general practice post event message (PEM) should be developed alongside the 111 referral standard as it is expected to be subset of the referral information and consultation will involve many of the same stakeholders.

The discovery phase report is referenced in Appendix 2

2.2.3 2021 1st Draft Information Model

In August 2021 a short commission delivered a draft information model from the outputs of the discovery work to support pilots for BaRS for 111 to emergency departments (ED). The 111 referral information model V0.2 was provided for this purpose, validated by the same project team from the discovery work, working with NHS Digital and NHSX and using existing PRSB standards components wherever possible for consistency with other standards and FHIR profiles.

3 Methodology and Consultation Approach

3.1 Project Objectives and Scope

3.1.1 Aims

To enable the flow of clear, succinct, and effective information for persons being referred on from 111 or 999 services to support the receiving organisations and clinicians in providing safer and more effective care.

The standard should be consistent with existing PRSB and other relevant standards and aim to be part of a future standard or set of standards for referrals from any source to any destination.

3.1.2 Objectives

- Develop a standard for all 111 and 999 service referrals to wherever the person goes next, replacing the current 111 report with clear, succinct, and effective information to inform the receiver.
- The standard will work for 111 online, call handler or clinical assessment services and 999 services, and be achievable with the current pathways triage system used in England and all the UK nations.
- Facilitate and incorporate improvements from the 111 to emergency department pilot running in parallel through NHS Digital.

The critical success factors are:

- A standard endorsed and supported by the relevant professional bodies and organisations
- A standard which is part of a full implementable package
- A standard proven through pilot use in one area (111 to ED) and verified through consultation to be suitable for all 111 referrals
- Clinicians, providers, and system suppliers who have been engaged and are aware and keen to implement or adopt the standard

3.2 Benefits

3.2.1 Benefits to the person contacting 111

An information standard for 111 referrals should support the person as follows:

- Individuals using the 111 services should trust that the information given to 111 will be passed on clearly and concisely to their next point of care so they do not need to repeat their story
- Individuals should be confident that their next point of care is correctly informed of their situation with a clear reason for referral so they can be referred to the correct services
- general practice should be notified of the 111 contacts (noted on the person's record) so there is consistency of care

3.2.2 Benefits to clinicians/professionals

For clinicians and other health and care professionals, an information standard would help ensure they can access all the information they need, supporting:

- Clear, easy to use information shared with the clinician so they can provide efficient, effective and safe treatment of the person
- Relevant information sharing – showing a clear reason for referral to allow a safe transfer or care

- Highlight chief complaint and clinical concerns to improve quality and allow improved feedback (where referrals are perceived as inappropriate for the setting referred to)
- Ensure the person's general practice is informed of the person contact and referral through 111 services

3.3 Scope

A key principle used for the standard is that it should pass on the new information gathered in the 111 service, but not pass on 3rd party information which the receiving services for the referral could get directly themselves, e.g. risks identified by the 111 service, not risks available from the general practice or shared care record.

3.3.1 In scope

Included in scope:

- 111 or 999 service referrals to all services
- Contact through 111 online, call handler and clinician assessment services
- The 111 post event message (PEM) to inform the general practice of the contact and, where there is one, the referral
- All age groups including children
- All UK nations
- Support to the 111 to emergency department (ED) pilot being managed by NHS Digital, and to revise the standard as appropriate with the pilot feedback

3.3.2 Exclusions from scope

Out of scope:

- 111 to 999 or 111 to another 111 service (e.g. across a country border) – The consultation however, included all nations.
- 999 to 111 referral or transfer. This is more complex and includes clinical validation of 999 triage and needs different data to the other 111 and 999 referrals included in scope.
- Referral from other sources to ED or other urgent care destinations. The overall vision is for a standard or set of consistent standards for referral from any source to any destination, which will be approached in stages with this being a key stage and aligning with other existing PRSB standards
- Specific work around any differences for Scotland, Wales or Northern Ireland, which would require separate funding from those countries.

3.4 Project Governance and Resources

The project reported into the already existing Booking and Referral standard (BaRS) product board.

The methodology and products were approved through the PRSB assurance committee.

The project team included two clinical leads (a GP and an ED consultant) plus a patient/person lead, all of whom continued from the previous 2021 work to ensure continuity.

3.5 Development and Consultation Approach

The development and consultation approach followed the proven and trusted PRSB methodology, although the work was spread over several years and phases (commissions).

Research and evidence gathering, initial shaping of the information requirements and developing of those information requirements through a multi-disciplinary workshop was conducted in the 2018 requirements work.

The 2021 discovery work validated the 2018 work and concluded it could apply to 111 services through a call handler or 111 online as well as through a clinical assessment service.

The 2022 (Phase 3) work approach included:

- Wide consultation through a survey for users of services, senders of referrals and receivers of 111 referrals to gain consensus and support for the standard and test it across the many different destination communities including with IT providers and system suppliers. This was followed up with specific engagement with areas with lower numbers of survey responses (dentistry, optometry, mental health and community pharmacy) to verify the draft 111 referral standard was suitable for those areas.
- Verifying that 999 services could provide the essential information of a 111 referral and therefore be included into scope of the standard.
- Engagement with GPs through interviews and focus groups to define the general practice PEM.
- Further work delayed to May/June 2022 to gather and analyse feedback from the 111 to ED pilots and update the standard as appropriate.

4 Consultation Findings

4.1 111 Referral wide consultation

The PRSB develops standards for use across the UK. As part of the consultation for the 111 Standard all UK nations were included in any stakeholder communications and encouraged to take part in the consultation. Specific conversations were held with both Scotland and Wales (NI didn't respond) during the 2021 discovery work to raise awareness and understand key differences.

4.1.1 Survey – 10 November 2021 – 12 December 2021

In November and December 2021, the project team launched a survey to a large stakeholder group which was closed on 12 December 2021. The Full 111 Referral Survey report is referenced in Appendix 3

Overall respondent information:

- 416 responses were collected
- 35% respondents were receiving services (n=136)
- 25% respondents were potential users of 111 services (n=94)
- 18% respondents were 111 service providers (n=69)
- 17% respondents classified themselves as 'other' (n=61)
- 4% respondents were 999 service providers (n=13)

4.1.2 General feedback on the items within the information standard:

- Key demographic information about the individual was considered to be the most important part of the referral e.g. name, address, NHS number
- Information about urgency and complaint also considered very important along with a summary of the need/support required
- Some demographic information was seen as the least important including ethnicity, immigration status and overseas visitor status
- Users of 111 services found the level of urgency and summary of needs most important with most demographics such as pronouns, religion, ethnicity, and gender are the least important

72% respondents did not think any other information should be shared as part of a 111 referral. Of those that thought additional information should be added, examples included COVID-19 status, medical history (including mental health), life-style factors (like alcohol use), risk to others and end of life preferences.

The information that some respondents suggested should be included in the 111 referral standard was information that could already be accessed using other methods. The principle of the 111 referral standard was that it did not share information that was already recorded elsewhere in the system e.g. general practice electronic record, Special Patient Notes (SPN's), and shared care record, but captured 'new' information relevant to the persons current complaint or issue.

4.1.3 Concerns about the standard

60 comments were received noting concerns about the standard (16% all respondents) with the majority referring to the layout and format of the existing PEM, but there were also concerns about information relevance:

- "[The length of the standard is] potentially overwhelming and of little relevance to a fit healthy individual with an isolated non-lethal acute injury"

- "[There is the] potential to include too much [information] burying important information in a mass of irrelevant information"
- "[Sometimes] clinicians get referrals and ask 'why am I being sent this…they could have been seen by their general practice etc" and this erodes trust in the pathways system"

4.1.4 Mitigating concerns raised during consultation

The concerns raised during consultation can be mitigated via:

1. Implementation guidance – which will reference that information captured is 'mandatory', 'required' or 'optional'. Very little information in the standard is 'mandatory', where it is 'required' or 'optional', it is captured where it is relevant to the individual.
2. Training – implementation of the standard via systems and technology will require some training. This training can reference how the information standard is used in practice i.e. not all information will be relevant.
3. System set-up – ensure that feedback on the layout and format of the PEM is feedback to NHSE and system suppliers who can develop the format based on said feedback
4. The use of the SNOMED CT : - ^1127581000000103 |Health issues simple reference set| when recording the chief clinical concern, has raised an issue over the ability of Primary Care systems to use and record the qualifier associated with a suspected diagnosis e.g. UTI with a qualifier of 'suspected'. The primary care clinical systems may only bring through the diagnosis of a UTI without the qualifier, causing an incorrect confirmed diagnosis to be recorded. This is mitigated in the hazard log and implementation guidance which make clear that diagnosis qualifiers should not be used in coded form until such time as primary care systems can handle them correctly.

As 111 Pathways (used in England 111 triage systems) is not yet SNOMED compliant, the symptom Group code (SG code) and Symptom Discriminator (SD) code descriptions (terms) will replace Chief Complaint and Chief Clinical Concern when identified by the CAS. The clinician can enter suspected diagnosis in free text.

4.2 Survey follow-up sessions

The survey reached a wide variety of stakeholders however, analysis of the survey highlighted a number of areas with a low number of responses, including some potential endorsers of the standard. Follow up sessions with those low responding groups were held on the following dates:

- Royal College of Psychiatrists (RCPsych) – 17 January 2022
- British Psychological Society (BPS) – 26 January 2022
- Office of the Chief Dental Officer (OCDO) – 18 January 2022
- British Dental Association (BDA) – 10 February 2022
- Royal Pharmaceutical Society (RPS)– 19 January 2022
- College of Optometrists – 31 January 2022

4.2.1 Key points from these sessions included:

Mental Health Focus Groups (RC Psych & BPS)

The Royal College Psychiatry raised a concern over the ability to record and share **all** medications a person may be taking when using the standard. Their concern was regarding medications that may be being prescribed by mental health trusts (e.g. clozapine / depot antipsychotics), but may not be recorded within the general practice record. The RC Psych suggested the inclusion of any 'over the counter' and 'medications' bought online that the

person maybe taking. Some medications bought online or over the counter relate to contraindications with a person's prescribed drugs and risks of overdose for mental health presentations.

The implementation guidance was updated to include the recommendations for the capturing of medications known be taken but not recorded in the general practice record.

Dentistry Focus Groups (BDA & OCDO)

The BDA policy team responded to the survey and engaged with the additional focus groups.

Dentists do not yet have access to shared care records, but increasingly it is noted that dentists require specific information about a person referred from 111. Individual requirements and in particular; obesity/bariatric (fit in dentist chair), anxiety, other mental health conditions, impairments would be helpful before treating a person.

The OCDO who are working closely with the PODAC programme (which includes the 111 referral) have highlighted that when a person calls 111 with an oral health issue the call is transferred to a 111 dental call handler. To ensure the person's own dentist is updated with any treatment or advice from the 111 service it has been suggested that the 111 referral standard should include a section to capture the person's registered / usual dentist (if they have one).

The standard was updated to include a new section for Dental Practice (based on the existing GP Practice section.

Community Pharmacy Focus Group (RPS)

Many pharmacies now have access to the Summary Care Record or GP Connect record viewer so are able to view some general practice information to support the direct care of an individual. As part of the discussion with RPS it was noted that 'new' Risks were not in the 111 Referral standard. This was taken back to the project team as an omission and 'risks' were added in to the Standard. Risks, currently can be added as free text or when SNOMED compatible, the standard will look to the SNOMED coding to capture any 'new' risks identified. To ensure there is no ambiguity as to whether there are risks or not, the standard mandates that the risk element requires a response so the 111 call handler or CAS clinician needs to state if there are 'no known risks'

Optometry Focus Group (College of Optometrists)

Many optometry practices in England are, and increasingly, offering urgent/emergency eye care services. These are commissioned locally but not consistently as yet across England. Local NHS111 Teams should be aware of these urgent/emergency commissioned services in optometry practices and the mechanisms to communicate with them, the provision of which will vary locally including how they receive referrals. The 111 Referral standard would support the digital communication between 111 and optometry. This is expected to be delivered by the PODAC program.

4.3 999 Services Validation

PRSB carried out a validation exercise to confirm that the 999 services could provide the essential information to populate the 111 referral standard. This was done on the basis that the referral must contain a minimum set of information regarding:

- the person with the concern / issue - the person demographics
- referral details – where from and to, and urgency
- presenting complaints
- chief complaint

The validation compared the 999 data model (used for transferring information from 999 to 111 CAS services for clinical validation) with the 111 referral standard which showed that the essential elements could be populated by the 999 service.

The validation work concluded that the draft 111 referral standard information could be extracted from the 999 services to provide a referral to non-ambulance related destinations and therefore be included in scope of the 111 referral standard.

The BaRS 999 to CAS Data Model for endorsement is shown in Appendix 4.

4.4 General Practice PEM Consultation

4.4.1 GP interviews re 111 Post Event Message – June 2021

The GP interviews asked GPs to feedback on the content and format of the Post Event Messages (PEMs) currently received in the General Practices systems from 111.The GP interviews were carried out via Teams during June 2021 using a prompting questionnaire.

Interviewees:

1/6/2021 Dr Andrew Sharpe, Surrey Heartlands GP and Shared Care Record CCIO

2/6/2021 Dr Ayesha Azhar, GP at NHS NENE CCG

3/6/2021 Kieran Sharrock, Lincolnshire Partnership NHS Foundation Trust

The main interview findings were that the PEM:

- Contains too much unnecessary information e.g., the negative responses that the NHS pathway algorithm capture are returned in the PEM
- The general practice Referral and the general practice PEM from 111 are not easily distinguishable by the receiving general practice
- Differences in the understanding of what actions need to be undertaken on receipt of a PEM ‘for information’ or ‘for action’.
- The rendering of the PEM document in the general practice Clinical System is reliant on the local receiving system configuration, not the 111 sending systems.
- General practice PEM Actions be sent back as part of the coded messaging back to general practice clinical system via general practice Workflow.

Following the GP interviews carried out in June 2021 the PEM element of the 111 Standard project was taken back by NHS Digital to be delivered by the NHS Digital PEM’s team.

4.4.2 Joint GPIT Committee Meetings

PRSB attended two Joint GPIT Committee meetings:

9th June 2021 – to update the committee on the 111 referral standard feedback from recent GP interviews regarding the general practice PEM and gather further insight regarding the PEM from the GPIT Committee members.

Outcomes

- The JGPIT committee are in full support of the PEM work and requested to be involved in the development of the general practice PEM.
- They agreed with the findings from the GP interviews, particularly regarding the location of the clinical information in the existing 111 reports. The important information not being easy to locate and could lead to increased clinical risk.

- Concerns were raised about the possible financial implications if making rigid changes to the PEM in England, without consulting the rest of the UK. As changes may need to be made to Scottish supplier systems and this would have a cost attached.

26th January 2022 – to provide an update on the 111 Referral standard survey. Gather views on the content and structure of the PEM, when it shouldn't be sent to the practice, and discuss the existing workflows in practices on receipt of the PEM to help inform the agenda and questions for the GP focus group sessions.

Outcomes

Discussions regarding the status of the 111 standard and the PEM. A Mentimeter interactive questionnaire was undertaken (see table 1 below). JGPIT members raised a concern regarding the requirement to read a PEM for information. Some GP's file the PEM in the patient record without reading / coding. A discussion was had as to whether the GP contract required GP's to read all PEMs for information. Further discussions with the NHS Policy team confirmed that the contract does not state what a GP should do on receipt of a PEM. It is for the clinician to assess the contents and decide what is appropriate to capture and code on the individuals general practice record.

Joint GPIT Committee meeting Mentimeter outputs are shown in Appendix 5

4.4.3 GP focus groups – February 2022

PRSB carried out some initial GP interviews in early 2021 and NHS Digital's PEM team carried out further discovery work during 2021 with GPs in England gathering feedback on the content and structure of the existing PEM and the processes within general practices on receipt of a PEM. NHS Digital's PEM report is shown in Appendix 6

The Post Event Message (PEM), received by the general practice following a person's encounter with 111, was brought back into the scope of the PRSB commissioned work in late 2021. PRSB utilised the NHS Digital's PEM report to support the additional GP focus groups and attended the Joint GPIT committee meeting in Feb 2022 to gather further insight and confirm the information required to flow back to the general practice in the PEM for information.

Two GP focus groups were held with attendees from three of the four nations. The 1st focus group was attended by 12 external delegates, 6 of which were GPs, the 2nd group had 16 attendees with 9 of them GP's. Each group was taken through the 111 Referral standard and asked which items from the information standard would improve the content of the PEM for information. Mentimeter was used to gather some of the information, from the GP Focus groups.

The Mentimeter outputs are shown in Appendix 7

Key findings included:

- 111 reports are currently received into general practice via ITK Messaging direct into their clinical systems or via email into the document management system.
- 111 Reports can be either 'For action' or 'For information'.
- Local system configuration is required to render the 'For information' or 'For action' in the document header The current 111 reports received by general practices, are not always clearly distinguishable as either 'For action' or 'For information'.

- This is translated from the sending system and rendered by the receiving system, but this is not consistent across the country. Hence the confusion over ‘For action’ or ‘For information’ within general practices.
- Some suppliers convert the XML coding applied at the provider end for either ‘For action’ or ‘For Information’ into human readable format so that it is displayed when rendered as a PEM in the receiving system. This is not visible to all recipients as relies on local system configuration.
- Local systems determine how the referral and PEM are rendered in a receiving organisation.
- A PEM for information (i.e. not a referral PEM) is processed differently in individual practices across the UK. Some PEMs are directly filed in the person’s general practice record and not read by the GP.
- Generally, the 111 encounter itself is coded to a person’s GP.
- Information within the PEM ‘For information’ is rarely coded into the general practice person record.
- Excluding demographic type data, the key information that should be included in the 111 PEM is as follows:
    - general practice details
    - Individual requirements
    - Safeguarding and risks
    - Referral details (where from, where to and urgency)
    - Plan and requested actions for both the general practice and the person
    - Presenting complaints or issues
    - Chief Complaint
    - Chief Clinical Concern
    - Diagnosis
    - Allergies and allergies (new)
    - Medications and medical devices (new)
    - Clinical summary (following CAS)

- There is an NHS England predefined ‘Never send list’ where a 111 PEM is not sent to the general practice. Discussions with GP’s highlighted that the never send list included some 111 reports that they felt should come to the general practice and as part of the Mentimeter questions GP’s identified when they would not want to receive a PEM. These are shown in the Mentimeter outputs, but are essentially calls which are about finding services or information rather than seeking help on a problem.

4.4.4 Variance in 111 systems and general practice processes across the UK

England

- NHS 111 use NHS Pathways clinical assessment tool
- Pathways is not SNOMED compliant
- 111 can book direct into general practice appointments and ED appointments
- 111 send a 111 report to General Practice which can be for action or for information

Scotland

- NHS24 cannot book direct into general practice appointments.
- Persons are advised to contact their general practice and a PEM is sent to the practice.
- The PEM in Scotland is received into the general practice system via Docman and work flowed as a PDF.

- The format requires improvement pending moving to coded structured data.
- Actions for the general practice need to be clearly stated at the top of the document, currently this is hard to find, usually at the bottom of the document.
- The 111 Referral standard would improve the format and content of the PEM.

Wales

- 111 Wales is undergoing a large 111 programme including the procurement of a new 111 system – Solus.
- The PEM informing the general practice of a contact with 111 includes the reason for the call and the duration of any symptoms.
- A clinical assessor will not be able to make a referral.
- The outcome is for the person: 'Advised to contact general practice'.
- Referrals are made only via the Clinical Support Hubs (CAS in England)
- 111 Wales are not able to book direct into general practice appointments so 111 referrals are always for the daytime GP to action as they feel fit, but highlighted by specific informational outcomes.

Northern Ireland

There was no feedback from the consultation that could be linked back to any individual roles, services or organisations from Northern Ireland.

- Health and Care Northern Ireland provide 111 type services via 5 separate GP OOH's service

5 The 111 Referral Information Standard

The 111 information Standard is developed in an information modelling tool called Art Décor. The export of the full 111 Referral standard from Art Décor is very long and can appear complicated to an untrained eye.

The table below provides a high-level view of the standard. The blue shaded sections are the sections included in the general practice post event message (PEM).

The full standard is referenced in Appendix 8.

Section Name	Conformance - Mandatory, Required, Optional	Description
Person demographics	Mandatory	The person's details and contact information.
Caller Details	Required	Name of caller, relationship, telephone number and preferred contact method. For use where the caller isn't the person needing care or advice,
GP practice details	Required	Details of the person's GP practice.
Dental Practice details	Required	Details of the person's usual dental practice.
Individual requirements	Required	Note that the Individual requirements section includes reasonable adjustment and specific elements for accessible information requirements to support communication.
Safeguarding	Required	Any safeguarding concerns identified
RIsks	Required	Any risks identified, includes risks to self or to others
Consent for information sharing	Required	This is a record of consent for information sharing under the common law duty of confidentiality. Where consent has not been obtained or sought, the reason why should be provided. Include best interests decision where person lacks capacity.
Referral details	Mandatory	Details of the referral; from where and to where and any person input into the selection. Also urgency of referral, which where the Pathways triage is used is derived from the DX code resulting from the triage process.
Presenting Complaints or issues	Mandatory	Presenting complaints or issues and the Chief Compliant which is manadatory. Where the Pathways triage is used the Chief Complaint is derived from the symtom group (SD) or sympton discriminator (SG) code resulting from the triage process.
Problem	Required	Provides either a diagnosis or the chief clinical concern. These are only likely to be available where there has been a clinical assessment.
Clinical Summary	Required	A summary of the person's contact such as reason for attendance, chief clinical concern or diagnosis and actions taken or required. Only likely to be available where there has been a clinical assessment.
Social Context	Required	The social setting in which the person lives, such as their household (e.g. lives alone), occupational history, and lifestyle factors.
Allergies and adverse reactions	Required	This is for person reported allergies or adverse reactions which may not be on the persons electronic health record. It is NOT to transfer the person's recorded allergies which the receiver can look up (e.g. via SCR, GP Record or shared care record).
Medications and medical devices	Required	This is for person reported medications and medical devices which may not be on the person's electronic health record. It is NOT to transfer the person's prescribed medications which the receiver can look up (e..g via SCR, GP Record or shared care record). The full section has been kept for consistency even if only some of the elements are needed for this use case. This is important for example if the person is taking over the counter medications (e.g St John's Wort) bought online or other medications which are not on the person's record such as mental health medications.
Plan and requested actions	Required	The details of any actions or plans for the person (or carer) or the receiving professional.
Person and carer concerns expectations and wishes	Required	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/ representative on behalf of the patient).Where the person lacks capacity this may include their representative's concerns, expectations or wishes.

5.1 Information Standard

The information model was developed in PRSB's Art-Décor information modelling tool. Wherever possible it uses existing components from PRSB standards to ensure consistency between standards and facilitate reuse, including items such as technical (FHIR) specifications. The new elements added for this standard are:

- Caller Details section – to provide details of the caller where it is not the person seeking care themselves.
- Referral Details
    - Person input to service selection – indicating if and what input a person had to their referral service selection
    - Person Referral Reference – a marker for a future reference the person could use on arrival at the referral destination
    - Journey ID – a marker for a future ID to track multiple referrals
- Presenting complaints
    - Repeat caller – to indicate the person has called more than twice in 96 hours
- Dental Practice – To provide details of a person's usual dental practice.

The information model will be published on the PRSB website and made available in machine readable form for use by system suppliers and technical message developers.

The information model includes implementation guidance at a section and element level, and a business rules document will be published alongside the standard.

111 Referral standard – Full version is referenced in Appendix 8

6 Clinical Safety Case

The NHS Digital Clinical Safety Group (CSG) operates a full Clinical Safety Management System (CSMS) that encompasses integration with health organisations and professional bodies. The essential structures of a CSMS have been implemented in this project through the consultation with healthcare professionals, persons, informaticians and system suppliers, during the development of the standard.

For this standard PRSB has produced a Clinical Safety Case and hazard log. These will be approved through the NHS Digital CSG and published on the PRSB website with the standard. Updates to the clinical safety case are the responsibility of PRSB.

The consultation process for the clinical safety case is described in the Clinical Safety Case Report. During the consultations, hazards were identified, reviewed and mitigations / actions considered. Nevertheless, some risks are inherent in the standards, but most have been either:

- mitigated during the development of the standards (including the clinical safety case)

or

- the residual risk has been transferred (with guidance) to the implementers

The Clinical Safety Case and Hazard Log are referenced in Appendix 9

7 Recommendations

The following recommendations are made to support implementation, adoption and the achieving the full benefits of the engagement and the standard:

1. 111 services should work towards using SNOMED CT for coding the outputs. SNOMED CT is the NHS's chosen standard for clinical terminology, and there are many advantages to using coded data at both the sending and receiving ends of the referral. The use of SNOMED CT is increasing across the NHS, is specified and used in the developing UK Core FHIR specifications and standards, for other transfers of care standards and used extensively in emergency departments and urgent care driven in part by the use of the emergency care dataset (ECDS) which uses SNOMED CT.
2. Consider if 111 call handlers in England are able to provide a summary for onward referrals as happens with NHS24 in Scotland.
3. Implementation of the general practice PEM should be combined with the implementing the 111 referral to general practices. Consider the workflow and handling in the general practice system to ensure the PEM is distinguished from the referral and both are handled in appropriate ways.
4. Consideration should be given to format and layout of the PEM to ensure it meets the requirements of 111 services and general practice services.
5. The current 111 report or ITK message could be edited to remove the negative responses to the pathways clinical triage, and instead clearly show the resulting disposition (symptom group and symptom discriminator) codes and urgency (DX codes). This would make the current 111 report useful and useable to both receivers of 111 referrals and to general practices receiving the "For Information" 111 report (or PEM).
6. In parallel with the recommendation 5 above, engagement with both general practice system suppliers and general practices could explain the difference between the current 111 report "For Action" (or 111 referral) from the 111 report "For Information" (or PEM) so they can be easily distinguished and handled in the appropriate ways. This could change the use of these current messages to be useful and effective, rather than difficult or ignored.
7. Revise the general practice PEM 'never send list' based on feedback from our GP consultation and further engagement with GPs. There are a number of never send conditions where the feedback indicated that GPs would like to receive the PEM.
8. Consider the existing service data sets; ECDS, Ambulance, Integrated Urgent Care when 111 moves to using SNOMED CT, to ensure the codes selected at 111 call handler and /or CAS level will be received and align with these already defined data sets.
9. Pilot and test the BaRS including the 111 referral standard in the other destination areas beyond 111 to ED, as is being planned in the BaRS programme.
10. Primary care systems should be able to handle qualifiers (e.g. a *suspected* diagnosis) so these functions in SNOMED CT can be used safely all across health and care. This is recognised as being beyond the 111 Referral standard and BaRS, but needs to be addressed, particularly as general practice systems move to being able to receive structured coded messages.

8 Conclusion

In conclusion,

- The 111 referral standard has been developed through UK wide consultation and consensus.
- The BaRS team are currently piloting the draft standard for 111 to ED as a First of Type. Learning from this implementation will be used to update the standard and inform further pathways going forward.
- The general practice PEM is a subset of the 111 Referral standard as agreed as part of the consultation.

This Final report is the accumulation of the work carried out to produce the 111 Referral standard and describes the activities undertaken. Following approval of the standard and this final report by the BaRS product board and the PRSB assurance committee, endorsement will be sought from the relevant professional bodies and other key stakeholders.

Once the standard is endorsed and the initial 111 to ED pilot completed, PRSB will support the BaRS programme with approval of an Information Standards Notice (ISN) to give the standard a formal and legal basis.

9 Appendices

9.1 Appendix 1 – Urgent care information flows report (2018)

Urgent care information flows – PRSB (theprsb.org)

9.2 Appendix 2 – PRSB discovery report

The discovery report from the 2021 work will be available on the 111 Referral Standard webpage.

9.3 Appendix 3 – PRSB 111 Referral Survey report

The survey report will be available on the 111 Referral Standard webpage.

9.4 Appendix 4 - BaRS 999 to CAS Data Model validation

Business Element
Patient demographics
Patient name
Patient NHS Number
Patient identifier (Local)
NHS number verification status
Patient telecom
Patient gender
Sex assigned at birth
Patient date of birth
Patient age group
Patient Address
Patient Ethnicity
Patient communication preferences
Patient's Registered General Practice (GP)
Overseas visitor status
Emergency contact
Social context
Household composition
Social circumstances
Accomodation status
Third party caller
Third party caller relationship
Third party caller name
Third party caller telecom
Third party caller gender
Third party caller communication preferences
Service provider information
Sending service name
Sending service ID
Receiving service name
Receiving service ID
Practitioner details
Organisation
Practitioner name
Practitioner Role
Practitioner specialty
Practitioner contact details

Timing data
999 Call connect date/ time
999 Disposition date/time
Validation breach date/time
Call back breach time
CAS Disposition date/time
Case identification data
JourneyID
999 CAD Case number
CAS Case Number
Incident location
Incident location
Incident Location ID (Property)
Incident Location ID (Property)
Incident Location Latitude
Incident Location Longitude
Incident Location Altitude
Incident Location Eastings
Incident Location Northings
Incident Location What3Words
Incident location type
Incident location supplementary information
999 Triage Information
Pathways SG code/description
Pathways SD code/description
Pathways Dx code/description
Pathways Pathway Template code/description
AMPDS Dispatch Code/description
ARP Code/description
Clinical summary
Patient expectations
CAS Triage/Assessment Information
Pathways SG code/description
Pathways SD code/description
Pathways Dx code/description
Pathways Pathway Template code/description
AMPDS Dispatch Code/description
ARP Code/description
Presenting complaint
Chief concern
Acuity
Next activity
Clinical summary
Patient expectations

New Allergy information
New medication information
Action for receiving service
Action for receiving service
Scene Safety
Scene safe?
Hazards present
Safeguarding
Safeguarding concern date identified
Safeguarding Coded value
Safeguarding free text
Resonable adjustments
Reasonable adjustment Date
Reasonable adjustment Coded value
Reasonable adjustment Free text
ResPECT Plan
ResPECT date
ResPECT Coded value
ResPECT Free text
Consent
Consent date
Consent Coded value
Consent free text

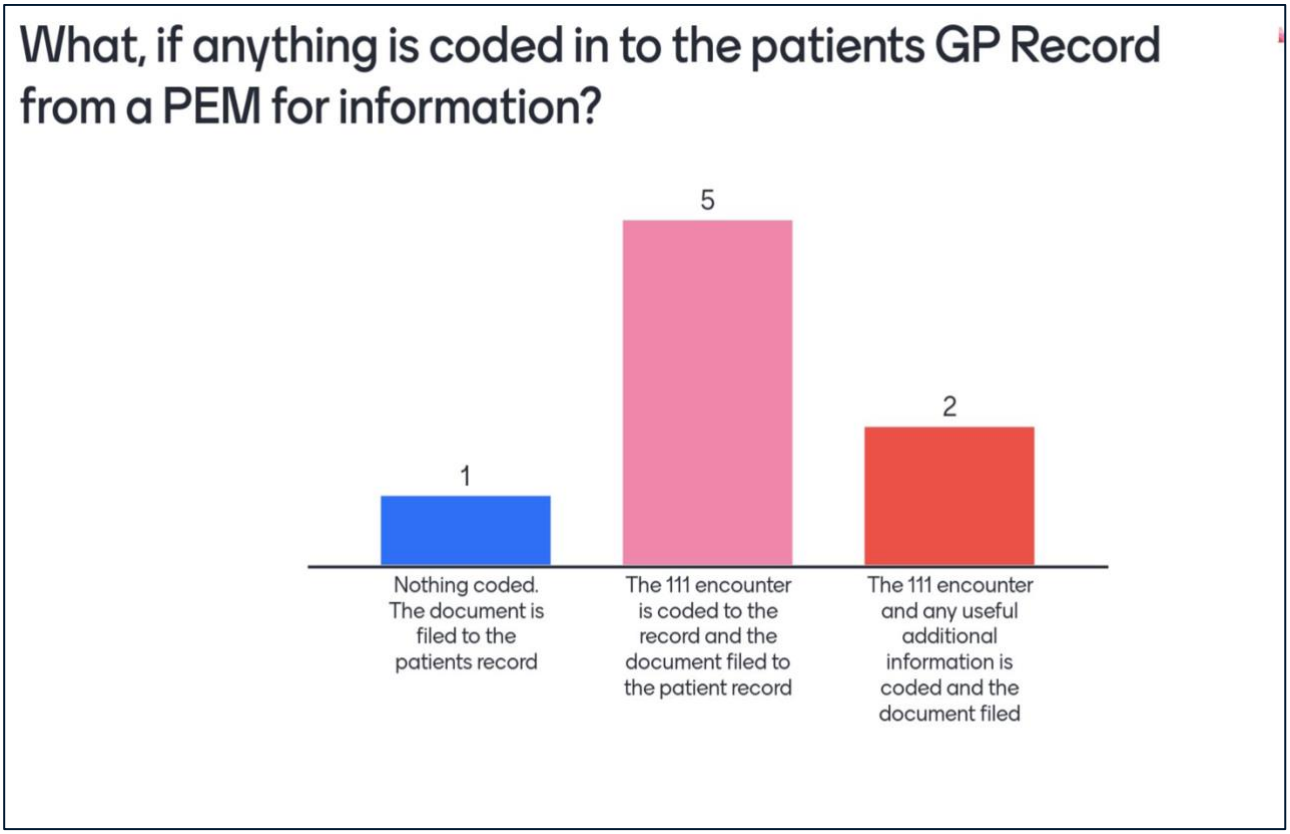
9.5 Appendix 5 – NHS Digital PEM's Report

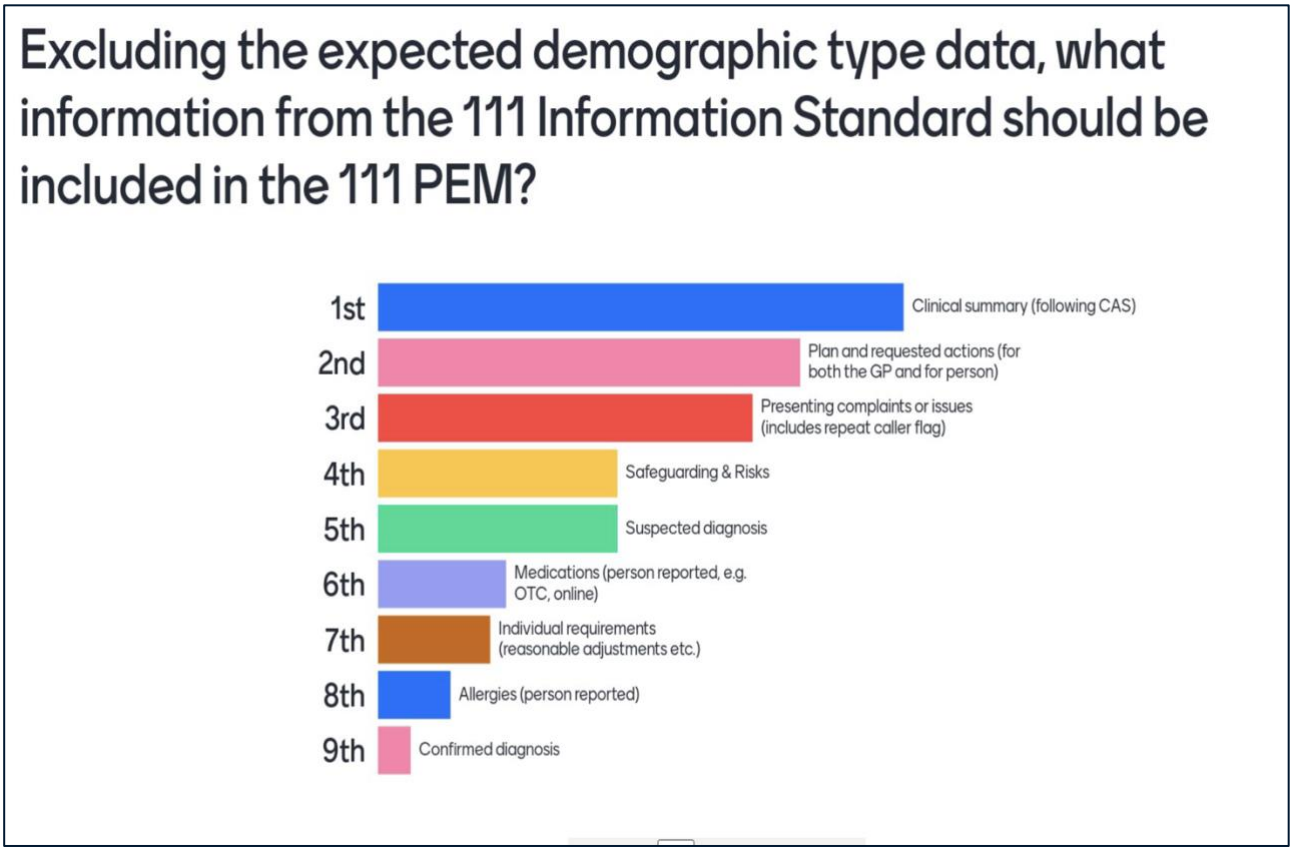
This is not a published report. Please contact PRSB (support@theprsb.org) to request a copy.

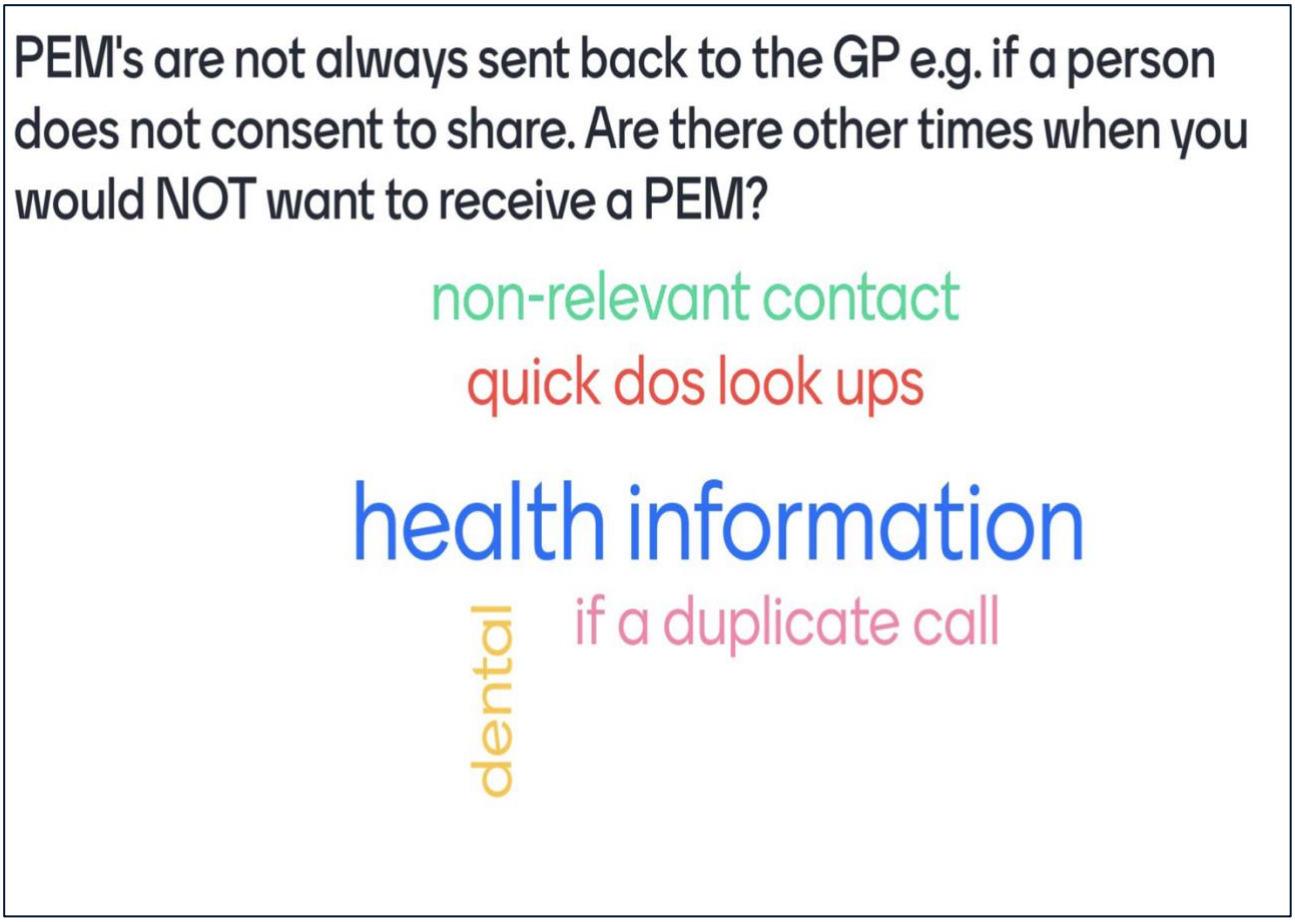
9.6 Appendix 6 – Joint GPIT Committee Mentimeter outputs

Q1	Currently, how easy is it, in the clinical system document workflow, to distinguish a 'PEM for Information' from a 'PEM for Action'?	Easy – 0 Somewhat easy – 1 Quite difficult - 4 Impossible - 1		
Q2	Is a 111 Encounter where a PEM for information is produced coded into the patient record?	Yes, always - 0 Sometimes - 4 Never - 2		
Q3	What things could or should trigger alerts or actions in the workflow ?	Need to ensure that we don't create a gap between the expectations of the patient or 111 services and the general practices obligations. A standardised free-text box for clinician only assessment to highlight specific action or alert to registered general practice. Safeguarding referral, clinician-to-clinician concern, need for urgent ref (USC referral criteria met) The patient or carer needs be given clear written information to satiety net if action not met Real safeguarding issues should be referred Specific action should be a referral No alerts should be for action in less than a week		
Q4	Are prescriptions given by 111 If included in a PEM for information coded into the patient record?	Yes always - 0 Sometimes - 3 Never - 0		
Q5	Excluding demographics what order should the New 111 Information Standard appear on the 111 PEM for Information?	**Respondent 1** presenting complaint Differential diagnosis Management plan	**Respondent 2** Action needed, diagnosis, history of complaint, examination, investigation, treatment	**Respondent 3** Presenting Symptoms Differential diagnosis Management plan Action to be taken by general practice

9.7 Appendix 7 – GP Focus Group outcomes (Menti slides)







The dental entry was later withdrawn (by the GP who submitted it) following discussion in the group.

9.8 Appendix 8 – PRSB 111 Referral standard - Full version

The full 111 Referral Standard will be available in the PRSB viewer via the 111 Referral Standard webpage. It will also be available on request in XML, JSON or Excel form as extracts from the PRSB modelling tool.

9.9 Appendix 9 – PRSB 111 Referral standard Clinical Safety case & Hazard Log

The safety case and hazard log will be available on the 111 Referral Standard webpage.