Review of the NHS 111star*lines undertaken by the NHS England and Improvement (London Region) End of Life Care Clinical Network

July 2019

NHS England and NHS Improvement

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Publishing approval number:

Version number: 1

First published: 15/07/2019

Prepared by: NHS England and Improvement (London Region) End of Life Care Clinical Network

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2 Executive Summary

The NHS 111star*lines were launched in London in January 2017 in response to a rising number of 999 calls from care homes; the service provides early telephone clinical support to London Ambulance Service (LAS) (NHS111star*5), Care Home (NHS111star*6), and Rapid Response (NHS111star*7) staff to improve patient care and reduce the requirement for ambulance transfer to hospital. The pilot showed that the number of 999 incidents in care homes following implementation was significantly reduced compared to that forecast. However, ongoing data collection demonstrated a fall in 111star*lines activity in Winter 2018 compared with Winter 2017. In response to these data, in January 2019, the NHS England and Improvement (London region) End of Life Care (EOLC) Clinical Network, Healthy London Partnership (HLP) and the London Academic Health Science Networks (AHSNs) initiated a mixed methods project to understand the experience of staff using the 111star*lines, the process and experience of calling the service, and the performance and variation in the service. Based on the evidence collected, recommendations have been developed to improve the utilisation of, process and experience of 111star*line calls.

A paper and digital survey was developed and cascaded for staff that use each of the 111star*lines to gain feedback on the experience of the service. Analysis of the new 111star*line provider dashboard, which collates data on call volume, transfer times, outcomes and call times was completed. In addition, a review of end to end calls - calls from clinical staff to 111star*line providers and the clinical response provided - was undertaken; calls were listened to and objective and comparable observations were recorded.

230 staff members from throughout London responded to the survey. Data revealed that awareness of the service was high with the majority having used the service in the last 12 months. Most respondents said that they had used the service one to five times in the previous 12 months, and predominantly did so out of hours. Over 70 percent of respondents indicated that they would use the service again. Care home staff generally reported high levels of satisfaction with the service overall, whereas LAS and Rapid Response staff indicated less satisfaction with call back times and clinical advice given and overall rating of the service. Thematic analysis of written responses to open questions in the surveys revealed several areas for improvement; call back times, call handler and clinician advice.

Analysis of the provider dashboard data showed that there have been nearly 90,000 calls received since the 111star*lines were launched. Call volume started to increase in October 2017 but decreased from July 2018 onwards. The majority of calls receive a call transfer within 20 minutes although performance has been variable. The 111star*5 line showed the most significant drop in achieving a 20-minute transfer time from August 2018 onwards. Calls to the three star*lines are predominantly received between 18:00 and 21:00 during the week and between 10:00 and 17:00 during the weekend. The commonest outcomes of the calls are either a call back from a health care professional with closure of the call, or referral to primary or community care for ongoing management. Only eight percent of calls result in an ambulance transfer to hospital.

Fourteen 111star*line calls from two of the four NHS111 providers in London were listened to and reviewed; two from LAS staff and twelve from care home staff. Nine resulted in in-depth case studies. Although the sample size was small, the data collected corroborated with that of the surveys, and highlighted areas for improvement; need for streamlining of information required, call back times and clarification to users of the service of its remit and response.

The following recommendations are made:

#	Recommendation deliverable	Target Milestone	Parties (Bold = Suggested Lead)
1	Consideration of whether the current service design fully meets the specific requirements of LAS crews, care home staff and rapid response services, and whether these are diverse enough to warrant different approaches.	December 2019	• **HLP;** • NHS X; • Integrated Urgent Care (IUC) commissioners; • IUC providers; • User groups (LAS crews, care home staff, rapid response teams).
2	Align service provision with the demand on the service i.e. more call handlers and clinicians available during winter readiness peak and during particular times of the week.	Plan by November 2019 Implement by January 2020	• **IUC commissioners;** • IUC providers.
3	Development of a single Standard Operating Procedure (SOP) for all IUC providers with a set of improvement Key Performance Indicators (KPIs) that should include: **3.1** Performance against agreed call back times. **3.2** % call handlers, senior clinicians, GPs and other relevant IUC staff trained in and using Coordinate My Care (CMC), and other relevant clinical assessment tools. **3.3** % flagged CMC records accessed and viewed. **3.4** Delivery of action plan in response to regular local end-to-end call reviews. **3.5** % 111*line calls that include a “whisper” at the beginning of the call to identify if it is coming from a 111star*line.	Agree ownership of action – IUC CGG July 2019 Delivery: October 2019	• **HLP;** • IUC commissioners; • STP IUC clinical leads; • IUC providers; • NHS England and Improvement End of Life Care Clinical Network.
4	Promotion of agreed KPIs with all key stakeholders.	September 2019	• **IUC clinical governance group (IUC CGG);** • **IUC commissioners;**

			• Urgent Emergency Care (UEC) Transformation & Delivery Board.
5	Development and delivery of training and guidance for % call handlers, senior clinicians, GPs and other relevant IUC staff, that includes the following: **5.1** Use of #hellomynameis – introduction of their name and role to caller, to form part of the call audit process. **5.2** Clarification of data to be collected by call handler; this should be minimised and streamlined depending on caller, e.g. call-handler script to ensure consistent script is used for all callers. **5.3** Use of CMC and other sources of information to support the delivery of high quality clinical care.	November 2019	Delivery: • **HLP;** • **STP IUC clinical leads;** • IUC providers; • IUC commissioners. Delivery: • **IUC providers.**
6	Convene and facilitate a task and finish group to develop guidance for LAS, care home, or rapid response staff, on use of the lines that includes the following: **6.1** Appropriate and inappropriate use of the 111star*lines (a flow-chart to support decision making). Guidance should offer expected timeframes for call back for differing clinical situations (see recommendation 6). **6.2** How to access the 111star*line services. **6.3** Clarification of the call process. (a flow-chart to outline what happens when calling the service), i.e. first speaking to a call handler before being transferred to a GP or clinician etc. **6.4** Guidance on how to hand over information. For example, the CARES framework for care home staff, or the SBAR communication tool. These are easy to use, structured tools that enable information to be communicated accurately between individuals. This should involve the caller clearly articulating the outcome they are aiming for.	Task & Finish Group initiation: September 2019 Guidance reviewed and approved, ready for dissemination: November 2019	• **HLP;** • LAS leads; • Rapid response team leads; • Enhanced Health in Care Homes Network lead; • IUC CAS clinicians; • STP IUC clinical leads; • Care home networks/ forums.
7	Initiation of regular standardised audit of listening to 111star*line calls with learning and actions plans presented at each HLP IUC clinical governance meeting and shared across IUC providers.	September 2019 (first review)	• **IUC CGG;** • HLP; • IUC providers.

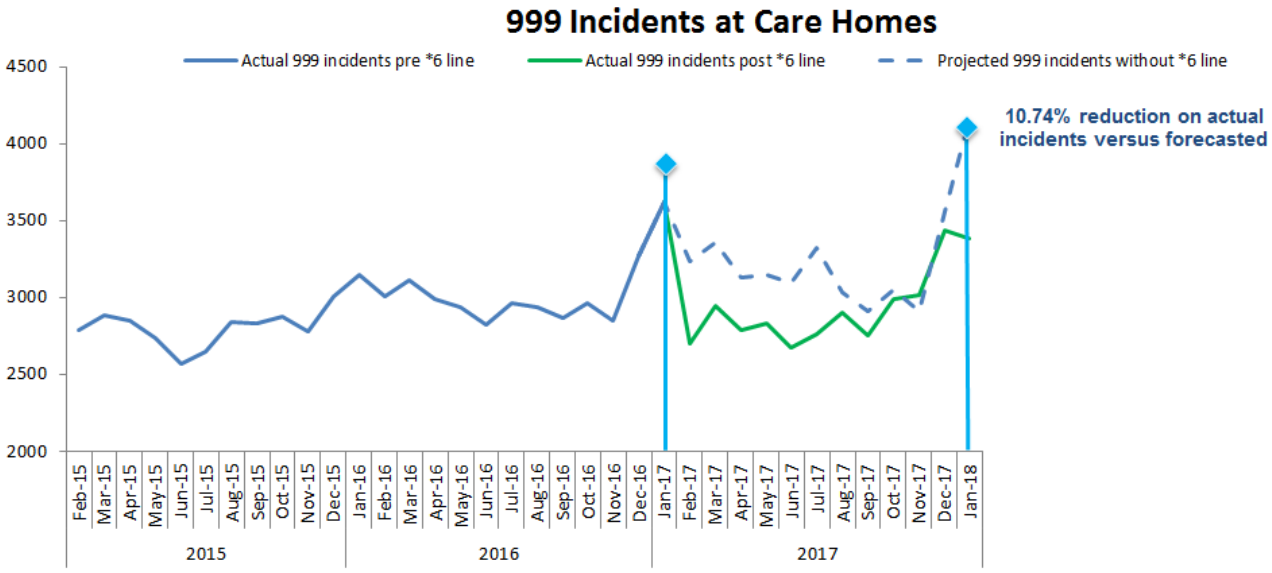
8	Oversight, collation, review and monitoring of an action plan to address missing ADASTRA and Patient Relationship Manager (PRM) data on call volumes, transfer times and outcome coding to increase the accuracy of end-to-end outcome reporting.	December 2019	• **IUC commissioners;** • IUC providers; • HLP.
9	Development and delivery of a single brand and communication strategy for LAS crews, care home staff and rapid response nursing teams, to increase awareness of the 111star*line services, to be adopted by IUC commissioners and IUC providers.	Development: November 2019 Delivery: December 2019	• Development: • **HLP;** • IUC providers; • IUC commissioners. Delivery: • **IUC commissioners;** • HLP; • NHS England and Improvement Comms team; • Care Home network; • ADASS; • LAS; • CQC; • IUC Providers; • Care Pulse.

3 Background

In 2017, after a successful bid to the NHS England National Director of Performance, London was chosen to pilot the 111star*line service. This new system allows care home, rapid response and LAS staff to connect to a senior clinician/GP in an NHS 111 contact centre, using their telephone keypad. The pilot was developed in response to care home staff reporting difficulties in contacting a residents' GP when needed.

From 2015 to 2016 the number of calls to LAS from care homes had increased by 6.5 percent with a peak of 3,273 incidents attended to by LAS during December 2016 and with a conveyance rate of 87 percent. Without an intervention LAS call outs at care homes were forecast to continue to increase; the solution of a 111star*line available through the NHS 111 system was therefore developed[1].

Figure 1 – The number of 999 incidents at care homes from February 2015 to January 2018



In January 2017, it was agreed to develop three 111star*lines within the NHS 111 system, using the NHS 111 cloud-based PRM, which identifies each call and securely routes it to the agreed end point. The service was designed to enable callers to use their telephone keys pad to connect quickly with a GP in an NHS 111 contact centre. The callers get through to the 111star*line by:

- Dial 111, press 9 and confirm your location, press star*5 for LAS crews.
- Dial 111, press 9 and confirm your location, press star*6 for care home staff.
- Dial 111, press 9 and confirm your location, press star*7 for rapid response community teams.

Since 111 is a public facing service, there is no notification of when to enter the 111star*line number to avoid the general public intentionally or accidentally accessing the 111star*lines. Furthermore, the automated public message is set by the national team and can vary.

The 111star*line calls are routed through an NHS 111 service adviser who takes the patient details and transfers the call immediately to a GP or other senior clinician; if a

GP or senior clinician is not available, they are given a guaranteed call back within 20 minutes.

On 23 January 2017 the pilot was launched with the aim to:

- Deliver improved patient outcomes;
- Support care home staff, rapid response teams and LAS with an appropriate clinical response which supports the principle of 'no decision alone';
- Reduce pressures on the wider UEC system through rapid access to a GP consultation.

The pilot was evaluated after six months and data showed that out of over 17,000 calls, 61 percent of the calls were closed by a GP in comparison to 14.3 percent for the overall NHS 111 service. This and other positive data at the time resulted in the service becoming 'standard' for London in September 2017. The value of the contract was split proportionally by population size. The five Sustainability and Transformation Partnerships (STPs) in London each commissioned the service with Clinical Commissioning Groups (CCG's)'s providing a funding contribution.

A year after the 111star*line pilot was implemented LAS call outs at care homes had decreased by 10.74 percent compared to the increased projected forecasts. The decrease equates to a reduction of 3,777 ambulances attending care homes and a reduction of 3,286 conveyances to Accident and Emergency departments (A&E). When the pilot launched in January 2017 five overarching (pan-London) principles were agreed. This was to allow each individual service provider to develop their own 111star*line SOP using their own templates and design, whilst embedding the agreed consistent principles. Subsequently support was secured from a number of commissioners and service providers: 111 providers, IUC service providers and GP OOH providers.

The overarching pan-London principles are:

- All 111star*line calls are to be routed to an agreed number via the NHS 111 line.
- The call handler receives an electronic 'call whisper' advising them that this is a 111star*line call. Calls are responded to by taking the caller name and contact details; and include a brief history of the patient requiring clinical advice/support.
- 111star*line call handlers will then pass the call to a GP. If a GP is not immediately available, the caller will be advised that the call will be placed in the GP Out Of Hours (GP OOH) or IUC CAS queue for call back (a call back within 20 minutes was the maximum wait agreed).
- All calls for 111star*lines are to be treated in exactly the same way, with no additional questioning regarding the caller's role or professional qualifications.
- LAS staff calling 111star*5 will be sent an SMS after using the service with a survey to capture their experience. Outcomes both positive and negative will be shared as health care professional feedback via the monthly NHS 111 IUC CGG meeting.

There are four providers for five STP areas of 111star*line services in London. Below is the list of providers in each STP footprint. See appendix 1 for a full breakdown by borough.

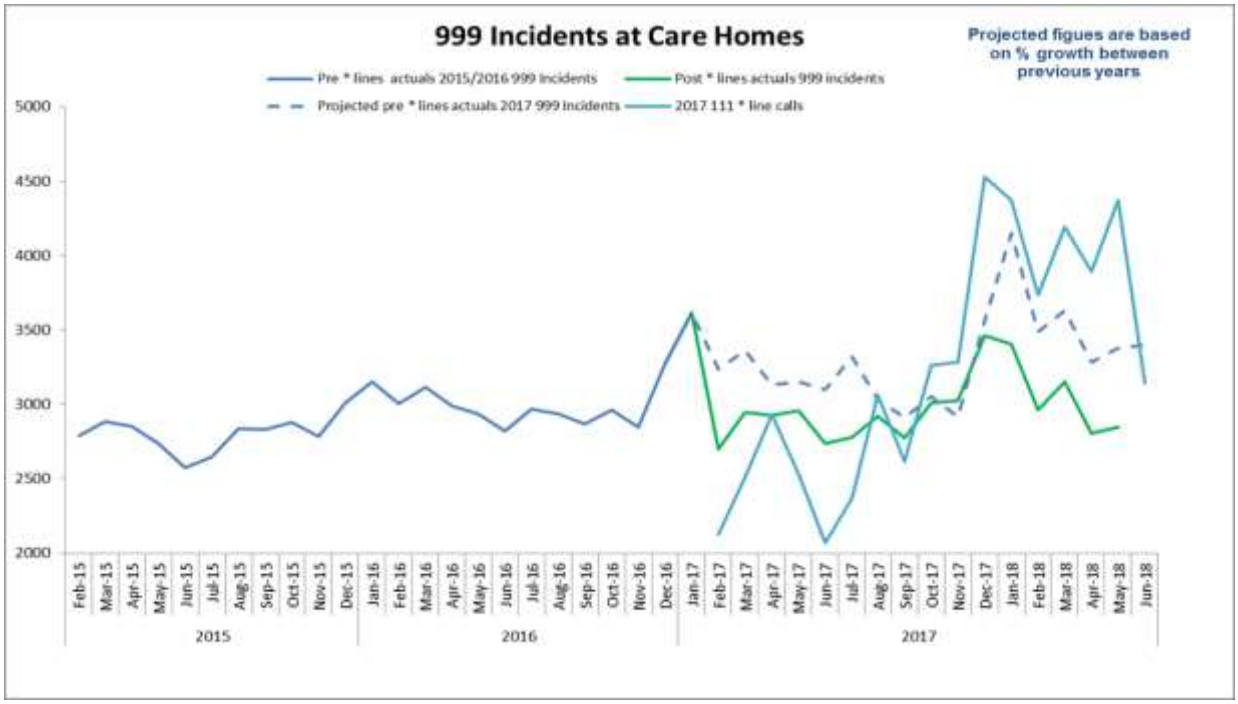
- LAS: South East London
- LAS NE: North East London

- LCW: North Central London and Inner North West London
- Vocare: South West London
- CareUK: Outer North West London

3.1 Communications strategy

After the 111star*lines pilot became standard practice in August 2017, HLP distributed posters promoting the 111star*5 and 111star*6 lines to LAS clinical staff and care home staff respectively, with a focus on informing services of these lines ahead of winter (see appendix 2). These were distributed across London using all of the networks and contacts that HLP had including its clinical provider contacts and working with commissioners and STPs to distribute within their local networks. The 111star*6 posters were distributed to care homes across London as part of a winter-readiness pack, which also included information about flu vaccinations for staff and residents. In Autumn 2018 double-sided 111star*6 cards and a further 111star*6 poster were also produced and sent to care homes. Designs were made for 111star*5 and 111star*7 posters, but these were not used at the time. The 111star*6 cards contained information about how to access the service, and its benefits. The impact of this communications campaign is demonstrated by the increase in utilisation of the lines from September 2017 onwards (see figure 2 below).

Figure 2 – The number of 999 incidents at care homes from February 2015 to June 2018 including the number of calls made to 111star*lines



From June 2018 onwards, use of the 111star*lines fell below the volume of calls experienced at the time of the initial communications push. As this decline in activity continued, further communications materials were produced. Removable stickers promoting the 111star*5 line were produced and sent to LAS crews, to put on their portable tablets, to remind them of the service. Business cards promoting the 111star*7 line were produced and sent to rapid response teams to put in their ID

card holders, to remind them of the service. Both were designed for their convenience, and the ease of access, following feedback from stakeholders and users of the 111star*lines. These were distributed in January and February 2019, again using HLP's networks and contacts, and through local networks from the STPs. This communications push coincided with the beginning of the review project, and as engagement with users and stakeholders started to reveal potential problems with the service, it was decided that further efforts to promote it should be put on hold until recommendations concerning the improvement of the 111star*lines were produced.

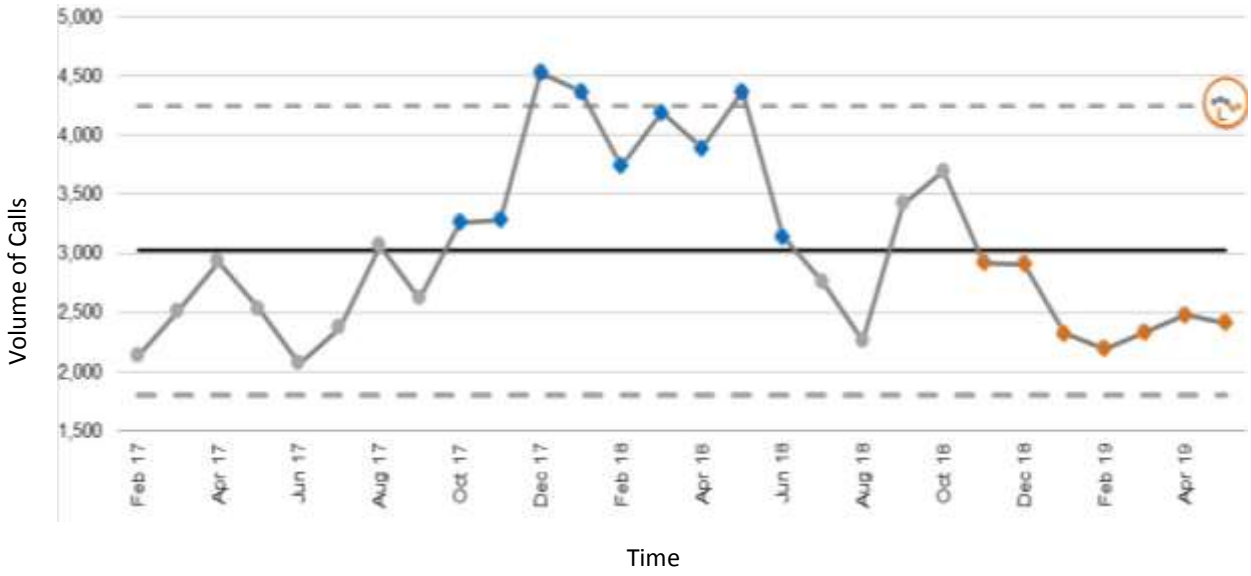
3.2 **Rationale for completing this review**

The NHS England and Improvement (London region) EOLC Clinical Network in partnership with the three AHSNs (The Health Innovation Network, UCLPartners and Imperial College Health Partners), produced data packs relating to the EOLC of care home residents for each London STP in 2018. The packs contain both national and local metrics including:

- Percentage of deaths in care homes.
- Ratio of LAS call outs and conveyances to an A&E department.
- Care home bed numbers.
- Percentage of care home residents with a CMC record whose preferred place of death was recorded.

The data packs were used to initiate conversations within each STP, with LAS, and with HLP. The project team collated feedback from these conversations and produced six project proposals to respond to the feedback, which were discussed with the London EOLC in care homes' steering group, the EOLC Clinical Leadership Group (CLG) and the NHS England patient sounding board (see below for project resource). Consensus was gained to review the 111star*lines services as a project. Alongside this, activity data from the 111star*line service from 2017 to 2019 (figure 3 below) showed there was an overall increase in call volume across the 111star*lines from October 2017 to June 2018. However, from July 2018 there had been a decrease in the number of calls with a sustained decrease starting from November 2018. The decline in activity supported the review of the service especially as other regions across England look to adopt similar services for their areas based on this exemplar.

Figure 3 – All 111star*line activity from 2017-2019 (data from the PRM call logs)



The aims of the review were to:

- Understand from staff what their experiences were of using the 111star*lines and what could be improved;
- Review the process and experience of calling the 111star*line service;
- Understand performance and variance across the different 111star*line providers;
- Develop recommendations to improve the use of, process and experience of 111star*line calls.

3.2.1 Project Resource

The project was funded and led by the EOLC Clinical Network and was supported by HLP and the three AHSN's who formed the steering group. The project team was hosted by the Health Innovation Network (HIN) with senior clinical project management support from the EOLC Clinical Network. The project ran from January 2019 until July 2019 and the team included two senior nurses, a palliative medicine registrar, with support from a GP, a data analyst and project managers.

4 Methodology

The project comprised of three elements:

1. Survey of users of 111star*lines.
2. Analysis of 111star*line provider dashboard data.
3. Review of end to end 111star*line calls.

A mixed methods approach enables triangulation to assure the validity of the findings.

4.1 Survey of users of 111star*lines

The 111star*line survey was developed using expertise and feedback from the 'EOLC in care homes' steering group as well as the target audience, including care home managers and ambulance frontline staff. An individualised survey was produced for each of the 111star*lines users to ensure that the data captured was relevant to the service. To maximise the number of responses obtained, a Word document of each survey was produced and taken to forums and events to capture service users at the time, and a SurveyMonkey link was distributed to as wide an audience as possible. The questions to each 111star*line survey are shown in appendix 3.

The 111star*5 survey was published via the LAS Facebook group, which is an active community of ambulance staff at all levels of the organisation. The survey was posted twice in a message which contained the link to SurveyMonkey. In addition, the survey was included in the electronic LAS staff newsletter with the link embedded. Separately to the 111star*5 survey LAS crews are sent a text message after every call to the service which provides continuous feedback via text; this feedback has been analysed as part of this report.

The 111star*6 survey was distributed electronically and in paper form, recognising that some care homes do not have internet access. The electronic version was shared with care home managers, STP and CCG leads and, the CarePulse resource centre. Paper copies of the 111star*6 survey were distributed to local borough care home forums, at Significant 7 training days, care home pioneers groups and South London care home leads forum. At these events responders could complete the survey at the time, scan and email the completed survey, or return it by post.

The 111star*7 survey was shared with key contacts within rapid response teams across London. Contact details for most of the Rapid Response providers were obtained. The covering letter, SurveyMonkey link, and printable paper versions of the survey were then sent to these contacts. STP colleagues were asked to provide assistance by helping to promote the surveys using any additional contacts they have.

4.2 Analysis of 111star*line provider dashboard data

111star*line calls are recorded in a system called Adastra across London with the reporting being produced by the PRM. Using the data collected from Adastra a dashboard has been developed and the dataset includes:

- Call volumes for 111star*5, 6 and 7 by CCG, provider and STP;

- Transfer times from call handler to clinician;
- Final outcomes of the calls (where recorded);
- A heatmap illustrating call volume by hour across the week.

The data has been collected from January 2018 to May 2019. Of note there is no data from CareUK in the dashboard.

PRM call log data has also been analysed which provides data on the number of calls for each provider. This data has been collected from January 2017 to June 2019.

4.3 **Review of end to end 111star*line calls**

Four 111star*line providers were approached via email by HLP to give the project team access to calls made to 111star*lines; three providers gave access. The calls were listened to by a mix of clinical and non-clinical members of the project team. After listening to the first calls a proforma was designed which allowed listeners to make objective and comparable observations of subsequent calls.

LCW provided the project team with a shareable file of calls, with patient-identifiable information removed. The project team listened to 10 calls initially, all of which were 111star*6 calls. The initial 10 calls were care home staff to call handler calls. At a second meeting, the project team listened to the call-back for five of the calls from the 111star*line clinician/GP to the care home staff . Any subsequent calls made by the clinician/GP to request further action to advance the patient's pathways were also listened to.

CareUK invited the project team to their 111 call centre, where they provided both call-handler and clinician parts of four calls; two 111star*6 calls and two 111star*7 calls.

VoCare invited the project team to their 111 call centre where the team listened to live calls, sitting with a call handler or senior clinician. This enabled the project team to ask staff questions to understand the call process. None of the calls listened to were to 111star*lines.

In total the project team listened to nine full end to end 111star* line calls and five sections of the call journey.

4.4 **Oversight of the project**

The EOLC in Care Homes Steering Group met monthly throughout the project to provide oversight and guidance to the project team. In addition, the team worked closely with the HLP Urgent and Emergency Care programme team throughout the project particularly during the review of the provider dashboard data, the end-to-end call reviews and to develop the recommendations. See Appendix 7 for details of the steering group and project team.

4.5 Survey of users of 111star*lines

4.5.1 Demographic data

Table 1 – Demographics of the survey responses

Demographics of survey responses	111star*5	111star*6	111star*7
Number of responses (completion rate)	100 (80%)	105 (95%)	25 (84%)
Paper responses	0	59	0
SurveyMonkey responses	100	46	25
Responders	Paramedics: 67 Technicians: 22 Other: 11(1)	Care Home Manager: 54 Nurse: 16 HCA: 4 Carers: 4 Clinical Manager: 4 Other: 14(2)	Nurse: 16 AHP: 5 Manager: 2 Other: 2(3)

(1) Other - Eight emergency ambulance crew, one paramedic manager, one clinical team manager and one clinical advisor.

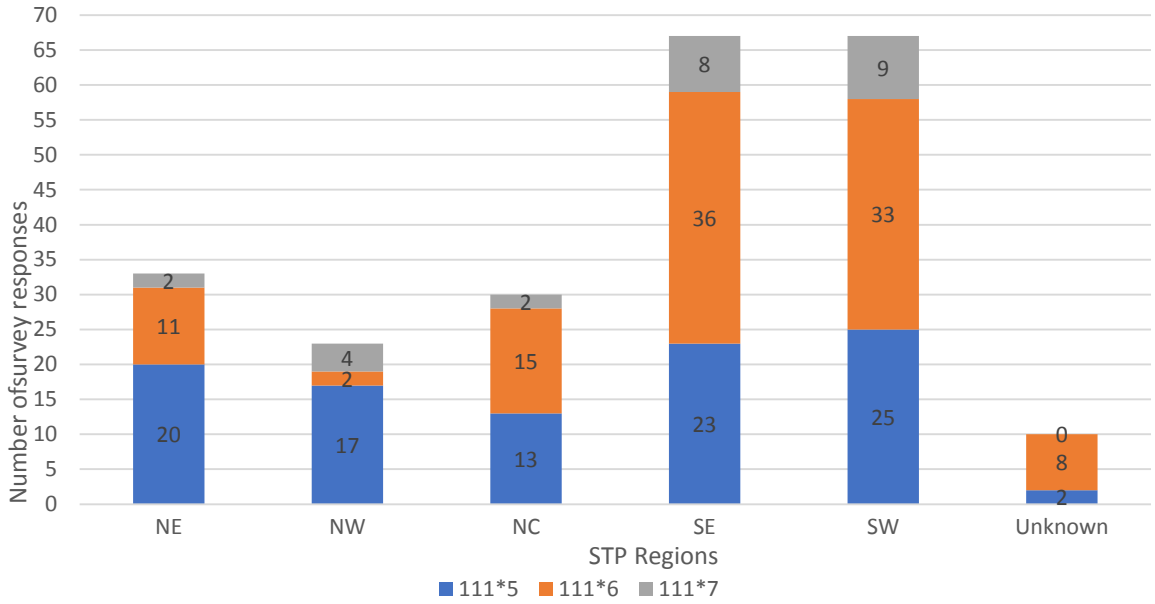
(2) Other - Commissioners, heads of care, trainers and administrators.

(3) Other – A GP clinical lead and a doctor.

4.5.2 Survey responses across each STP region

Survey responses for 111star*5 were evenly distributed across the STPs however 111star*6 and 111star*7 were predominantly received from South London.

Figure 4 – The total number of responses for each STP region for each 111star*line



4.5.3 Survey responders awareness and usage of the 111star*line service

Awareness by survey respondents for 111star*5 and 111star*6 was high at 89% and 94% respectively. Responders to the 111star*7 survey had lower levels of awareness at only 64%. Usage of the services in the last 12 months was lower compared to awareness but was still high.

Figure 5 – The number of responders that were aware of each of the 111star*lines

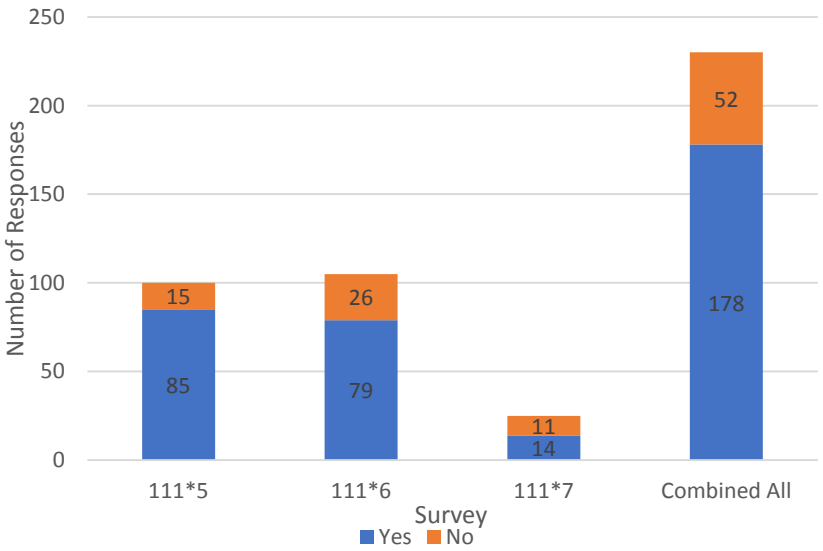
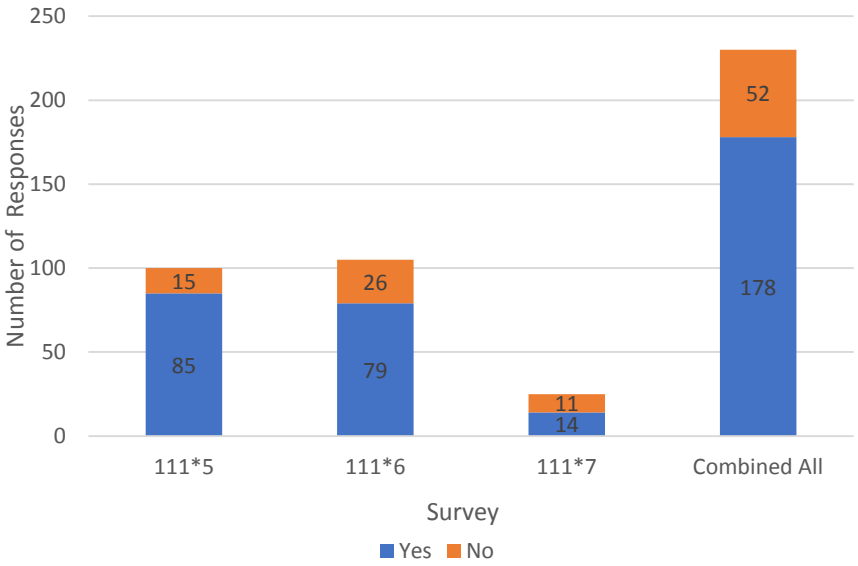


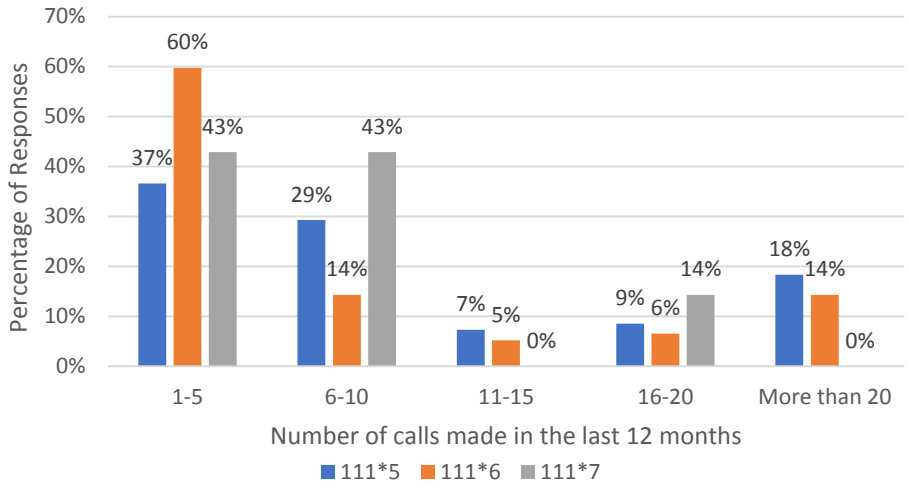
Figure 6 – The number of responders that had used the service in the last 12 months for each 111star*line



4.5.4 Self-reported frequency of use of the 111star*lines in the last 12 months

Across each of the 111star*lines the majority of responders said that they have called between one and five times in the last 12 months.

Figure 7 – The frequency responders used the 111star*line by percentage in the last 12 months



4.5.5 Self-reported time of use for each 111star*line

Responders were asked to select when they mainly used the 111star*line from four options and were able to select more than one. The chart below shows that across each of the 111star*lines responders are mostly using the services out of hours.

Table 2 –The timeframe that responders are mainly using each of the 111star*lines

Timeframe of accessing 111star*lines	111star*5		111star*6		111star*7	
9am - 5pm Weekday	7	8%	12	15%	1	7%
9am - 5pm Weekend	39	47%	43	55%	9	64%
5pm - 9am Weekday	67	81%	37	47%	7	50%
5pm - 9am Weekend	68	82%	52	67%	9	64%

4.5.6 Equipment used for LAS to contact the 111star*5 line

The 111star*5 survey asked how LAS called the 111star*5 service, and the respondent was able to select more than one option as well as explain their rationale. There were 83 responses in total, with 92 percent using their personal phone to contact 111star*5, and 19 percent using the patient's phone. The reasons given for using personal phones varied, but were predominantly due to ease, lack of delays, the ability to receive calls back, the unavailability of work phones and infection control concerns about using patients' phones. Respondents who used a patient's phone reported not wanting to use their personal phone because they did not want call backs after leaving the scene or to have their personal number linked to the call. The radio handset has a low usage at only 5 percent, which was reportedly because the radios are hard to hear, have poor signal, are difficult to use and cannot receive call backs. Where the radio was used was because the responder noted there is a cost to use their own phone or because they were in the control room. Only one responder said they had used a work mobile.

4.5.7 Experience and value of response from NHS111star*line staff

Responders were asked to select their level of agreement with statements related to the call handler call (two statements), and the clinical advisor call (seven statements). An overall rating is calculated for each statement which provides an average aggregate score.

Table 3 – 111star*5 survey responders level of agreement to nine statements

Statements about the 111star*5 service	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Avg Rating
I always speak to a GP within 20 minutes	64%	29%	4%	3%	0%	1.45
111*5 supports me to not send people to hospital	16%	20%	29%	21%	13%	2.96
I feel confident in the service and don't need to seek advice from elsewhere	12%	20%	23%	36%	9%	3.11
My initial call was answered quickly by the call handler	12%	17%	17%	41%	12%	3.24
The GP provides helpful advice	5%	13%	23%	44%	15%	3.49
I feel the right amount of time is given to my call	4%	9%	20%	51%	15%	3.64
I feel confident to follow the advice I am given	4%	3%	17%	53%	23%	3.88
I am able to answer the questions asked by the call handler	4%	4%	5%	60%	27%	4.01
I feel confident I can answer the questions asked by the GP	3%	1%	5%	59%	32%	4.16

Table 4 – 111star*6 survey responders level of agreement to nine statements

Statements about the 111star*6 service	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Avg Rating
I always speak to a clinical advisor within 20 minutes	3%	18%	21%	44%	14%	3.49
111*6 supports me to not send people to hospital	1%	9%	36%	39%	15%	3.56
I feel confident in the service and don't need to seek advice from elsewhere	3%	9%	22%	47%	19%	3.71
I feel the right amount of time is given to my call	1%	8%	21%	51%	19%	3.79
My initial call was answered quickly by the call handler	3%	8%	12%	60%	18%	3.83
The clinical advisor provides helpful advice	1%	1%	18%	56%	22%	3.99
I am able to answer the questions asked by the call handler	5%	6%	3%	52%	34%	4.03
I feel confident to follow the advice I am given	1%	1%	12%	54%	32%	4.13
I feel confident I can answer the questions asked by the clinical advisor	1%	1%	4%	63%	31%	4.21

Table 5 – 111star*7 survey responders level of agreement to nine statements

Statements about the 111star*7 service	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Avg Rating
I always speak to a clinical adviser within 20 minutes	57%	14%	14%	7%	7%	1.93
I feel the right amount of time is given to my call	29%	7%	29%	36%	0%	2.21
I feel confident in the service and don't need to seek advice from elsewhere	43%	7%	36%	14%	0%	2.21
The clinical adviser provides helpful advice	36%	0%	36%	29%	0%	2.57
The *7 line supports me to not send patients to hospital	21%	36%	14%	14%	14%	2.64
I feel confident to follow the advice I am given	29%	14%	21%	29%	7%	2.71
My initial call was answered quickly by the call handler	23%	23%	15%	31%	8%	2.77
I feel confident I can answer the questions asked by the clinical adviser	7%	0%	0%	57%	36%	4.14
I am able to answer the questions asked by the call handler	0%	0%	0%	57%	43%	4.43

4.5.8 Overall rating of the 111star*line services

Responders were asked to select a rating between poor and excellent for the service. An overall rating is given for each 111star*line based on one being the poorest and five being the highest.

There were 75 responders for 111star*5, with the majority of responders scoring the service overall as poor. There was an average or below average rating scored by 81 percent of responders (n=61). There were 78 responders for 111star*6, with the majority scoring the service as good. It received an average rating or above by 91 percent of responders (n=71). There were 14 responders for 111star*7, with the majority scoring the service as poor. It received an average rating or below by 93 percent of responders (n=11).

Table 6 – The rating for the service given as a percentage for each of the 111star*lines

	Poor	Fair	Average	Good	Excellent	Overall Rating
111star*5	37%	21%	23%	17%	1%	2.24
111star*6	1%	8%	21%	55%	15%	3.76
111star*7	50%	7%	36%	0%	7%	2.07

4.5.9 Use of the 111star*lines in the future

The majority of all responders would call the 111star*lines again. Almost every 111star*6 responder would call again, whilst slightly fewer would call 111star*5 and 111star*7.

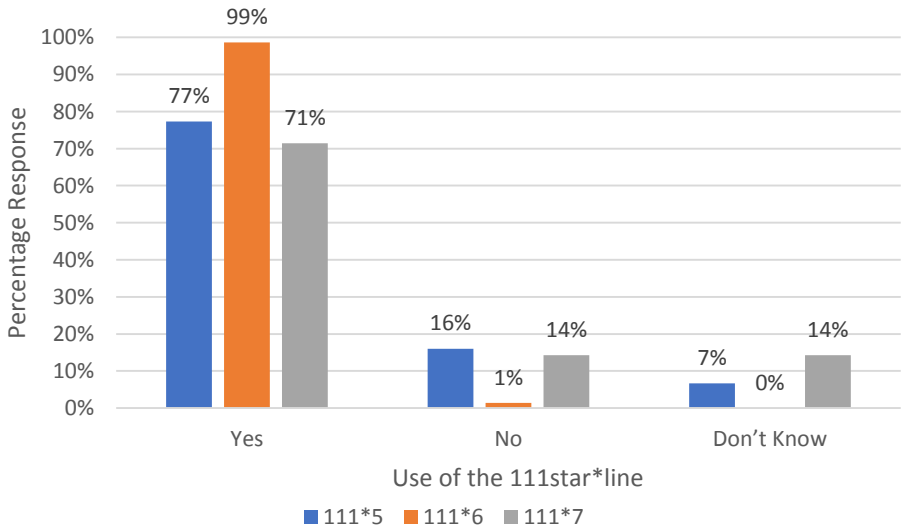


Figure 8 – The percentage of responses that would use the 111star*line again

4.5.10 Thematic analysis of survey free text comments

A thematic analysis was completed on the comments section from the survey responders. There were 56 comments from the 111star*5 survey, 38 comments from the 111star*6 survey and 8 comments from the 111star*7 survey. The analysis was used to identify, analyse and report patterns within the qualitative data. The comments were coded, put into themes, and then further divided into positive or negative responses.

Table 7 – The number of positive, negative and neutral references for each 111star*line

References	Feedback on 111star*5	Feedback on 111star*6	Feedback on 111star*7
Negative	121 (75%)	27 (41%)	33 (77%)
Positive	18 (11%)	29 (44%)	1 (2%)
Neutral	22 (14%)	10 (15%)	9 (21%)
Total	161 (100%)	66 (100%)	43 (100%)

4.5.10.1 Feedback on Call Handler response

There were 53 references to the initial part of the call including the call handler process with 51 (96 percent) of the references being a negative statement. The way that the call handler responds was a key theme. From each 111star*line it was commented that the call handler asked too many unnecessary questions or inappropriate questions, and that they could not divert from their script. Another described the call handler's manner as "*robotic*".

From 111star*6 there were two references to the call taking too long with callers often put on hold for long periods of time. Several of the 111star*5 responses observed that the call handlers did not know that the caller was a clinician or that they were calling from LAS and that they had to provide this information themselves. Comments also noted that they were either unable to get through to the 111star*line service, or that there was no difference to simply using the normal 111 line.

"*It makes absolutely no difference calling the star*5 line versus routine 111. You are asked the same questions*"

The response by the call handler was not felt to be tailored to the level of experience of the caller with paramedics feeling that they were treated as non-clinicians.

"Every time I use it I get treated as a [non] *professional. Being asked if* [the] *patient* [is] *alert and can't progress the call unless I answer questions- I'm a paramedic on scene* [the call handler] *try and give worsening advice to call back for advice - it's demoralising what are they going to do call [an] ambulance there's one on scene"*

For 111star*5 and 111star*7 the advice was on occasion considered unhelpful or irrelevant.

"Being asked to call back if anything changes to speak to a call adviser is a bit of an insult to a paramedic on scene"

However, for 111star*6 there were several references to the questions being difficult to answer or in the case of 1 HCA "*Too many medical questions asked".*

There were eight references to LAS technicians being refused referrals and having to go through the normal 111 process. One comment noted that while there was an agreement in place for technicians to refer, the call handler did not always follow this process.

"Recognise that there is an agreement between London ambulance and 111 that frontline staff can refer patients even if they are not registered ie technicians. Call handlers/health advisors need to know this and take referrals from non-registered front line staff. It seems to be very hit and miss on which call handler/health advisor knows this agreement."

Time was another key theme that emerged from the comments. The main concern was that the advice for the call backs was variable with some call handlers informing callers it would be 10 minutes, 20 minutes, 30 minutes, 1 hour or 2 hours. 30 minutes was the most common time given noted in 5 of the 6 references to call back times.

4.5.10.2 Feedback on Clinician response

There were 34 references relating to the second part of the call process, when a clinician is responding to the caller. 26 (76 percent) of the references were a negative statement. In the case of all three 111star*lines, references were made to GP visits being arranged. Although the majority of statements about this were negative, there were three positive statements from 111star*6 responders that visits were done within the estimated time.

However, 12 references regarding visits were negative as it was felt that GPs were reluctant or too busy to attend patients, and would rather send the patient to A&E than arrange a visit. Two responders to 111star*7 observed that, despite being told a visit would take place, no doctor came. The waiting times for visits was also felt to be an issue, particularly at night. Comments from 111star*5 and 111star*7 were that the clinicians would try and send the person to hospital unnecessarily and that the response was variable depending on which clinician is handling the call.

"some of the patients our practitioners ask advice for, [are sent] *to A&E unnecessarily and are asked to call 999 rather than organise a visit themselves. This is especially true, when it comes to more difficult decision-making processes, where end of life scenarios and tricky family dynamics play into it."*

There were two references to GPs not understanding how the callers work, for instance in regard to their capacity or the level of information they have access to.

"The GP's could also be made aware of the limits and capabilities of paramedics to enhance our teamwork."

In some cases, 111star*5 callers noted that they would speak to a nurse or paramedic rather than a GP which was felt to be of little use as they need to speak to a higher clinical grade.

4.5.10.3 Feedback on Service Quality

There were 164 references relating to the service quality of the 111star*lines. 117 (71 percent) were negative statements. There were 25 responses that were positive about the service across each of the 111star*lines (111star*5=6, 111star*6=18, 111star*7=1) which noted how helpful the service was, how professional and friendly the staff are and how useful it is to have advice particularly out of hours.

The major theme regarding the service quality concerned the time taken for a call back. There were 61 references relating to time with 54 (89%) being negative across the 3 111star*lines, the positive comments were only 111star*6 callers. The positive comments were primarily statements about the service being "*prompt*" and dealing with the calls quickly. The negative ones concerned the length of time it takes to receive a call back from a clinician and in many cases this was the only issue with the service.

"*However my only problem with the system is that it still takes an extended period of time for a call back. I would say from my experience and speaking to others I would get a call within 30 minutes 1 in 10 or 15 calls. Often waits for call backs exceed an hour."*

The handover process was another theme that came from the responses, with 10 negative references. The comments were that the caller would have to repeat the information they have already provided to the call handler, and when the clinician calls back, they have to repeat everything again.

“When you get through to somebody you explain why your calling then you wait to speak to the clinical adviser and you have to explain everything again it would be helpful if the person you initially spoke to had passed on the information to the clinical adviser, so you don't have to repeat everything again.”

111star*5 and 111star*7 responders also noted that their initial calls could not be traced when they called again to chase; this caused delays and a need to start the process again. In other examples the call was not closed appropriately so the caller would receive calls days later about the patient or 999 would be called without speaking to the caller.

“111 adding crew mobile numbers to patients’ records, meaning further calls asking to speak to the patient - sometimes days/weeks after the initial referral to 111!”

Both 111star*5 and 111star*6 comments noted that the service has helped them to avoid unnecessary hospital admissions and helped them manage their patients appropriately, such as

*“I strongly feel that they respond to our calls promptly and advise or support us to refer our clients to hospital when absolutely required." (111*6)*

*"Prompt and helpful, a good service, especially for out of hours and weekends." (111*6)*

Some comments from 111star*5 were more focused on the potential benefits for example “*when the service works well, it is an excellent service*” and “*The Service is a great idea in theory to speed up the pace of calling a GP to refer a patient on”.*

However, across the three 111star*lines the reverse is also true, particularly from 111star*5 and 111star*7, where calling the service leads to unnecessary hospital admissions.

” Generally, 111 will err on the side of caution. Working in a community rapid response team, we are obviously trying to keep patients out of hospital, so it can be frustrating when the only advice given after a lengthy triage is to call 999. I’m a Paramedic, I know when to call 999”

*4.5.10.4 Feedback on Caller understanding of 111star*lines*

Some of the comments showed a lack of understanding and awareness about the 111star*lines; responders had different understanding and expectations of the service; for example, some were expecting to speak to a GP straight away and not having to wait at all.

*"There is confusion amongst staff about how to access star*5. I believe if better instructions are given, more staff would use it. It took me a while to realise you don't press it in one sequence or too soon. Press 9 first. Then press star*. Wait. Then press 5."*

A few comments suggested making information about the 111star*lines clearer, as there was some confusion about how to access the service.

"*Not enough information about its use or when it is appropriate. How are they contacted? Do you dial 111? Do you need to be a paramedic? Is it a referral? What are the hours? Much more information and publicity needed."*

For some responders across each of the 111star*lines it is the only service available to them to access out of hours support and for one responder the only reason they call is because there are no other options. Three responders from 111star*5 noted that they would contact the out of hours GP directly rather than call the 111star*line as they would experience fewer delays.

4.5.10.5 Feedback on End of Life Care

There were six references related to end of life care from 111star*6 and 111star*7, with mixed responses.

"Recently assistance around end of life care has been very good lately."

"Some of the patients our practitioners ask advice for, are sent to A&E unnecessarily and are asked to call 999 rather than organise a visit themselves. This is especially true, when it comes to more difficult decision-making processes, where end of life scenarios and tricky family dynamics play into it."

A story from a palliative care nurse felt the change away from direct contact via *[an OOH GP service],* to 111star*7 has led to poorer palliative care due to the delays in getting hold of a GP.

"The switch from direct contact to [an OOH GP service], to [111] has been nothing but disastrous. We are a palliative care night team and have not yet had a positive experience dealing with [111] instead of an OOH GP service. It has taken at least 1-2hrs every time to try and get hold of a Doctor. Our patients are usually imminently dying and acutely symptomatic, we will be calling only for real emergencies and this way of doing things is delaying their care significantly. I am the matron of the service and once I stayed behind at work to ask why this has to take so long, the manager of that shift (whom it took over an hour to get hold of as the call handler wouldn't put [me] *through to anyone senior) knew of the star*7 line but had no idea if it worked. One patient for example, needed urgent paracetamol prescribing as they were dying and symptomatic with a very high fever. It took 2 hours to eventually get through to a Dr by which time they had died. Horrifyingly, when they were asked at that point to come and verify the death the [rapid response] team were told they had to start all*

*over again because it was a different request! We work with paramedics who use the star*5 process. They say its again not great but its far better than the service we are currently getting through star*7."*

4.5.11 LAS staff text feedback on 111star*5 service

Between January and April 2019 there were 146 responses from LAS providing feedback on 111star*5. Staff reported that in 50 percent of cases the call directly avoided a conveyance to A&E and 81 percent were confident that the service was a viable alternative to conveyance.

There were positive statements about the helpfulness of the service and the GPs providing good advice.

"*It's a great service and the Dr are fantastic to speak to and run through any idea or concerns if any"*

"Very happy with the plan we made for onward treatment for the patient. Provided the care they required and ensured their safety."

The negative statements mostly focused on the time it takes to receive a call back.

"Consistently waiting over an hour for gp call backs on patients Filling in this form at 1 [hr] 20 mins post origin call. Often convey patients rather than face this delay to getting an ambulance back in service."

"GP holds up emergency ambulance for nearly an hour and still we do not get a call back."

4.6 111star*line provider dashboard data

4.6.1 111star*line call volume across STPs

There have been 87,255 calls made to the 111star*lines since January 2017; an average of 2909 calls per month. However, the average number of calls per month in 2019 has decreased compared to 2017 and 2018. A Statistical Process Control (SPC)[2] chart looking at data from all providers shows that there was a rise in calls in October 2017, and that this was sustained until June 2018. Since then, the number of calls shows no special cause variation. This means that the number of calls each month for July 2018 to June 2019 is similar to the initial pilot phase of the project. Appendix 4 shows an SPC Chart of call volume for each STP.

Table 8 –The number of 111star*line calls made in each STP from January 2017 to December 2017

	2017													
STP	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**	**Avg.**
NCL (LCW)	39	348	522	609	507	456	553	456	513	596	810	976	**6385**	**532**
NEL (LAS)	36	479	516	548	490	301	392	391	404	703	848	1075	**6183**	**515**
ONWL (Care UK)	11	352	366	459	384	360	323	365	336	480	373	689	**4498**	**375**
LCW INWL	11	157	191	206	182	112	34	923	503	179	90	271	**2859**	**238**
SEL (LAS)	25	370	435	556	458	367	500	422	360	625	558	734	**5410**	**451**
SWL (Vocare)	28	422	480	553	510	473	568	506	501	678	605	783	**6107**	**509**
Total	**150**	**2128**	**2510**	**2931**	**2531**	**2069**	**2370**	**3063**	**2617**	**3261**	**3284**	**4528**	**31442**	**2620**

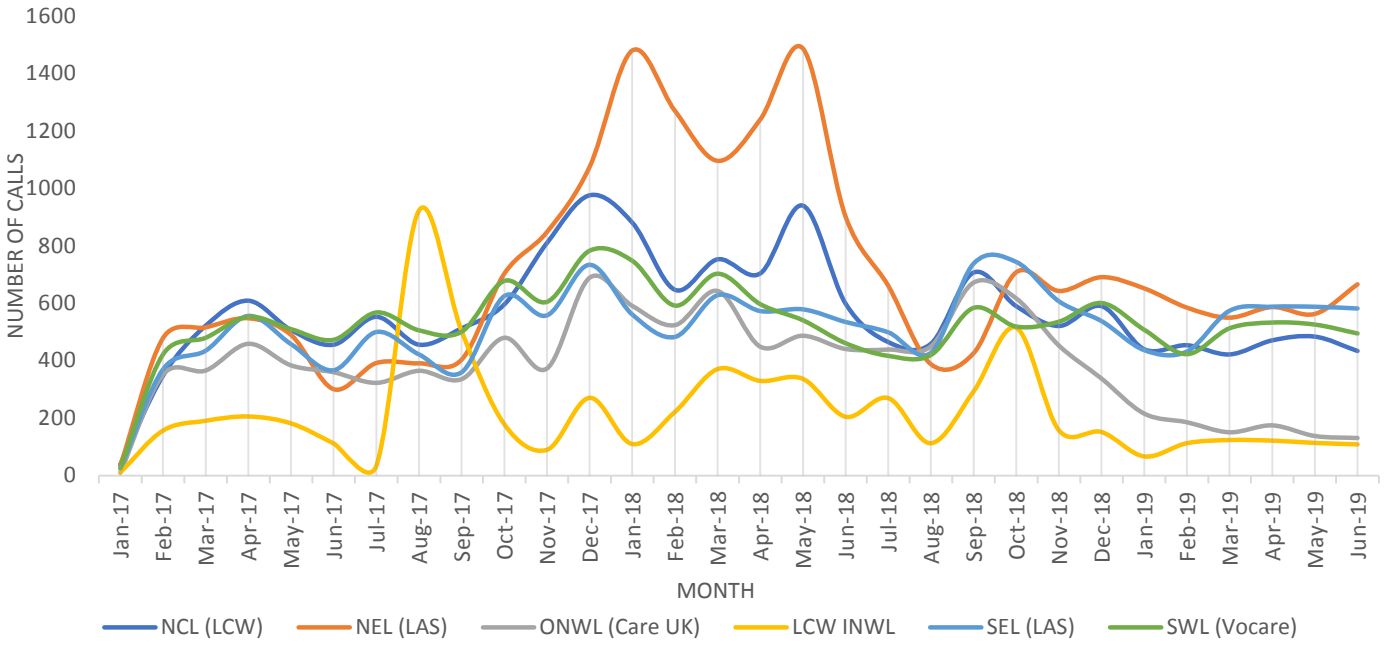
Table 9 –The number of 111star*line calls made in each STP from January 2018 to December 2018

	2018													
STP	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**	**Avg.**
NCL (LCW)	881	647	753	704	940	599	465	459	707	590	521	590	**7856**	**655**
NEL (LAS)	1480	1270	1096	1240	1487	902	661	388	426	708	643	691	**10992**	**916**
ONWL (Care UK)	591	524	643	449	487	441	439	450	672	617	453	338	**6104**	**509**
LCW INWL	110	222	371	330	337	205	270	113	293	515	158	152	**3076**	**256**
SEL (LAS)	561	483	628	573	579	535	499	428	738	744	607	538	**6913**	**576**
SWL (Vocare)	748	592	703	597	541	461	417	420	584	519	536	601	**6719**	**560**
Total	**4371**	**3738**	**4194**	**3893**	**4371**	**3143**	**2751**	**2258**	**3420**	**3693**	**2918**	**2910**	**41660**	**3472**

Table 10 –The number of 111star*line calls made in each STP from January 2019 to June 2019

	2019									2017-2019	
STP	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Total**	**Avg.**		**Total**	**Avg.**
NCL (LCW)	440	454	422	471	484	434	**2705**	**451**		**16946**	**565**
NEL (LAS)	652	585	550	587	563	666	**3603**	**601**		**20778**	**693**
ONWL (Care UK)	216	186	151	175	138	131	**997**	**166**		**11599**	**387**
LCW INWL	67	113	124	122	114	109	**649**	**108**		**6584**	**219**
SEL (LAS)	437	432	574	588	588	582	**3201**	**534**		**15524**	**517**
SWL (Vocare)	508	423	513	533	526	495	**2998**	**500**		**15824**	**527**
Total	**2320**	**2193**	**2334**	**2476**	**2413**	**2417**	**14153**	**2359**		**87255**	**2909**

Figure 9 –The number of calls received for each STP from January 2017 to June 2019



4.6.2 Analysis of 111star*line and provider call transfer times to a clinician

There were 34,142 calls between January 2018 and May 2019, and of these 28,736 (84 percent) where a transfer time has been recorded in Adastra. Transfer time is the time a call is transferred to a clinician as either a warm transfer or call back. Of all calls 73 percent are transferred within 20 minutes and 111star*7 has highest percentage of calls at 78 percent of calls transferred within 20 minutes.

Table 11 – The volume and percentage of calls by transfer time for each 111star*line and combined

	111*5		111*6		111*7		All	
Transfer Time	**# of calls**	**%**	**# of calls**	**%**	**# of calls**	**%**	**# of calls**	**%**
0	5472	41%	5543	47%	1995	54%	13010	45%
1-20	3869	29%	3271	28%	875	24%	8015	28%
21-40	1292	10%	889	8%	279	8%	2460	9%
41-60	634	5%	569	5%	150	4%	1353	5%
61-80	446	3%	304	3%	77	2%	827	3%
More than 80	1559	12%	1203	10%	309	8%	3071	11%

There is variation across providers in the number of calls that have a transfer time between 0 and 20 minutes. LCW, Vocare and LAS are transferring more than 80 percent of their calls within 20 minutes with LCW over 90 percent. LAS NE is significantly lower with less than 60 percent being transferred within 20 minutes. There is no data for CareUK.

Table 12 - The volume and percentage of calls by transfer time for each provider

	LAS		LAS NE		LCW		Vocare	
Transfer Time	**# of calls**	**%**	**# of calls**	**%**	**# of calls**	**%**	**# of calls**	**%**
0	5992	61%	3359	25%	1567	76%	2092	60%
1-20	2438	25%	4428	33%	306	15%	843	24%
21-40	692	7%	1461	11%	84	4%	223	6%
41-60	305	3%	894	7%	40	2%	114	3%
61-80	153	2%	595	4%	16	1%	63	2%
More than 80	320	3%	2550	19%	55	3%	146	4%

Across all 111star*lines 14 percent of calls take more than one hour to be transferred and there were 39 calls with a transfer time of more than 12 hours. The majority of these calls came from LAS NE accounting for 33 of the 39 calls; Vocare had three calls and LAS had three calls. The three longest transfer times were from LAS NE at 26 hours, 24hours and 22 hours. LCW has just under half of its data missing transfer times whilst Vocare has a third.

Table 13 – Additional information on transfer times by provider

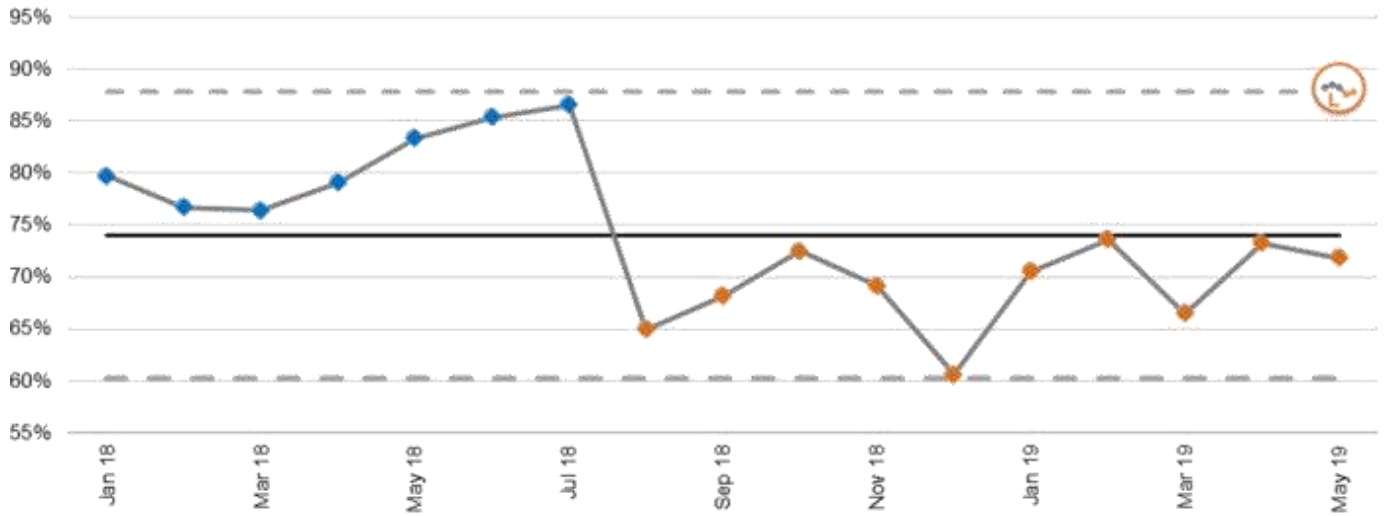
Provider	Average (mins)	Range (mins)	Number of Missing Transfer Times	Total number of calls	% of calls with missing transfer times
LCW	8	650	2015	4082	49%
VoCare	15	1013	1712	5193	33%
LAS	13	1260	448	10346	4%
LAS NE	54	1587	1243	14530	9%

An analysis of the transfer time by month for all 111star*lines shows that there was variation between January 2018 and May 2019 in the percentage of calls transferred within 0 and 20 minutes. An improvement is noted between January 2018 and July 2018, but from August 2018 until May 2019 there is a significant decrease in percentage of calls achieving 0 and 20 minute transfer times. This is most prevalent for a transfer time within 20 minutes and an SPC chart showing the change can be seen in figure 10. Between August 2018 and May 2019 the range for 111star*5 0-20min transfers is 58 percent and 70 percent, whereas the ranges for 111star*6 and 111star*7 are higher (60-79 percent and 66-84 percent respectively).

Table 14 – The percentage of calls transferred within 0 and 20 minutes by 111star*line

star *line	Transfer Time	2018												2019				
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
*5	0	50%	45%	48%	46%	53%	70%	67%	27%	29%	43%	44%	36%	50%	51%	30%	27%	25%
	20	84%	80%	81%	79%	85%	87%	88%	62%	63%	70%	66%	58%	64%	68%	61%	69%	68%
*6	0	45%	44%	41%	46%	50%	57%	53%	31%	36%	42%	45%	33%	62%	63%	50%	42%	44%
	20	75%	73%	70%	76%	79%	82%	85%	66%	71%	72%	70%	60%	77%	78%	74%	79%	78%
*7	0	66%	63%	66%	59%	64%	75%	71%	50%	60%	60%	60%	49%	55%	67%	22%	25%	22%
	20	82%	79%	83%	89%	91%	91%	89%	72%	84%	81%	74%	69%	74%	79%	67%	72%	67%

Figure 10 – Percentage of calls transferred within 20 minutes from January



2018 to May 2019 for all lines

For SPC charts for each 111star*line and provider see appendix 5. The performance by providers varies significantly.

Volume of calls

4.6.3 Analysis of the time calls are made

The tables below show heat maps for when calls are received by time of day for each 111star*line. Green shows the lowest amount of calls whereas red shows the highest number of calls.

Time of year

Table 15 – The frequency of calls by time of day for all calls

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
*5	714	615	486	441	447	418	243	401	382	442	567	595	595	531	512	477	490	754	875	1046	1077	1074	930	893
*6	463	404	326	313	253	303	352	351	485	552	863	965	818	694	697	680	709	688	1210	1361	790	633	605	522
*7	94	76	78	58	51	53	39	73	124	208	278	290	284	237	251	220	213	171	284	292	236	214	172	114

Table 16 – The frequency of calls by time of day for weekday (Monday-Friday) calls

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
*5	492	430	353	294	311	284	159	244	145	104	207	206	206	168	190	170	183	388	558	736	749	717	604	589
*6	306	274	228	231	177	202	204	157	146	172	216	237	230	230	205	235	257	341	775	941	544	419	388	355
*7	68	52	54	44	34	36	27	30	58	71	78	75	88	70	96	77	75	75	186	202	169	160	124	83

Table 17 – The frequency of calls by time of day for weekend (Saturday-Sunday) calls

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
*5	222	185	133	147	136	134	84	157	237	338	360	389	389	363	322	307	307	366	317	310	328	357	326	304
*6	157	130	98	82	76	101	148	194	339	380	647	728	588	464	492	445	452	347	435	420	246	214	217	167
*7	26	24	24	14	17	17	12	43	66	137	200	215	196	167	155	143	138	96	98	90	67	54	48	31

4.6.4 Analysis of outcomes recorded for all calls

There are two distinct pathways undertaken from the 34,152 calls made between January 2018 and May 2019. The split is between those outcomes that have followed the pathway and those calls that have deviated from the agreed pathway which has a significant impact on outcomes.

Table 18.1 shows the summary outcomes for calls that have utilised the agreed pathway of DX76 and DX77

Dx76 Call back by Healthcare Professional within 30 minutes

Dx77 Call back by Healthcare Professional within 60 minutes

This means the callers patients details were taken and the case added to the GP Queue within the 111 Clinical Assessment Service.

Table 18.2 shows the outcomes where the call handler has commenced a NHS Pathways Triage and not passing the case directly to the Clinical Assessment Service Queue. By not passing to a GP within the CAS, because of the complexity of the calls, there are high amounts of Ambulance referrals.

When a call handler follows the agreed process of transferring the call to a healthcare professional only 3% of these calls result in an ambulance referral.

Table 18.1 – The total number of calls where the agreed pathway was followed for a specific outcome and shown as a percentage of the of outcomes

	Total	%
Ambulance	508	2.9%
ED	259	1.5%
Primary & Community Care	11,134	64.5%
Referred to Other Service	637	3.7%
Call Closed	4,731	27.4%
Grand Total	**17,269**	**100.0%**

When a call handler does not follow the healthcare professional pathway and follows NHS pathways module 0, there is a higher rate of ambulance dispatch, 13%, and the referrer not always getting to speak with a clinician.

Table 18.2 – The total number of calls where the call handler has not followed the agreed pathway, shown as a percentage of the total of outcomes

	Total	%
Ambulance	2,154	12.8%
ED	834	4.9%
Primary & Community Care	3,415	20.2%
Referred to Other Service	3,062	18.1%
Call Closed	7,418	43.9%
Grand Total	**16,883**	**100.0%**

4.6.5 Analysis of outcomes after a consultation with a healthcare professional

When a call handler follows the process of transferring the call to a healthcare professional only three percent of these calls result in an ambulance being dispatched. When a call handler does not follow the healthcare professional pathway and follows NHS pathways module 0, 20 percent of these calls end with an ambulance being dispatched without the caller speaking to a clinician.

4.7 End-to-end 111star*line calls review

The project team worked with two providers to review a total of 14 calls, 10 from LCW and 4 from CareUK. 12 calls were 111star*6 and 2 calls were 111star*5. Nine calls in total were reviewed in full.

LCW: Five calls were listened in full, reviewed using the proforma and case studies produced.

CareUK: Four calls were listened in full, reviewed using the proforma and case studies produced.

The full case studies for each call can be found in appendix 6 and section 3.3.1 provides a summary.

Eight out of the nine calls that had a case study produced had a call handler section of the call to listen to. Three of the calls were resolved by the call handler without requiring a clinician ringing the caller back. Four call handlers provided a call back time of one hour, and one offered 30 minutes.

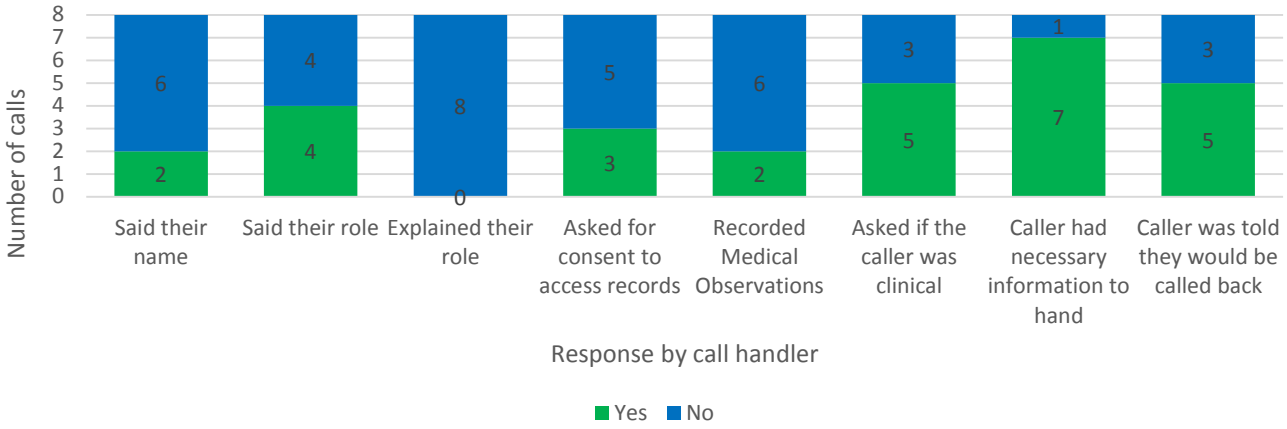
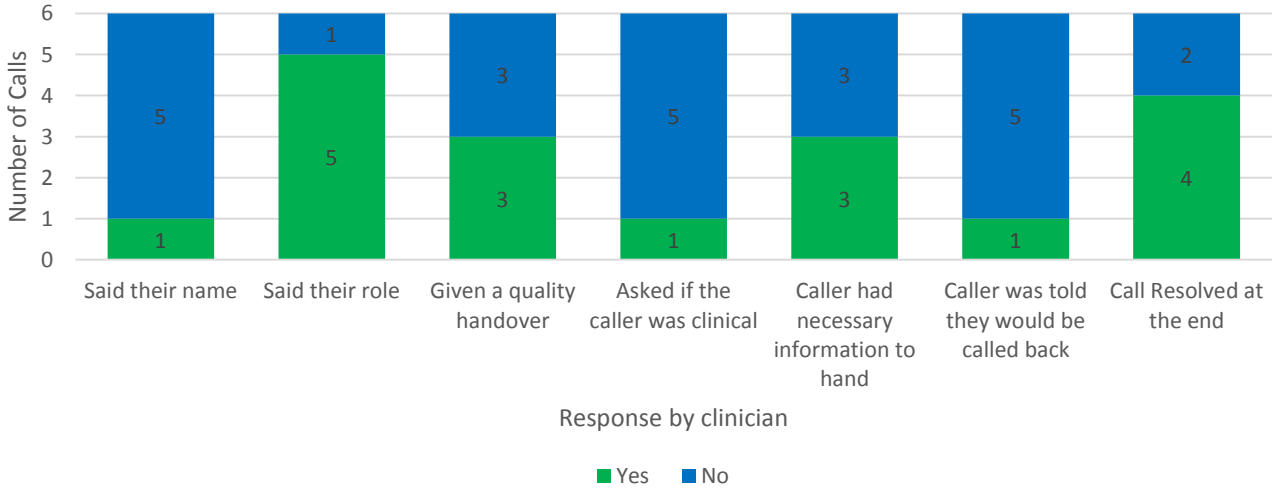


Figure 11 – Call handler response

Five out of the nine calls that had a case study produced had a clinical follow up to review. One of the calls had two follow ups, one initially from a nurse and a second with a GP. Only the nurse provided their name when introducing themselves.

Figure 12 – The clinical follow up response



4.7.1 Summary of case studies

	Case Details	Outcome	Comments
Case A1 **111 star*6 call from a residential home calling regarding a resident**	• Patient complained of 'chest contractions' so an ambulance was dispatched (unclear whether 999 or 111star*6 was called). • LAS on scene called 111star*6. Patient was well but had high blood pressure. They wanted to speak to a GP	• Fax for prescription is sent to local pharmacy four hours after confirmation of increased dosage of medication.	• The second call to the call handler took nine minutes, with questions irrelevant to the caller's original query. • There were six calls made in total which could have been

	regarding increasing blood pressure medication. • A GP call backs and agrees to increase the medication. • Care home team lead calls 111star*6 four hours later as no prescription was received • Pharmacist calls back care home. Fax sent to local pharmacy for care home to collect.		resolved in two.
Case A2 **111star*6 call from nurse in nursing home regarding a resident**	• Nurse reports patient has by-passing catheter and vomiting coffee grounds. • Call handler recorded vital signs when the nurse calling offered them • Call handler informs caller they will receive a call back in one hour	• GP calls back within 18 minutes. • GP enquires if patient is for 'active treatment' – nurse unsure and couldn't find information • GP requests ambulance to take patient to hospital.	• Call with call handler takes six minutes which could be shorter. • Readings that were taken did not appear to be handed over to GP. • Unclear if GP could have prevented an ambulance if they had visited.
Case A3 **111star*6 call from staff nurse in nursing home regarding a resident**	• Patient has a chest infection, blood pressure is dropping, fast pulse and breathing is rapid. Nurse calls 111star*6 as worried that they are unwell. • Call handler informs caller they will receive a call within one hour. • Caller wanted a GP to visit patient.	• GP recognises patient sounds sick • Nurse mentions end of life medications are in the home • GP asks if patient is 'for' hospital, she says they are for active care • GP tells nurse to call for an ambulance.	• Long pauses of silence by the call handler. • Despite low blood pressure/high pulse/reduced alertness call handler advises call back in 1 hour • GP asks nurse to say all of the observations again. • GP did not access additional information – detailed CMC record states patient is in last days-weeks of life and not for hospital readmission
Case A4 **111star*6 call from staff nurse in nursing home regarding a resident**	• Patient has a high temperature and positive urine dip • A GP had visited prior to the call and ruled out a chest infection, and had given a prescription for liquid antibiotics • Nurse calls 111star*6 as the pharmacy doesn't stock that antibiotic • Call back from GP who changes the prescription	• Staff asked to collect prescription from local pharmacy. • Pharmacy had no medication in stock. • Prescription faxed new prescription for different antibiotic.	• Call with call handler was disjointed and did not align to what caller was asking. • Nurse did not have information to hand when GP calls. • Two additional calls needed because medication was not in stock.
Case A5 **111star*6 call from staff nurse in nursing home**	• Patient has blood in urine and an infection. • Call handler advised a 111star*6 nurse would call the care home back • Advanced nurse practitioner	• Prescription was written by the GP but care home could not send someone to collect it • An OOH GP visit was arranged.	• GP repeated questions asked in previous call. • Call was short and concise without unnecessary detail.

regarding a resident	assessed patient over the phone, and advised a GP would call the care home • GP called care home and offered to write a prescription, however care home staff unable to collect • Instead a GP home visit was arranged.		• Potentially unnecessary GP visit – only needed because care home staff can't pick up prescription
Case B1 **111star*6 call from team leader in a nursing home**	• Elderly patient had a 2x2 inch cut on their foot. • Patient had a wet cloth on wound. • Team leader did not have nursing capacity to take patient to A&E. • Caller could not give patient pain relief.	• Clinician provided advise to manage the wound with a dry dressing. • An ambulance was called out for the patient.	• Rapid response might have been able to treat this patient in the care home, and therefore avoid hospital admission
Case B2 **111star*6 nurse calling about a care home resident**	• Patient had fallen out of bed and hit their head. • Nurse wanted OOH GP to visit patient. • Call handler told nurse they would receive a call back from a GP.	• GP call not available to listen to. • Separate notes state GP provided advice and case was resolved.	• Nurse was looking for reassurance from a senior clinician.
Case B3 **111star*5 call from paramedic in a patients home**	• Patient could not remember their GP details and address • Call handler provides paramedic with patient's details using Spine check.	• Query was resolved by call handler by checking Spine for patients GP details.	• Unsure if 111star*5 is best used as a method to find patient information. • Could have used the LAS clinical hub
Case B4 **111star*5 call from paramedic in a patients home**	• Paramedic wanted to speak to GP. • Patient unwilling to go to A&E. • Patient known to be a frequent caller • Paramedic did not want to wait for GP call back, but also felt they couldn't leave.	• Call handler advised LAS stay with patient, but LAS did not want to wait • Patient would receive a call from a GP in 30 minutes.	• Handover of information could have been better. • LAS understandably are not keen to wait for long periods on scene for call backs for non-life threatening scenarios.

5 Limitations

The major limitations of this study are:

5.1 Limitations of the survey of users of 111star*lines

There were more respondents to the survey from South London compared to North London (134 to 96). The higher response rate in South London is likely to be associated with attending the South London care home forums as well as the HIN having established relationships with the care homes in South London. The 111star*5 response has a bias towards those that access and are active on the LAS Facebook page as this was the only location it was posted.

5.2 Limitations of the 111star*line provider dashboard data

The 111star*line dashboard is still in development and was created in order to identify the outcomes of 111star*line calls. There are some gaps in the data around the transfer time to a clinician and this is currently being investigated. The dashboard data is taken from Adastra feeds dating back to January 2018 however, at the beginning the 111star*line outcome data was limited and it took time for providers to adopt the same method for tagging these calls on their Adastra system. The team currently receive no star*line data from Care UK in relation to outcomes as their method of identifying these types of calls in Adastra does not yet allow distinction between 111star*line calls in the PRM data feeds, hence you cannot organise their data in terms of outcomes for each 111star*line. There are potentially some data quality issues with some providers as there are 39 calls that go beyond 12 hours. It is not clear whether the calls beyond 12 hours are taking a significant time to be called back or if it is a process issue with the call not being closed appropriately.

5.3 Limitations of the end-to-end 111star*line calls review

Given that the team only listened to 14 calls, and there are over 2,000 calls to the 111star*lines every month, this is clearly a small sample size. We are therefore unable to draw representative conclusions from the calls alone, but they give a very valuable insight into the process, and support themes from the survey responses and dashboard data. In addition, the team listened to calls from only two of the four providers; it would be ideal to listen to calls from all four.

5.4 Other limitations

The study is aware that there are additional initiatives that are also providing support to care homes across London. These additional services have not been mapped as this was outside the scope of this review. The team acknowledges that these additional services may have an impact on the 111star*line service for example reducing the volume of calls in certain areas, but we are unable to assess this.

6 Discussion

6.1 Awareness, understanding and access to the 111 star*line services

Awareness of 111star*5 and 111star*6 is high with very few survey responders not being aware of the services. Awareness of 111star*7 is lower, although this was a much smaller sample size and may not be representative. It is however important to take into account that staff who are unaware of the service are less likely to respond, and therefore the survey is likely to overrepresent the proportion of potential users who are aware of the service. There were several comments in the survey feedback suggesting that the service would benefit from more promotion, as not all members of staff seem to be aware of it.

Other survey comments demonstrated that there are users who have a misconception or are unclear about the 111star*line process. Some expect to speak directly to a clinician when they call and are not aware that they will speak to a call handler first. The misconception could stem from the assumption that if a caller is a clinician requiring more senior clinical support, it is unnecessary for a call handler to triage the call. The poster that is shared to promote the 111star*6 service does state that callers will speak to a call handler before being transferred to a clinician, or that when there is a high volume of calls, a GP or senior clinician may not be immediately available.

The 111star*line call reviews demonstrated that, at times, there is a lack of clarity regarding the role of the service. There was a wide range of reasons for calling the 111star*lines service within this small sample, including acutely unwell patients, a need for routine repeat prescriptions and checking the GP address of a patient. There is potentially a need to be more explicit within the communication strategy about which circumstances 111star*lines should be used in, and signposting to other services if these might be more appropriate. Another area that has been raised as a concern is how to practically call through to the 111star*line. It is possible that callers have incorrectly entered the details and have accessed the normal 111 service rather than the 111star*line service, and might be providing feedback based on this, as some comments suggest there is no difference between the services.

6.2 Call Volume and Timings

The provider dashboard data showed that there was significant improvement in the volume of calls being received across all of London beginning October 2017 which was sustained until June 2018. Thereafter, the volume of calls is similar to that in period before improvement was noted, despite the winter readiness campaign in August 2018. The same trend is seen across all providers except for LAS in South East London which has remained consistent since February 2017.

The survey data showed that there are large numbers that use the service very infrequently, and a much smaller proportion using the service frequently, up to almost twice a month. There is insufficient evidence to ascertain why use of the service is so low. There are a variety of possible reasons including using other sources for clinical support, a relatively stable patient population who infrequently

need medical attention or a previous negative experience meaning that users avoid using the service again.

The service is mostly used out of hours when GP practices are closed, which is expected and in line with how the service is promoted. This is important information for service planning, and particularly when making decisions regarding staffing levels. It is more challenging and potentially costly to recruit staff to work more unsociable hours, although this is clearly when the service is used most often.

6.3 Call Back Times

The 111star*lines service is promoted with a guaranteed call back time from a GP or senior clinician with 20 minutes,

However, from the survey responses the major concern raised by users of all three 111star*lines, but particularly by rapid response and LAS staff, was the call back time from a clinician. This is in contrast to the dashboard data which show that the majority of calls are answered within 20 minutes.There is however variation by provider so the likelihood of speaking to a GP or senior clinician within 20 minutes depends on where the user is working/calling from.

Across all 111star*lines, there was a drop in the percentage of calls achieving a 20 minute call from August 2018 onwards when the winter readiness campaign started. LAS NE data showed a significant drop in performance for 0 and 20 minute transfers, including a five month period in which there were no calls with a 0 minute transfer time, and as the provider with the most calls, this will have the largest impact on the overall service.

The provider dashboard data also show that there has been a greater reduction in the number of 111star*5 and 111star*7 calls receiving a 20 minute transfer time than 111star*6 calls, which aligns with survey feedback that demonstrates that LAS and rapid response staff are much less satisfied with the call back times. However, the dashboard data show that transfer times for 111star*7 calls was better than for 111star*5, so it is surprising that rapid response staff are as dissatisfied as LAS. It is also possible that their expectations are higher as they work in a fast paced environment which needs quick decision making. Both LAS staff and rapid response teams are required to stay on scene with the patient whilst waiting for a call back. Care home staff on the other hand are able to go about their duties in the meantime. This may well be leading to some of the frustrations that have been reported in the survey.

None of the calls listened to in the end-to-end review were offered 20 minutes as a call back time. This experience is corroborated by the survey responders as they state they are offered a variety of different call back times. Offering a guaranteed call back of 20 minutes which isn't adhered to can lead to unrealistic expectations and a negative first impression of the service.

6.4 Users of 111star*lines

The majority of 111star*5 callers are paramedics, with a smaller proportion of ambulance technicians. A concern has been raised through the survey by technicians who indicated that when they contact the service they are not always able to refer, and are treated differently from paramedics. This is in contrast to one of the agreed operating principles: "All calls for 111star*lines to be treated in exactly the

same way, with no additional questioning regarding the caller's role or professional qualifications". No calls were listened to from a technician in the end-to-end reviews, so it is not possible to verify that this was occurring. Call handlers need to be aware that technicians can refer, otherwise there is a risk they may stop calling the service.

Users of the 111star*lines indicated they had the confidence to manage the calls which is backed up by the calls reviewed; the callers appeared competent and had the necessary information to hand. There were some calls where the callers would provide large amounts of clinical information to the call handler which was uninterrupted, significantly extending the time of the call. Clear guidance on how to hand over information to the call handler and clarification of the call handler roles would speed up the process allowing the caller to speak to a clinician more quickly if needed.

6.5 **Outcomes**

The 111star*line provider dashboard data show that when the call handler follows the standard 111star*line protocol which involves transferring the call to a healthcare professional the outcomes are much better. The likelihood of an ambulance being dispatched is much higher when the caller does not speak to a clinician. There is a chance that some of the ambulances dispatched could have been avoided if the correct procedure had been followed.

The 111star*line provider dashboard is potentially a highly valuable source of information, and could significantly help to further shape and improve the service. However, there are examples of areas where it is difficult to accurately interpret the data and draw meaningful conclusions. For example, there are several calls from LAS to 111star*5 where the recorded outcome is either 'ambulance dispatch' or 'Attend A&E or Urgent Care Centre (UCC)', which presumably both mean that the LAS caller conveyed the patient to A&E or UCC; separating these two outcomes could be interpreted differently.

Another way in which the dashboard could be useful is to understand the common reasons for calling. For example, if such data indicated that a large proportion of calls are related to catheter care, to end of life care or to pharmacy and medication queries, services could be planned accordingly.

There were positive statements from 111star*5 and 111star*7 responders stating how good the service is and how the advice has helped to avoid taking a patient to hospital. However, in some cases users perceive that the service still leads to patients being conveyed to A&E. This is due to a delay in receiving a call back or the 111star*line clinician advising an ambulance when the caller felt that other options could be more suitable.

As the number of 111star*line calls reviewed was low, it is not possible to draw conclusions on outcomes related to these calls. An ambulance was dispatched in three out of the nine case studies, but it was out of the scope of this work to follow the full patient journey and to identify whether it was an appropriate conveyance.

6.6 **Response of 111 staff to calls**

The end-to-end call reviews revealed that the call handler section of the call was often very long; one call took nine minutes before a call back by a clinician was offered. In some calls, extensive clinical details were taken, and one call handler spent some time recording observations despite some uncertainty over whether they knew what they were recording. Whilst this is of course necessary for clinicians to know, this may not a helpful use of time, particularly since the clinician often asks for the same details when they speak to the caller. Whilst some repetition of questioning is necessary, this can understandably also be frustrating for the caller. The nature of the handover within providers is not known, but may be worth reviewing, as well as ensuring that call handlers only collect basic information required to make a decision on the outcome.

None of the call handlers clearly stated their purpose which is primarily to take information and then decide on an outcome. For one provider, the call handler states "You are through to integrated and urgent care", which leaves it unclear to whom a caller is speaking. From the calls listened to, at times it felt as though the caller was surprised to hear that they would get a call back, and the presumption must be that they thought they were already speaking to a clinician given the number of questions that had been answered. User satisfaction with the service may increase if it is made clearer that the call handler is there to take brief questions and then refer to a clinician.

From the small number of calls reviewed, it is not possible to know how often additional information was used to help with decision making, such as primary care records or CMC. It was noted in one call that the GP did not access the patient's CMC record and an ambulance was dispatched. Reviewing the record would have helped with decision making and significantly improved patient care as the person was noted to be for end of life care. Best practice would be that CMC should be reviewed and that clinicians are aware of the service and are familiar with its use.

Very few of the call handlers and clinicians answering the calls provided their name and would often only provide their job role. Dr Kate Granger's campaign #hellomynameis showed the importance of this and how it can help to build trust and rapport[3]. Incorporating their name into the introduction is a simple change that could improve the caller experience.

A theme which emerged from the survey, particularly from LAS staff was that the call handlers did not always communicate with them as if they were experienced healthcare professionals. There are processes and questions that call handlers are required to follow to maintain patient safety; however, rewording the script when they are speaking to a clinician might minimise this experience. Some providers call handlers are not receiving "whispers" that identify the call as a 111star*line; if this was in place, the call handler might feel better equipped to tailor the call to a clinician.

Callers have high expectations of the service, with several of the survey respondents and callers that were listened to during the reviews, clearly expecting a GP to visit the patient. There is a limited resource of OOH GPs, and as such it is not always feasible for them to attend every patient about whom there has been a call. Additional support and guidance for callers about when to call the 111star*line service and what to expect may help to further manage expectations.

7 Recommendations

#	Recommendation deliverable	Target Milestone	Parties (Bold = Suggested Lead)
1	Consideration of whether the current service design fully meets the specific requirements of LAS crews, care home staff and rapid response services, and whether these are diverse enough to warrant different approaches.	December 2019	• **HLP;** • NHS X; • IUC commissioners; • IUC providers; • User groups (LAS crews, care home staff, rapid response teams).
2	Align service provision with the demand on the service i.e. more call handlers and clinicians available during winter readiness peak and during particular times of the week.	Plan by November 2019 Implement by January 2020	• **IUC commissioners;** • IUC providers.
3	Development of a single SOP for all IUC providers with a set of improvement KPIs that should include: **3.1** Performance against agreed call back times. **3.2** % call handlers, senior clinicians, GPs and other relevant IUC staff trained in and using CMC, and other relevant clinical assessment tools. **3.3** % flagged CMC records accessed and viewed. **3.4** Delivery of action plan in response to regular local end-to-end call reviews. **3.5** % 111*line calls that include a "whisper" at the beginning of the call to identify if it is coming from a 111star*line.	Agree ownership of action – IUC CGG July 2019 Delivery: October 2019	• **HLP;** • IUC commissioners; • STP IUC clinical leads; • IUC providers; • NHSE/I End of Life Care Clinical Network.
4	Promotion of agreed KPIs with all key stakeholders.	September 2019	• **IUC clinical governance group;** • **IUC commissioners;** • UEC TD Board.
5	Development and delivery of training and guidance for % call handlers, senior clinicians, GPs and other relevant IUC staff, that includes the following: **5.1** Use of #hellomynameis – introduction of their name and role to caller, to form part of the call audit process.	November 2019	Delivery: • **HLP;** • **STP IUC clinical leads;** • IUC providers; • IUC commissioners. Delivery:

	5.2 Clarification of data to be collected by call handler; this should be minimised and streamlined depending on caller, eg call-handler script to ensure consistent script is used for all callers. **5.3** Use of CMC and other sources of information to support the delivery of high quality clinical care.		• **IUC providers.**
6	Convene and facilitate a task and finish group to develop guidance for LAS, care home, or rapid response staff, on use of the lines that includes the following: **6.1** Appropriate and inappropriate use of the 111star* lines (a flow-chart to support decision making). Guidance should offer expected timeframes for call back for differing clinical situations (see recommendation 6). **6.2** How to access the 111star*line services. **6.3** Clarification of the call process. (a flow-chart to outline what happens when calling the service), i.e. first speaking to a call handler before being transferred to a GP or clinician etc. **6.4** Guidance on how to hand over information. For example, the CARES framework for care home staff, or the SBAR communication tool. These are easy to use, structured tools that enable information to be communicated accurately between individuals. This should involve the caller clearly articulating the outcome they are aiming for.	Task & Finish Group initiation: September 2019 Guidance reviewed and approved, ready for dissemination: November 2019	• **HLP;** • LAS leads; • Rapid response team leads; • Enhanced Health in Care Homes Network lead; • IUC CAS clinicians; • STP IUC clinical leads; • Care home networks/ forums.
7	Initiation of regular standardised audit of listening to 111 star*line calls with learning and actions plans presented at each HLP IUC clinical governance meeting and shared across IUC providers.	September 2019 (first review)	• **IUC Clinical Governance Group;** • HLP; • IUC providers.
8	Oversight, collation, review and monitoring of an action plan to address missing ADASTRA and PRM data on call volumes, transfer times and outcome coding to increase the accuracy of end-to-end outcome reporting.	December 2019	• **IUC commissioners;** • IUC providers; • HLP.
9	Development and delivery of a single brand and communication strategy for LAS crews, care home staff and rapid response nursing teams, to increase awareness of the 111star*line services, to be adopted by IUC commissioners and IUC providers.	Development: November 2019 Delivery: December 2019	• Development: • **HLP;** • IUC providers; • IUC commissioners. Delivery:

			• **IUC commissioners;** • HLP; • NHS E/I Comms team; • Care Home network; • ADASS; • LAS; • CQC; • IUC Providers; • Care Pulse.

8 References

[1] Sutton, E. (no date) *Responding to urgent needs at home - 111 star*Line and AHP/Paramedic collaboration*

[2] NHS Improvement. (2018) *Statistical process control tool*. Available at: https://improvement.nhs.uk/resources/statistical-process-control-tool/

[3] Granger, K. (no date) *Key Values.* Available at: https://www.hellomynameis.org.uk/key-values/

9 Appendix

9.1 Appendix 1 – Breakdown of providers coverage by borough

Provider Name	Areas covered
LAS (London Ambulance Service)	South East London • Bexley • Bromley • Greenwich • Lambeth • Lewisham • Southwark
LAS NE (North East London 111)	North East London: • Barking & Dagenham • City & Hackney • Havering • Newham • Redbridge • Tower Hamlets • Waltham Forest
LCW (London Central & West Unscheduled Care Collaborative)	North Central London: • Barnet • Camden • Enfield • Islington • Haringey North West London • West London • Central London • Hammersmith & Fulham
Vocare	South West London: • Croydon • Kingston • Merton • Richmond • Sutton • Wandsworth
Care UK	North West London: • Brent • Ealing • Harrow • Hillingdon • Hounslow

9.2 Appendix 2 – Communication strategy

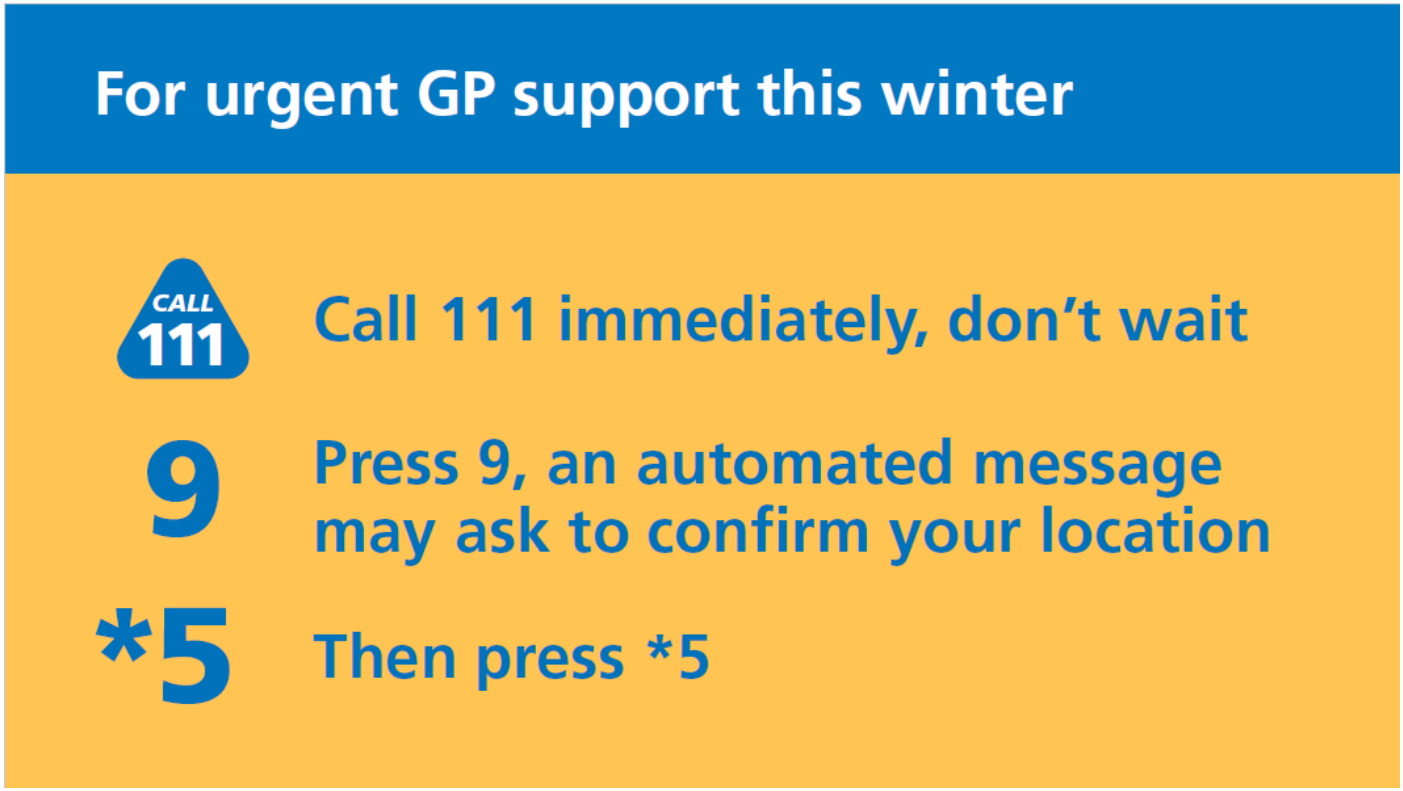
9.2.1 Star*5 LAS staff telephone line poster

Dial 111. Press 9 to continue. An automated message may ask you to confirm your location.
When you hear the message "This call is recorded for quality purposes", press * wait for the beep, then press 5.
You will be connected to a Call Handler at the local NHS 111 service who will transfer you to a GP or arrange for a 20 minute GP call back. To feedback on this service contact england.nhs111submissions@nhs.net.

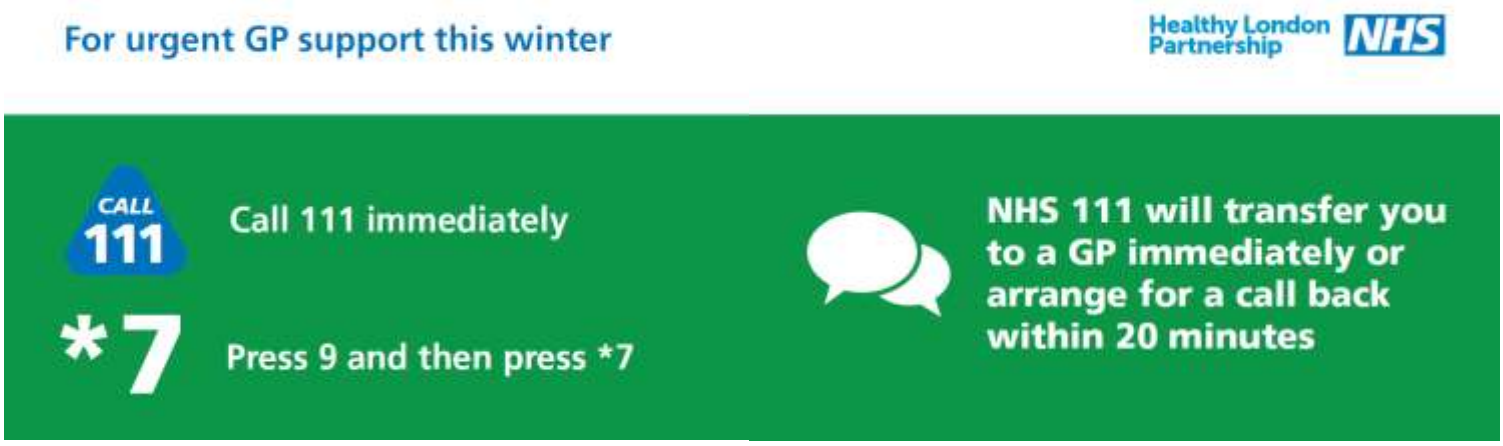
9.2.2 Star*6 care home staff telephone line poster

Dial 111. Press 9 to continue. An automated message may ask you to confirm your location.
When you hear the message "This call is recorded for quality purposes", press * wait for the beep, then press 6.
You will be connected to a Call Handler at the local NHS 111 service who will transfer you to a GP or arrange for a 20 minute GP call back. To feedback on this service contact england.nhs111submissions@nhs.net.

9.2.3 Star*5 removable stickers



9.2.4 Star*7 business cards



9.2.5 Star*6 poster

9.3 Appendix 3 – Survey questions for each 111star*line

Qn. #	111*5	111*6	111*7
About You	What is your job role?	What is your job role?	What is your job role?
	What is your organisation type?	What is your organisation type?	What is your organisation type?
	Which STP/Sector are you part of?	Which borough is your care home located in?	Where are you located?
1.	I am aware of the NHS 111*5 service	I am aware of the NHS 111*6 service	I am aware of the NHS 111*7 service
2.	I have called 111*7 in the last 12 months	I have called 111*7 in the last 12 months	I have called 111*7 in the last 12 months
3.	How many times have you called 111*5 in the last 12 months?	How many times have you called 111*6 in the last 12 months?	How many times have you called 111*7 in the last 12 months?
4.	When do you mostly use 111*5?	When do you mostly use 111*6?	When do you mostly use 111*7?
Extra	How do you call 111*5?	N/A	N/A
Extra	Please tell us why you call using the device(s) chosen above?	N/A	N/A
5.	Based on your general experience of using 111*5, please select how much you agree with the following statements:	Based on your general experience of using 111*6, please select how much you agree with the following statements:	Based on your general experience of using 111*7, please select how much you agree with the following statements:
5.1.	My initial call was answered quickly	My initial call was answered quickly	My initial call was answered quickly
5.2.	I am able to answer the questions asked by the call handler	I am able to answer the questions asked by the call handler	I am able to answer the questions asked by the call handler
5.3.	I always speak to a GP within 20 minutes	I always speak to a clinical adviser within 20 minutes	I always speak to a clinical adviser within 20 minutes
5.4.	I feel confident I can answer the questions asked by the GP	I feel confident I can answer the questions asked by the clinical adviser	I feel confident I can answer the questions asked by the clinical adviser
5.5.	The GP provides helpful advice	The clinical adviser provides helpful advice	The clinical adviser provides helpful advice
5.6.	I feel confident to follow the advice I am given	I feel confident to follow the advice I am given	I feel confident to follow the advice I am given
5.7.	I feel the right amount of time is given to my call	I feel the right amount of time is given to my call	I feel the right amount of time is given to my call
5.8.	I am confident in the service provided by the *5 line and don't need to seek advice from anywhere else	I am confident in the service provided by the *6 line and don't need to seek advice from anywhere else	I am confident in the service provided by the *7 line and don't need to seek advice from anywhere else
5.9	The *5 line supports me to not send patients to hospital	The *6 line supports me to not send patients to hospital	The *7 line supports me to not send patients to hospital
5.10	Overall, how would you rate the 111*5 service:	Overall, how would you rate the 111*6 service:	Overall, how would you rate the 111*7 service:
6.	Would you call NHS 111*5 again?	Would you call NHS 111*6 again?	Would you call NHS 111*7 again?
7.	Please tell us any more about your experience of 111*5	Please tell us any more about your experience of 111*6	Please tell us any more about your experience of 111*7

9.4 Appendix 4 – Membership of Project steering group and project team

NHS England and Improvement (London region) EOLC in Care homes steering group:

Name	Role
Caroline Stirling (Chair)	NHS England and Improvement (London region) EOLC Clinical Network Clinical Director
Clare O'Sullivan	GP, Sutton
Rebecca Jarvis	Programme Director, Healthy Ageing, Health Innovation Network
Briony Sloper	Senior Improvement Advisor, Urgent and Emergency Care Programme, Health London Partnership
Jane Sproat	Enhanced Health in Care Homes Improvement Manager, Urgent and Emergency Care Accelerated Improvement Team, Healthy London Partnership
Henry Ireland	Innovation Delivery Manager, Imperial College Health Partners
Laura Cook	Programme Lead Dementia and EOLC Clinical Networks, NHS England and Improvement (London region)
Matthew Salt	Project Manager, EOLC programme, UCLPartners

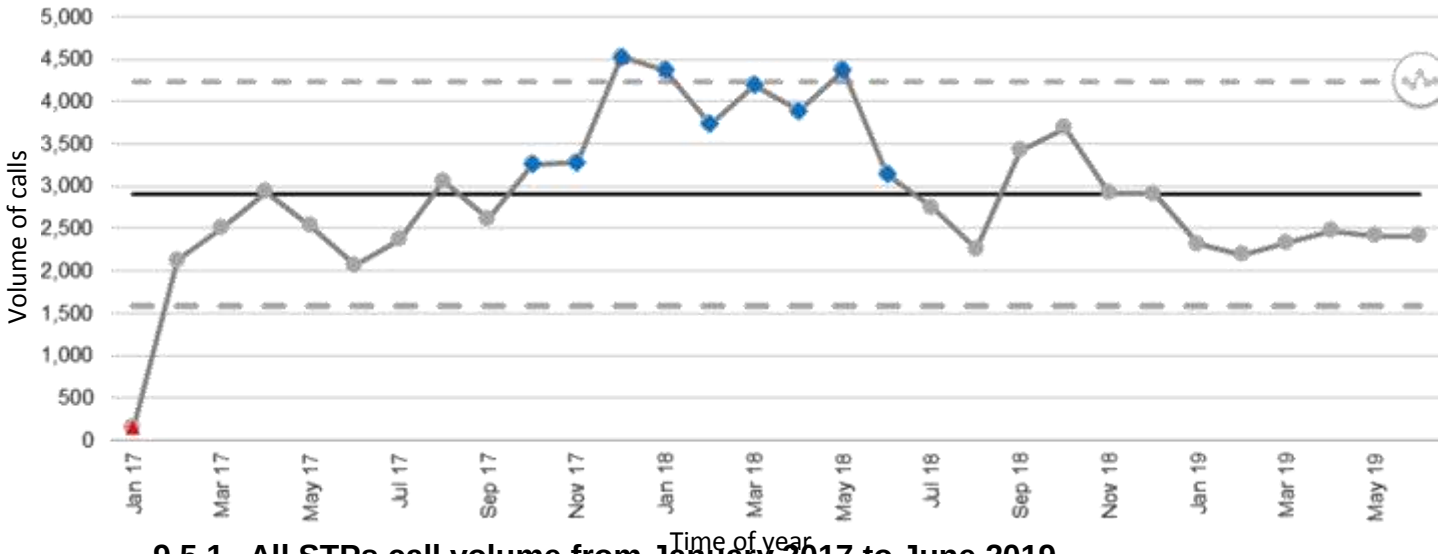
Project Team:

Lucy Quinn	Senior Clinical Project Manager, NHS England and Improvement (London region) EOLC Clinical Network
Josh Brewster	Project Manager, Healthy Ageing and Mental Health, Health Innovation Network
Dr Charlotte Bryan	Clinical Lead for the project, Health Innovation Network
Charlene Chigumira	Project Manager, Healthy Ageing and Patient Safety, Health Innovation Network
Lydia Davies	Project Support Officer, Health Innovation Network Health Innovation Network

HLP team:

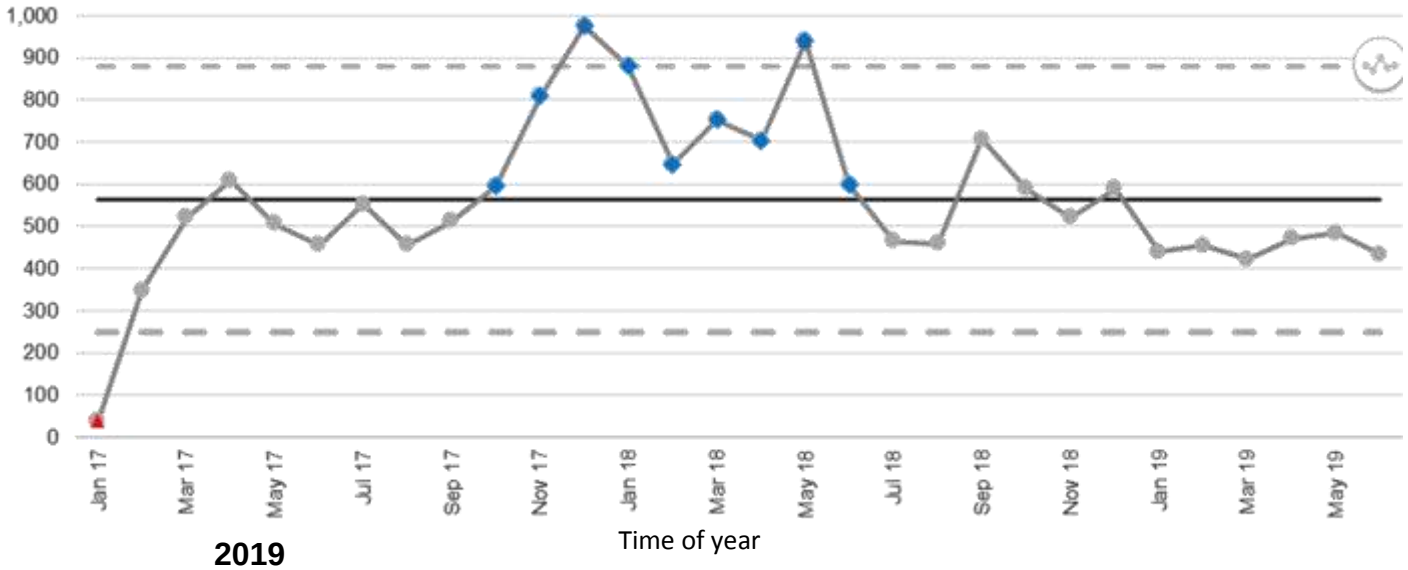
Dan Heller	Dan Heller, Programme Manager Urgent and Emergency Care, Healthy London Partnership
Touqir Ahmed	, HLP
Alice Green	Improvement Support Manager, Urgent and Emergency Care, Healthy London Partnership
Greg Hudson	***, HLP
Eileen Sutton	***, HLP
Cerrie Baines	Improvement Support Manager Enhanced Health in Care Homes Programme – Accelerated Improvement Support Team, Healthy London Partnership

9.5 Appendix 5 - SPC chart of call volume for each STP

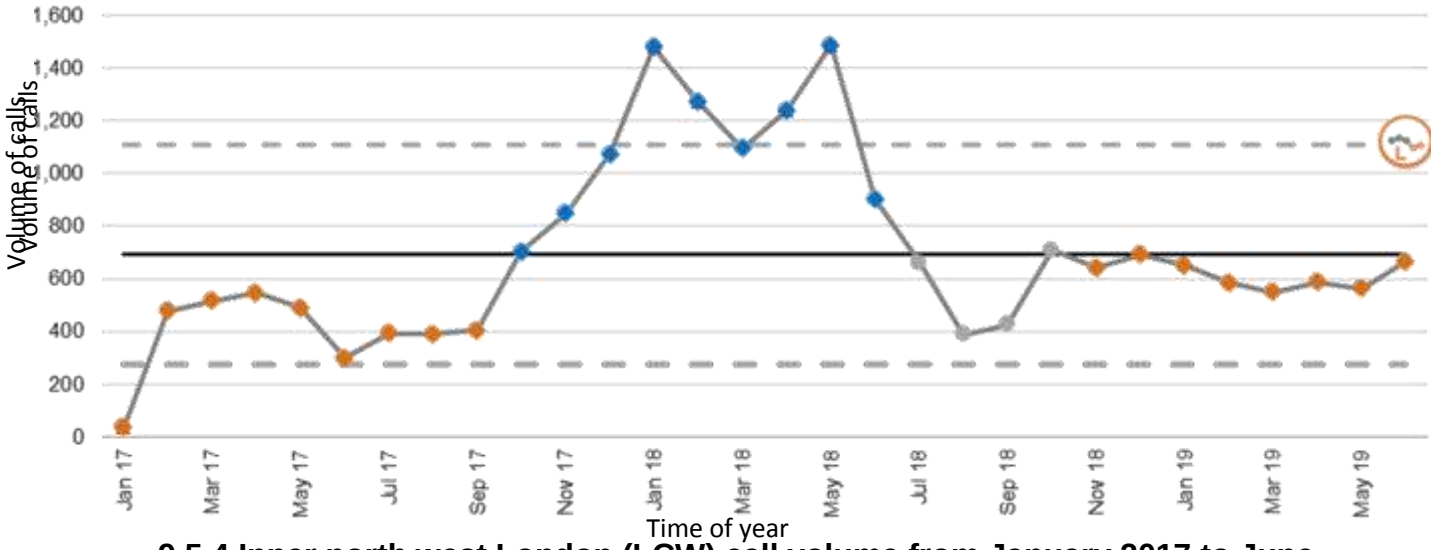


9.5.1 All STPs call volume from January 2017 to June 2019

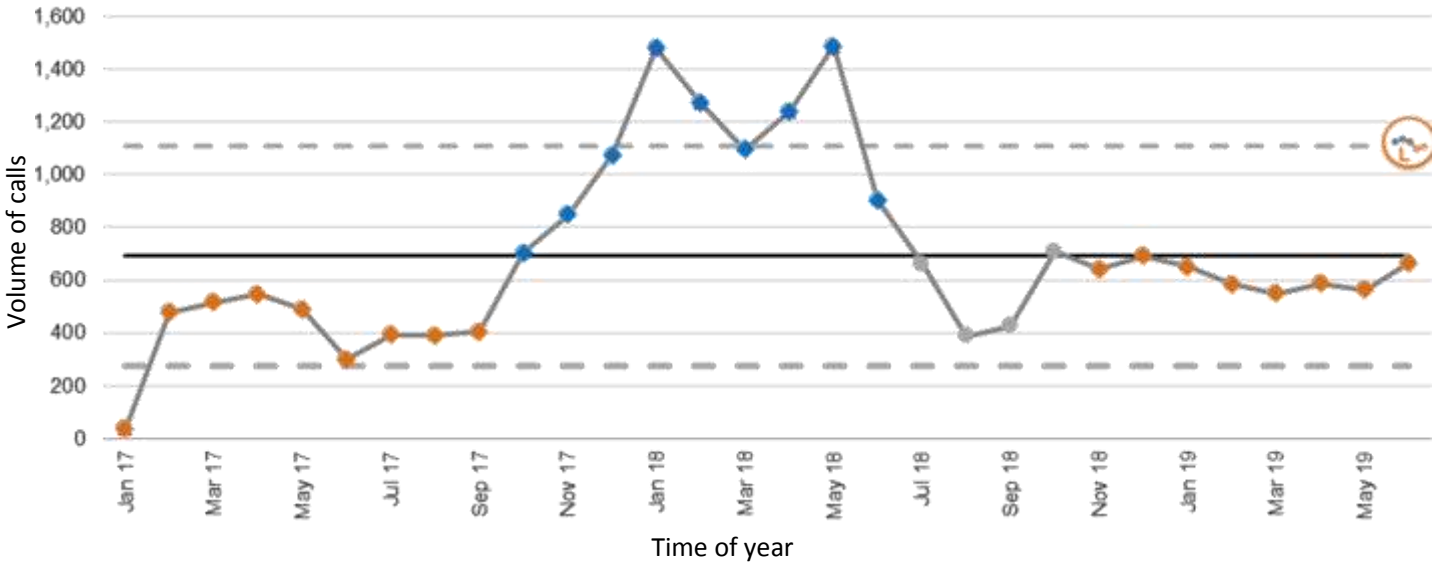
9.5.2 North central London (LCW) call volume from January 2017 to June 2019



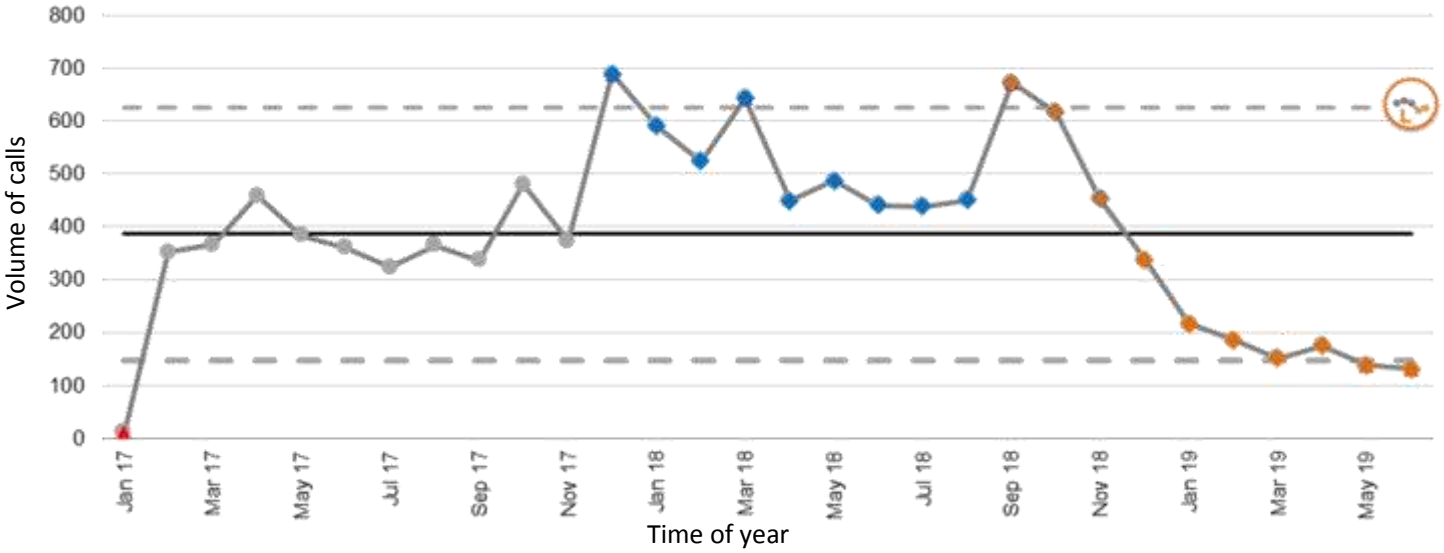
9.5.3 North east London (LAS) call volume from January 2017 to June 2019

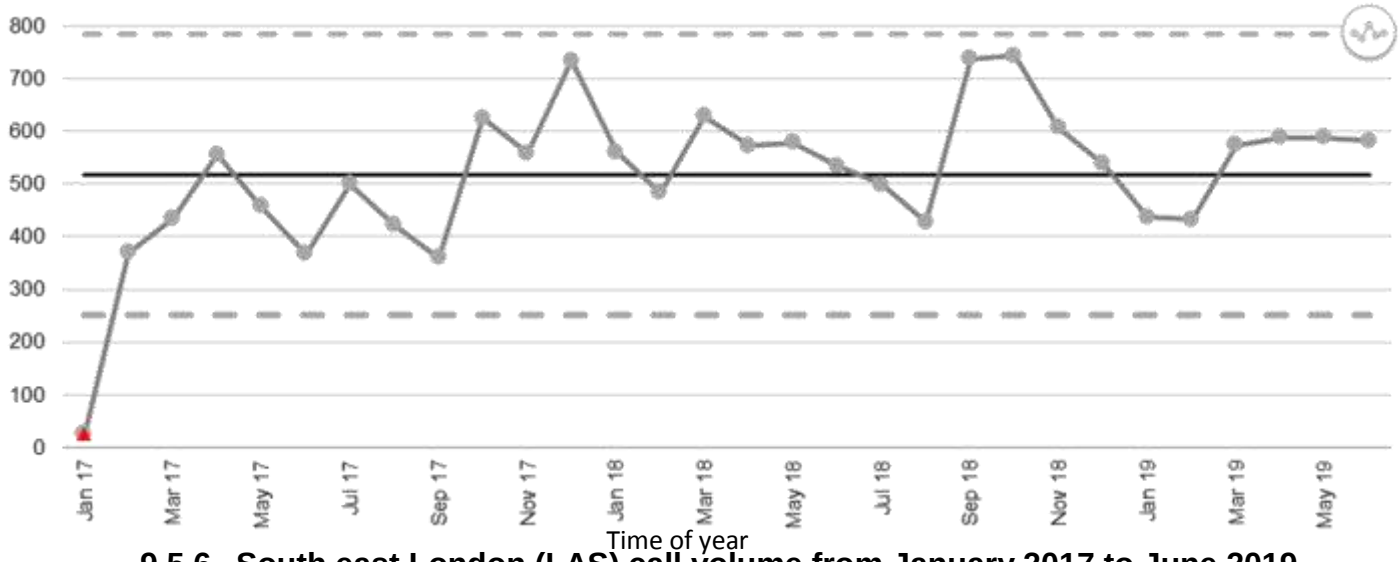


9.5.4 Inner north west London (LCW) call volume from January 2017 to June 2019



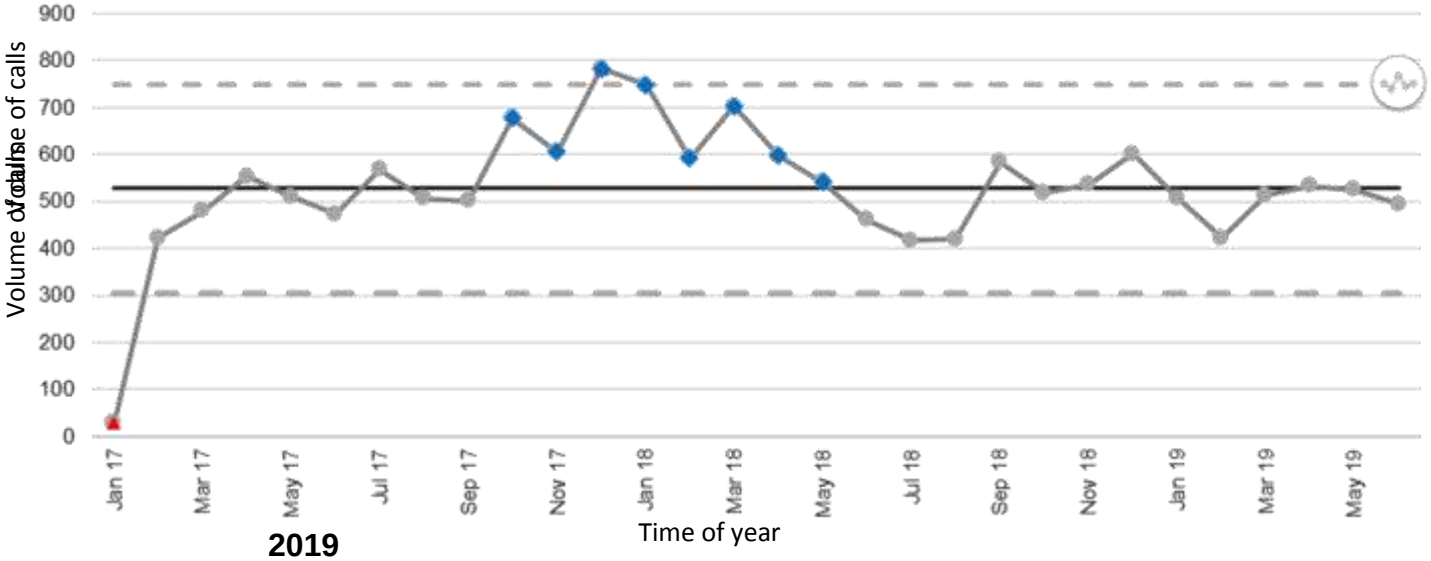
9.5.5 Outer north west London (CareUK) call volume from January 2017 to June 2019





9.5.6 South east London (LAS) call volume from January 2017 to June 2019

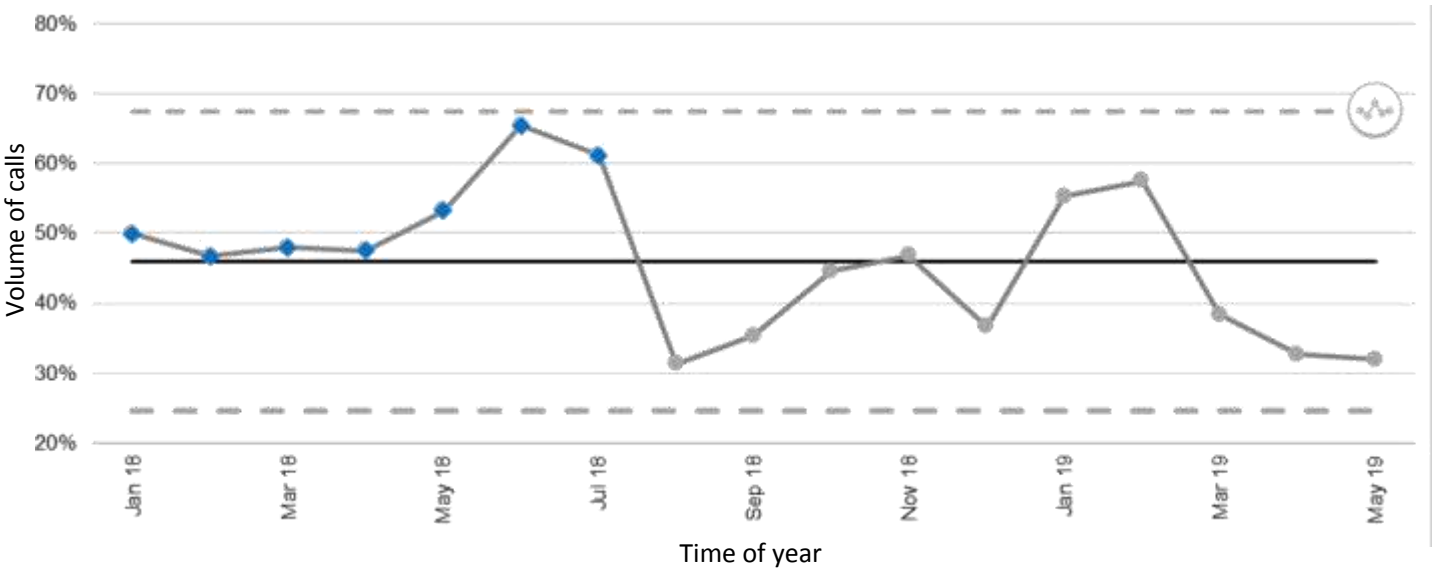
9.5.7 South west London (Vocare) call volume from January 2018 to May



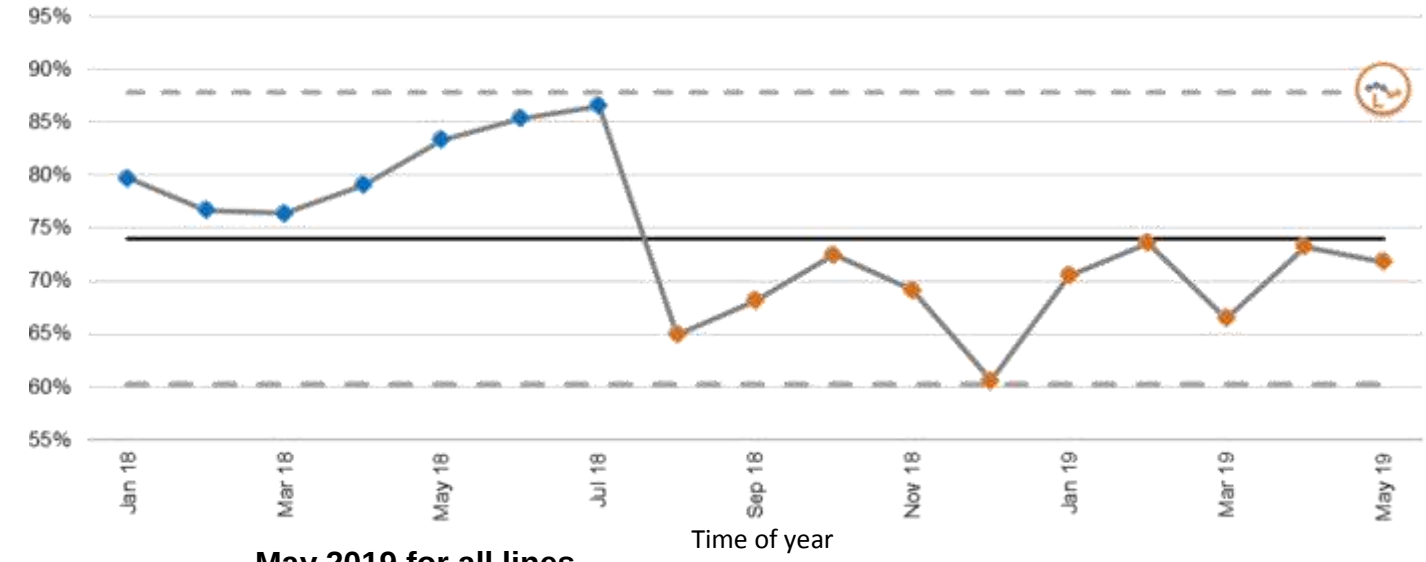
2019

9.6 Appendix 6 - Detailed breakdown of transfer times by month and SPC charts for each 111star*line and provider

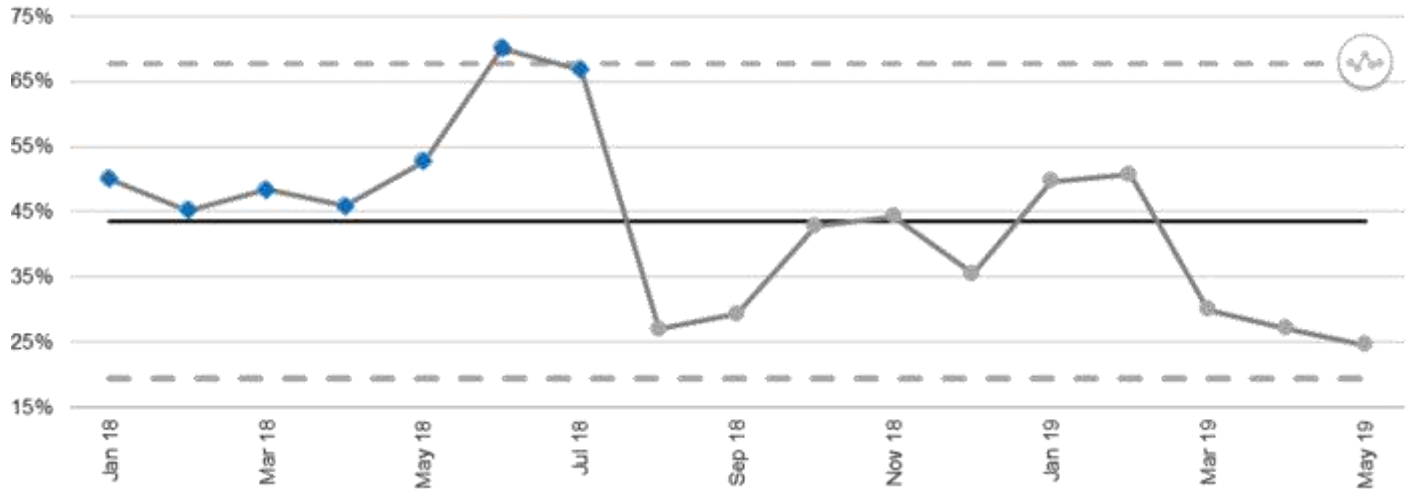
9.6.1 Percentage of calls transferred within 0 minutes from January 2018 to May 2019 for all lines



9.6.2 Percentage of calls transferred within 20 minutes from January 2018 to May 2019 for all lines



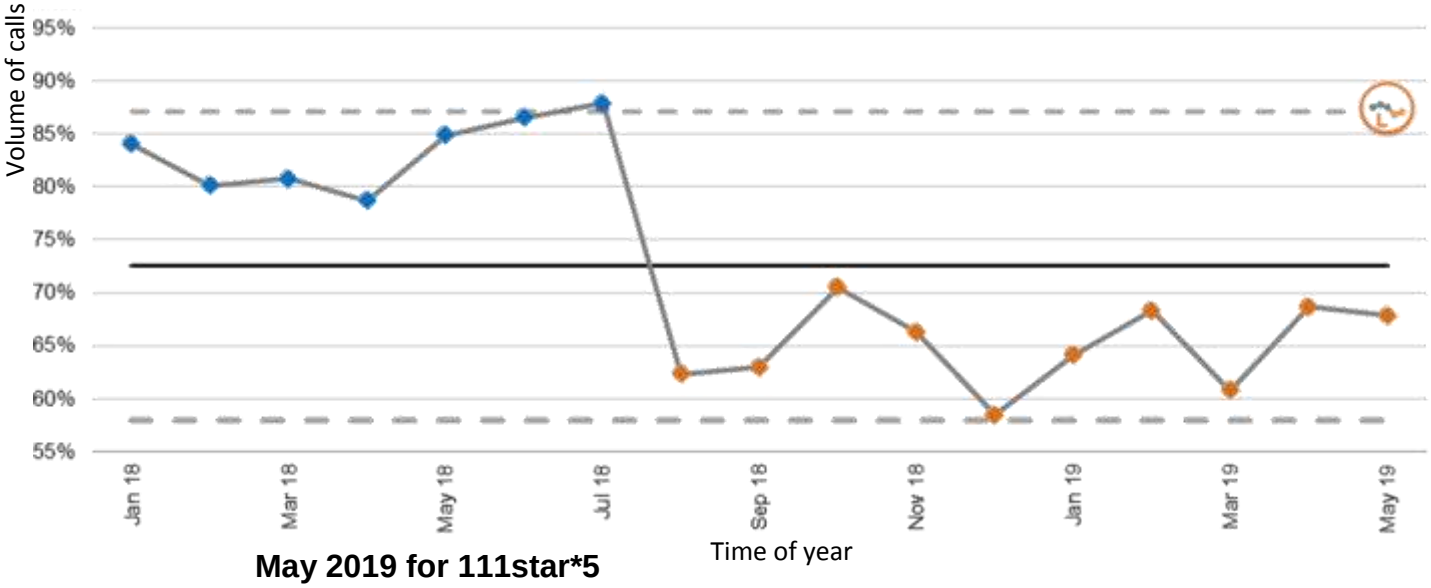
9.6.3 Percentage of calls transferred within 0 minutes from January 2018 to



Time of year

May 2019 for 111star*5

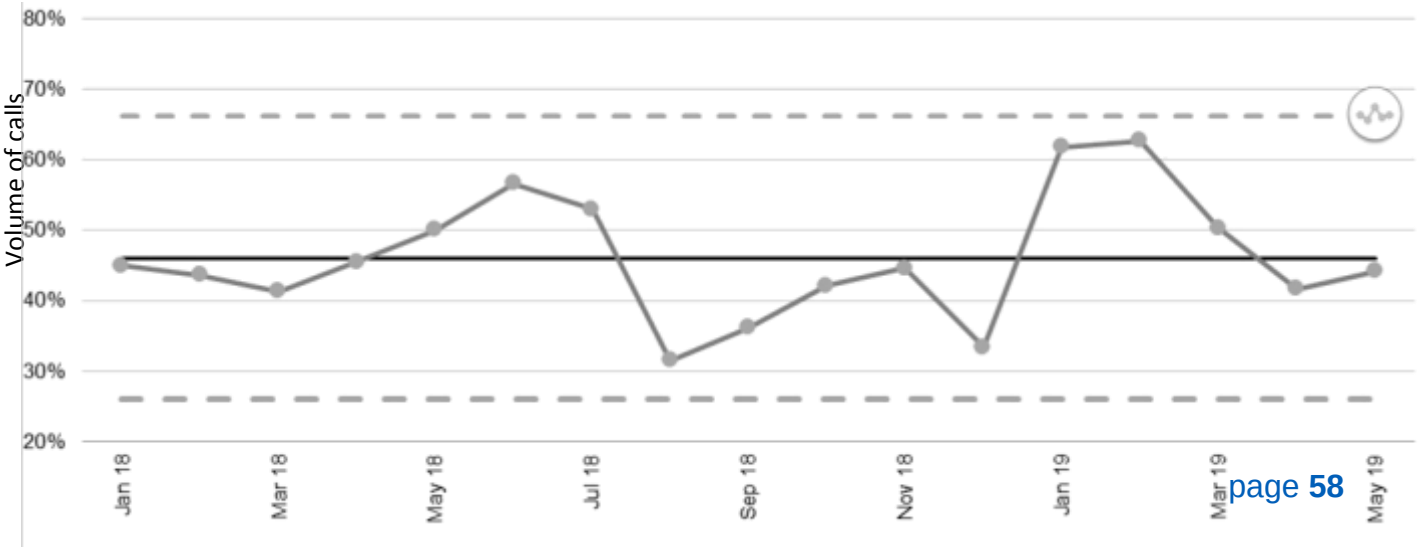
9.6.4 Percentage of calls transferred within 20 minutes from January 2018 to



Time of year

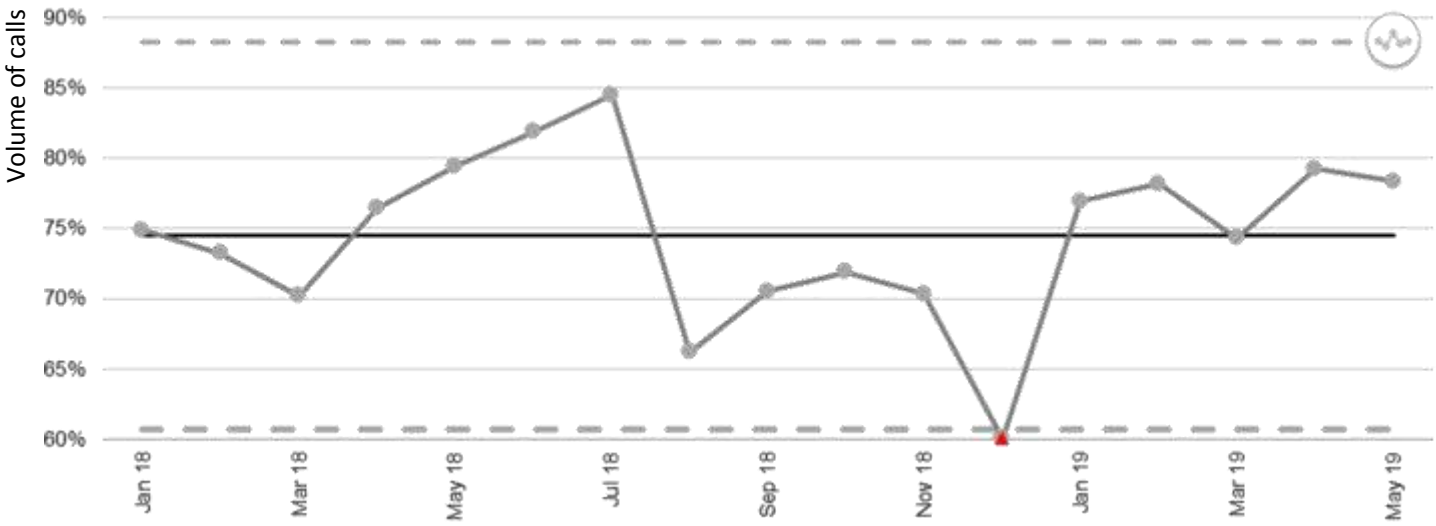
May 2019 for 111star*5

Percentage of calls transferred within 0 minutes from January 2018 to May 2019 for



111star*6

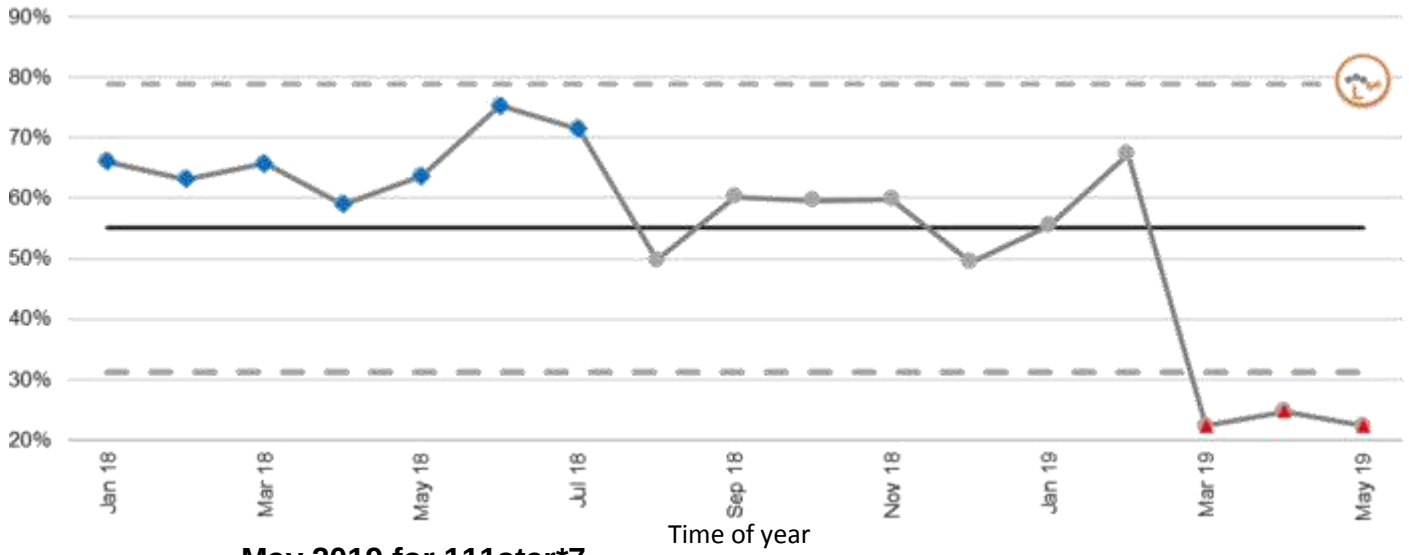
9.6.5 Percentage of calls transferred within 20 minutes from January 2018 to



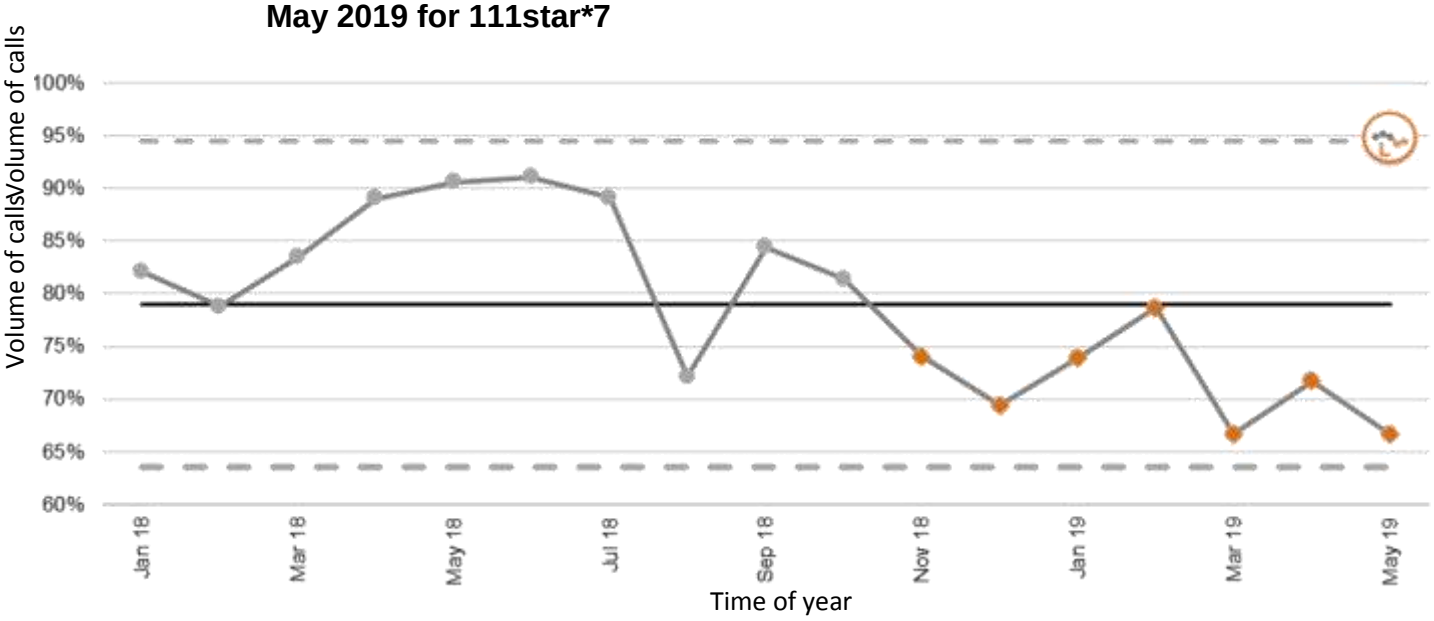
May 2019 for 111star*6 Time of year

Volume of calls

9.6.6 Percentage of calls transferred within 0 minutes from January 2018 to May 2019 for 111star*7



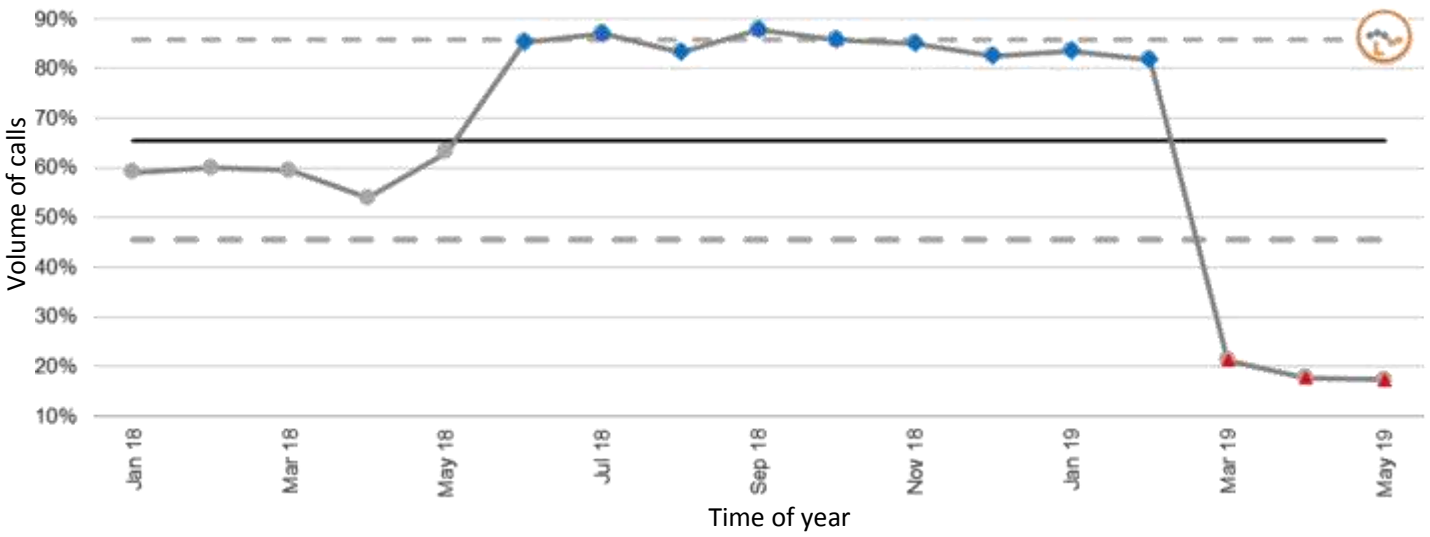
9.6.7 Percentage of calls transferred within 20 minutes from January 2018 to May 2019 for 111star*7



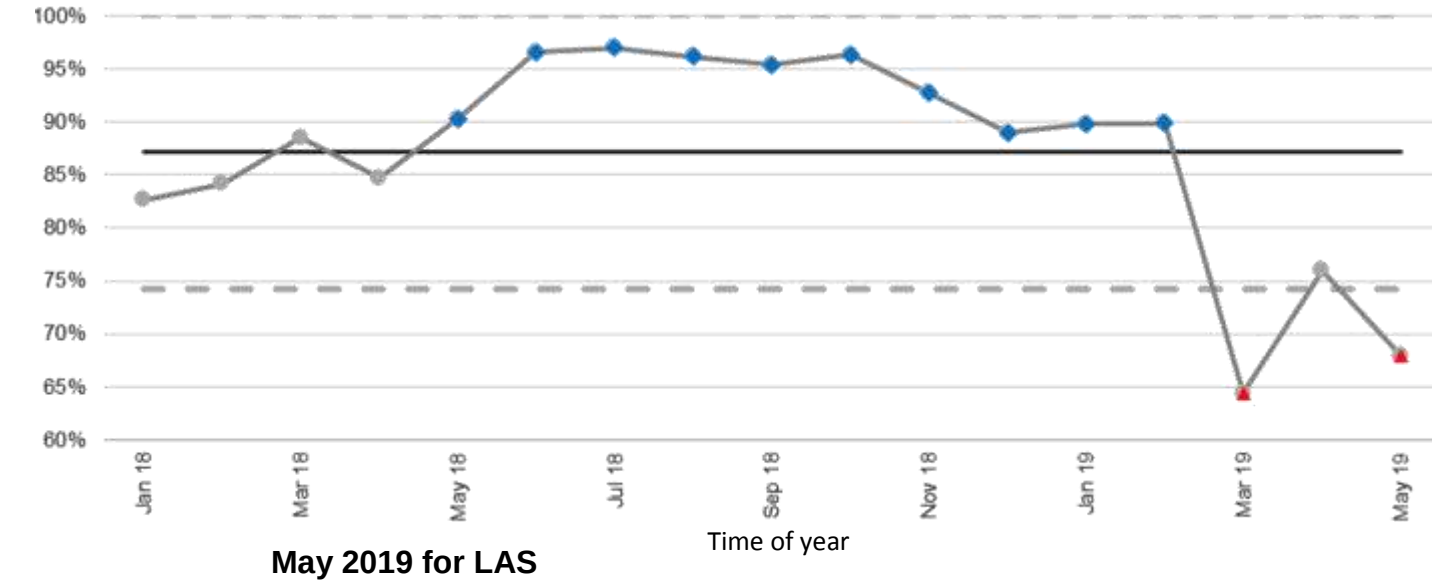
9.6.8 The percentage of calls transferred within 0 and 20 minutes by provider

		2018												2019				
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
LAS	0	59%	60%	60%	54%	63%	85%	87%	83%	88%	86%	85%	83%	84%	82%	21%	18%	17%
	20	83%	84%	89%	85%	90%	97%	97%	96%	95%	96%	93%	89%	90%	90%	64%	76%	68%
LAS NE	0	44%	40%	27%	45%	48%	52%	48%	0%	0%	0%	0%	0%	21%	26%	27%	24%	22%
	20	79%	73%	52%	76%	77%	77%	82%	43%	49%	45%	34%	34%	44%	50%	52%	62%	65%
LCW	0	0%	10%	5%	13%	21%	27%	21%	21%	19%	29%	4%	5%	96%	92%	91%	94%	91%
	20	53%	55%	63%	73%	79%	65%	64%	67%	61%	63%	61%	70%	99%	98%	96%	98%	96%
Vocare	0	59%	52%	55%	48%	51%	53%	49%	46%	57%	58%	59%	51%	70%	72%	71%	97%	51%
	20	81%	78%	76%	73%	86%	81%	82%	85%	86%	85%	85%	76%	88%	90%	90%	100%	86%

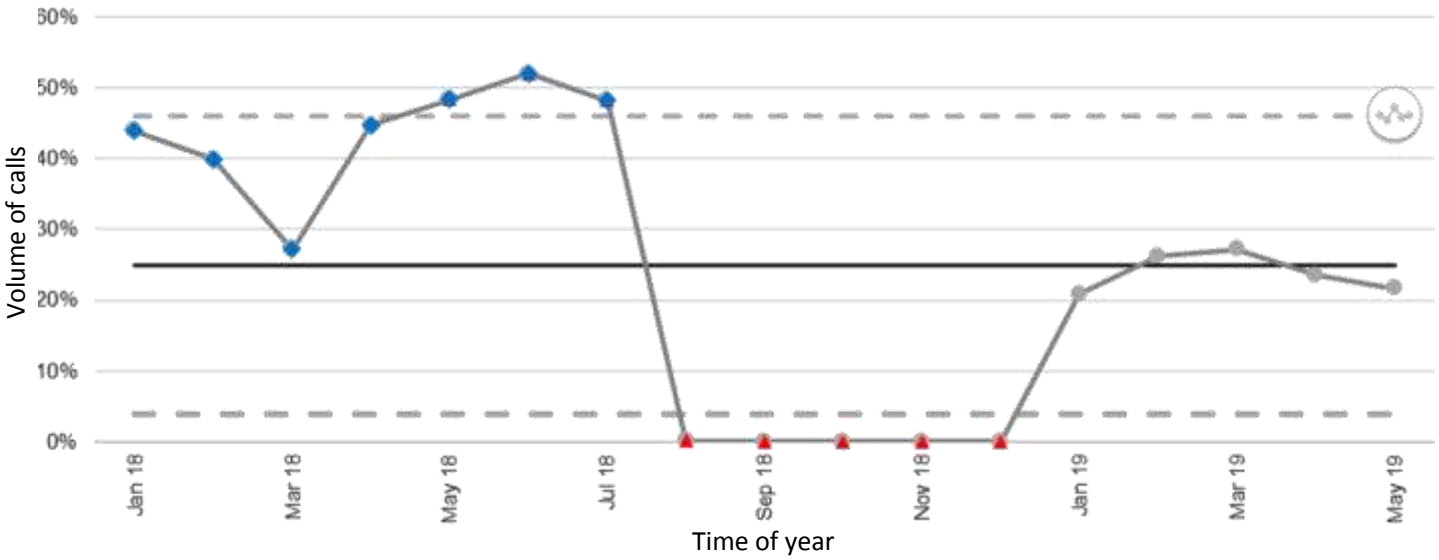
9.6.9 Percentage of calls transferred within 0 minutes from January 2018 to May 2019 for LAS



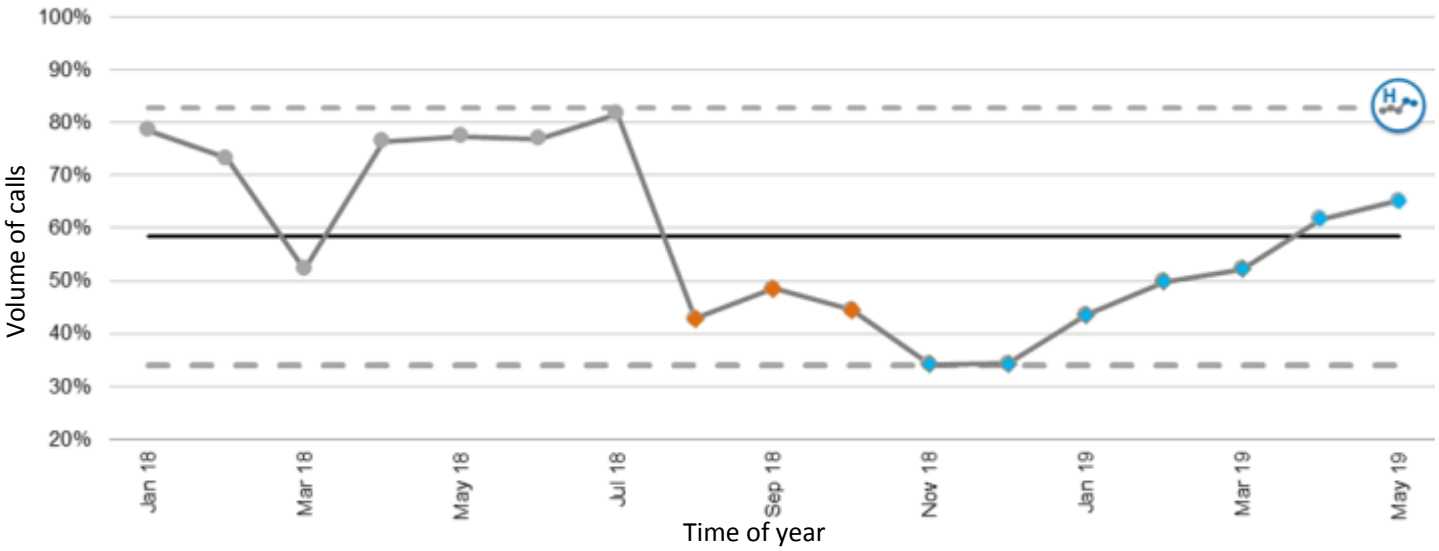
9.6.10 Percentage of calls transferred within 20 minutes from January 2018 to May 2019 for LAS



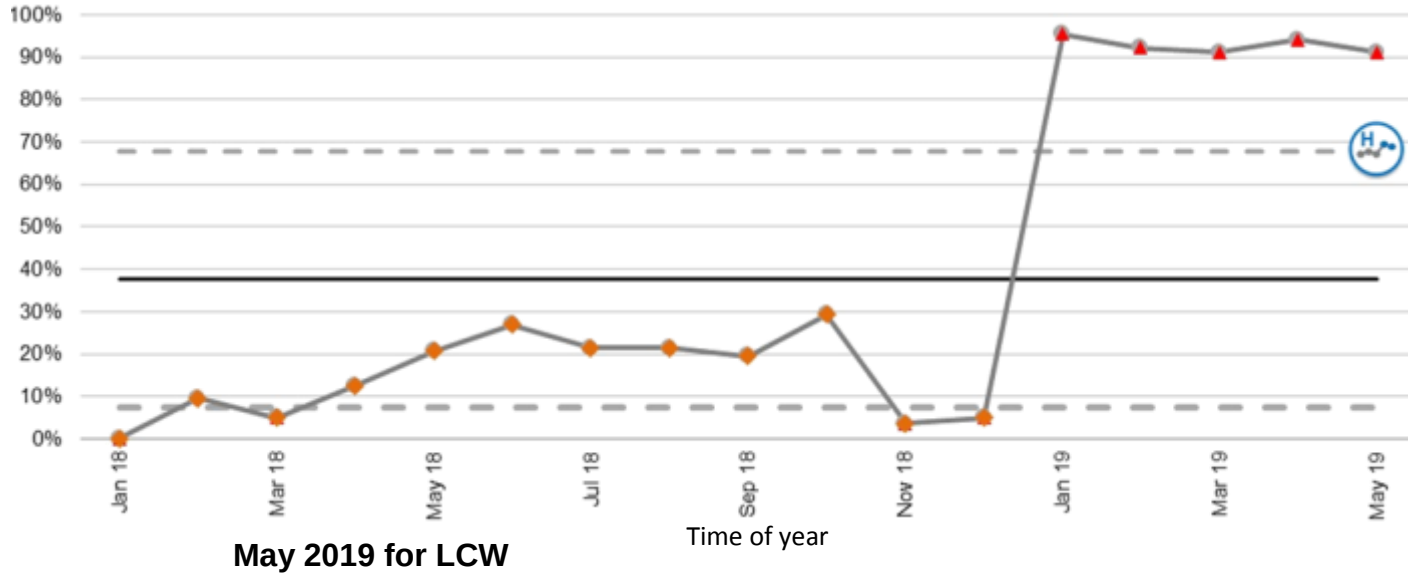
9.6.11 Percentage of calls transferred within 0 minutes from January 2018 to May 2019 for LAS NE



9.6.12 Percentage of calls transferred within 20 minutes from January 2018 to May 2019 for LAS NE

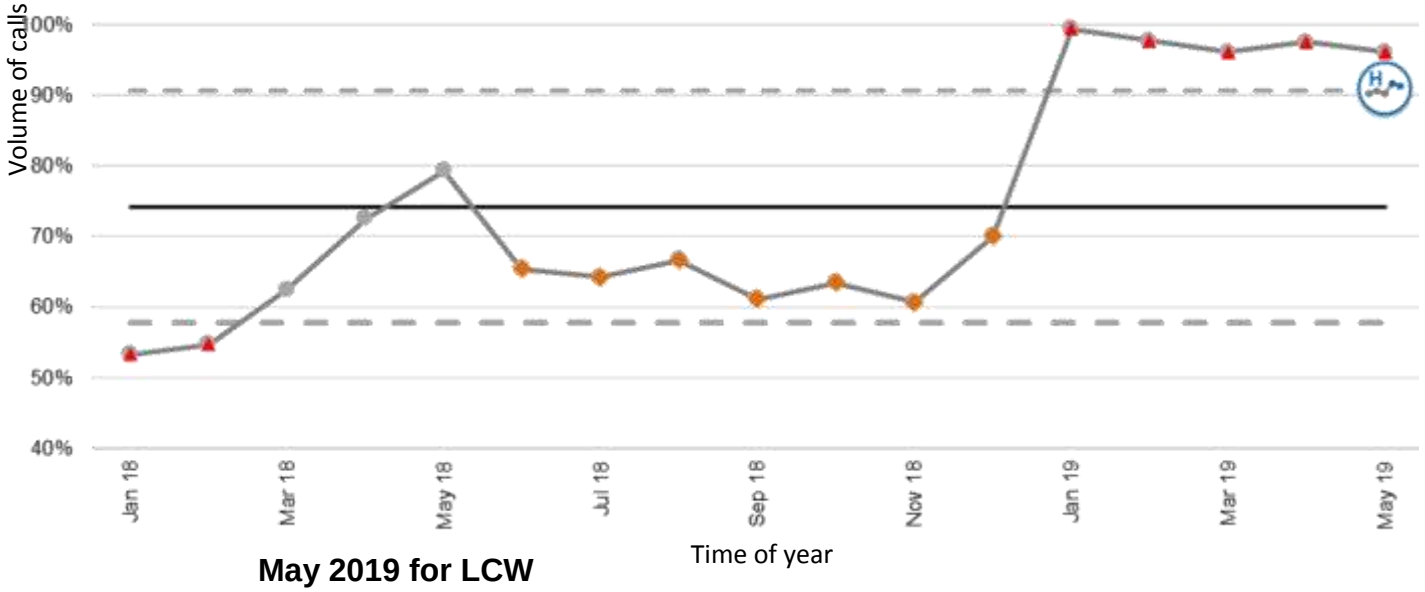


9.6.13 Percentage of calls transferred within 0 minutes from January 2018 to



May 2019 for LCW

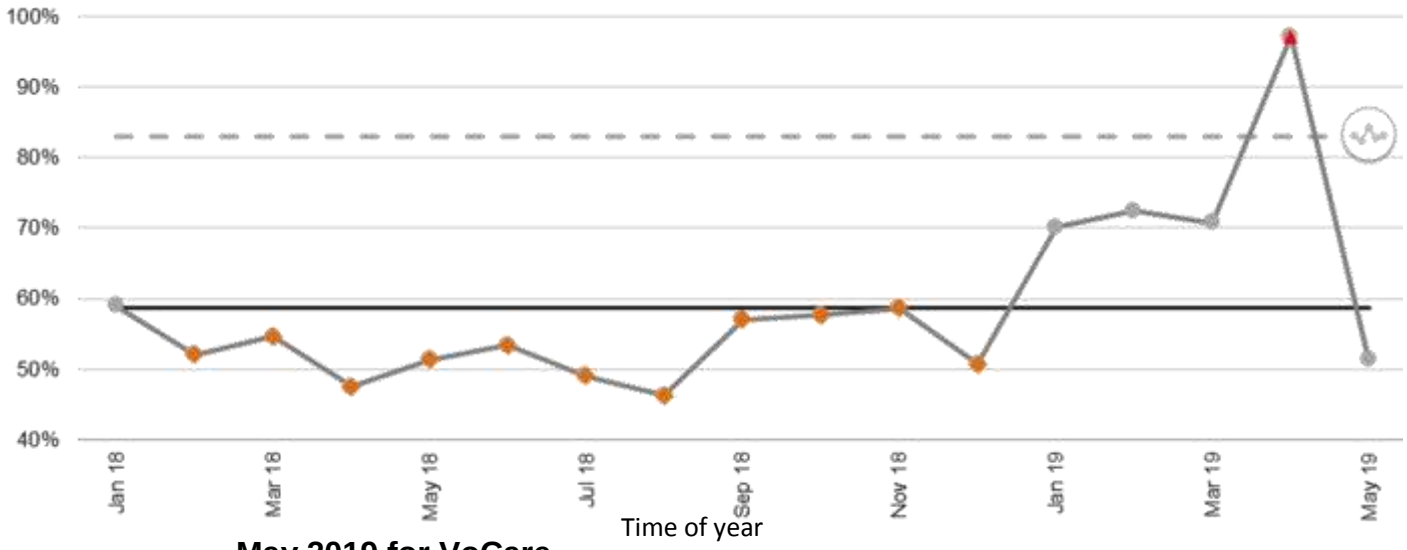
9.6.14 Percentage of calls transferred within 20 minutes from January 2018 to



May 2019 for LCW

Volume of calls

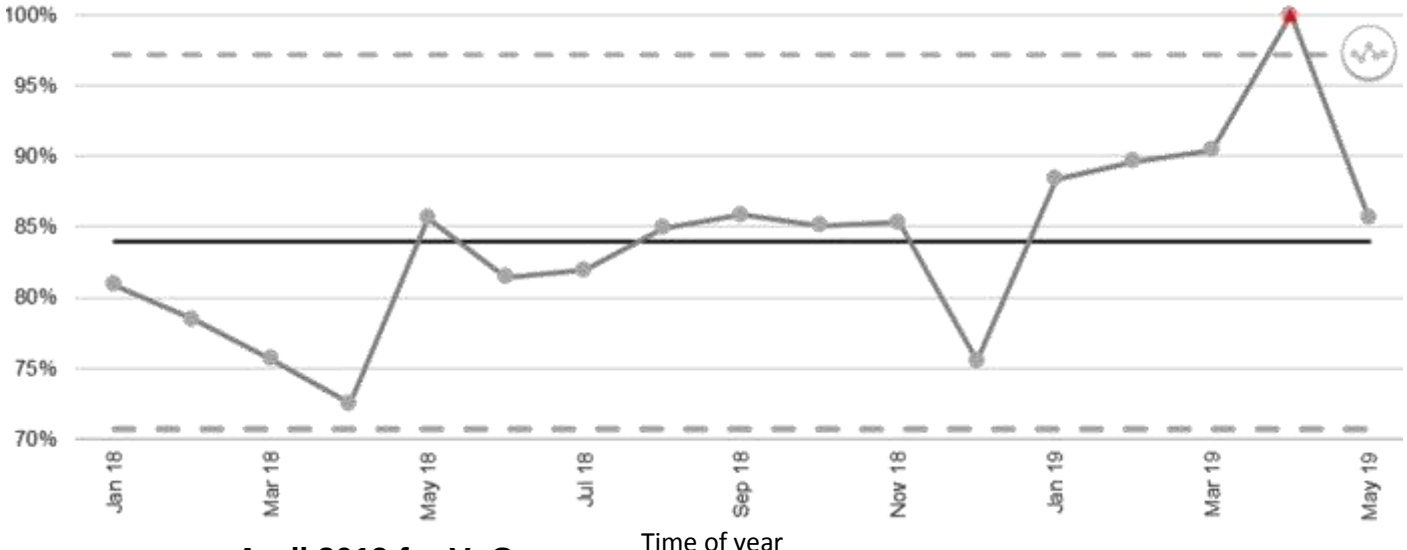
9.6.15 Percentage of calls transferred within 0 minutes from January 2018 to



May 2019 for VoCare

9.6.16 Percentage of calls transferred within 20 minutes from January 2018 to

Volume of calls



April 2019 for VoCare

9.7 Appendix 7– 111star*line narrative case studies

Volume of calls

LCW - Case study 1:

On 12th January 2019, between 14:10 and 14:21pm, a residential home called a 111 Pathways call advisor as one of their patients was complaining of 'chest contractions'. The 111 Pathways call advisor dispatched an ambulance. Due to a language barrier between the paramedic and care home resident, an Arabic interpreter was called to support the conversation. At 15:10pm, LAS used 111star*6 to request to speak to a GP. The paramedic reported to the call handler that the 'chest contractions' had resolved and they wanted to

seek advice from a GP as they believed that the patients' blood pressure medication needed increasing.

Thirty minutes later, at 15:40pm, the GP called back the paramedic who had remained at the scene with the care home resident. The paramedic stated to the GP on the phone that, although the patient is systematically well, their blood pressure is high (209/97). The paramedic also told the GP that, on recent admission, the patients' blood pressure medication (perindopril) had been reduced from 8mg to 6mg. Following this conversation, the GP agreed to increase the perindopril dose back up to 8mg and advised that the patient is reviewed by a regular GP when the surgery re-opens. The GP informed the paramedic to call back if the patient becomes symptomatic and to relay this information back to the care home staff.

At 15:58, the paramedic called the 111 Pathways call advisor to fax over confirmation of increased dose of medication. During this call, the paramedic was passed to the administration team to complete this task.

Nearly four hours later at 19:41, the care home team leader called a care navigator via 111star*6 to 1) confirm the paramedics had attended earlier that day to review their resident, 2) confirm that the doctor had increased the residents blood pressure medication and 3) inform the call handler that they had not received a fax for the prescription; this call lasted nine minutes. When the call was answered, the call handler did not provide their name, explain their role or inform the caller that they are not a clinician. The call handler introduced the caller with "You are through to integrated urgent care", kept questions to a minimum and did not ask for medical observations. The call handler did ask if the caller was a carer or a nurse. Following this brief conversation, the call handler went straight into the Decision Support Tool (DST) after putting the caller on hold without explaining why they were doing so. The call was disjointed and many questions were asked and that felt irrelevant to the query of the caller. When the call handler returned to the phone call, they informed the care home team leader that they would receive a call from a GP within one hour. The caller had all the necessary information to hand throughout the call however they did not sound satisfied at the end.

Although the care home team leader was expecting a call back within an hour from a GP, three minutes later, at 19:53, they received a call from a pharmacist, this call lasted until 20:06. The pharmacist reviewed the patients' history and confirmed that a fax had been sent to the residential homes local pharmacy for collection.

In conclusion, the situation could have been resolved in two calls, rather than six. The first call should have been from the care home to the call handler to get appropriate triage and the second call should have been to the GP to increase the dosage of the medication and fax the prescription.

LCW - Case study 2:

On the 9th March 2019 at 7:47, a care home nurse called the 111star*6 care navigator to report a patient whose catheter had been bypassing and who had been vomiting. The call handler, when answering the phone, asked the callers relationship towards the patient and their main reason for the call before they proceeded down the DST. Despite the nurse having to repeat the patients symptoms numerous times, the call handler recorded the observations. When recording the observations, the call handler was sometimes confused, unaware that 'pulse' and 'heart rate' were the same and 'sats' and 'saturations' were also the same. The call took six minutes and the call handler advised the nurse that a GP would call back within one hour.

Within 20 minutes, at 8:11am, the GP called back the nursing home. The GP did not provide their name when contacting the nursing home or clarify what they were calling about. The

GP just asked to speak to a nurse and announced they were an out of hours GP. It took a long time to speak to the right nurse and when the right nurse got to the phone, the GP asked similar open ended questions that the call handler asked in the previous call. The nurse informed the GP of her observations, including the patients catheter bypassing urine overnight, episodes of coffee-ground vomiting at 6:30am and the patients pale appearance. The nurse also provided the GP with other observations, including blood pressure rate (129/73), heartrate (91), respiratory rate (18), saturation rate (96%) and temperature (36.6) which the GP recorded. Following this, the GP enquired as to whether the patient has a DNAR, to which the care home staff confirmed, and whether the patient was for "active treatment", although the nurse could not find any information to suggest otherwise. Following the GP reviewing the patients medications and making an assessment of their condition and diagnosis, the GP told the nurse that he would be calling for an ambulance for their patient. The GP called the nursing home back at 8:29am to confirm he had fulfilled his action and that the ambulance will be with them within an hour.

In conclusion, the first call was approximately six minutes, but this could have been shorter as the call handler struggled to take down the readings which were then required again by the GP and it was not clear they had the previous recording. If the GP was local (this is unknown to whether they were), they could have done a visit to the patient to prevent calling out an ambulance.

LCW - Case study 3:

At 2:46 , on March 10th 2019, a care home nurse called a 111star*6 care navigator regarding a patient with a chest infection. This patient was asleep but their blood pressure had dropped and their breathing has become much more rapid. The call handler introduced the call with "You are through to integrated urgent care", but did not provide their name or role. It did not appear that the caller was aware that they were not speaking to a clinician. The call handler did take readings and went through DST. The care home nurse ideally wanted a GP to come out and check on the patient as they were aware that the patient was end of life. However, the call handler stated that a GP would give the nurse a call back within an hour. The call was ended there and the call handler did not go through the exit checklist, which highlights what to do if a patient deteriorates. The call finished at 02:53 taking nine minutes in total.

Four minutes later, at 2:57am, a GP called the nursing home back. At the introduction of this call, the GP did not provide their name, their role or why they were calling. Although the nurse had already been asked observations via the call handler, the GP asked the observations again, leaving the nurse to re-explain why she had called and the GP noting the observations; as well as making a note of the patients' medications. The GP asked if the patient was 'for' hospital and the nurse responded that the family confirmed the patient was 'for' active treatment. The GP advised the nurse to call an ambulance. The GP did not appear to check for any additional records.

On review, the patient had a comprehensive CMC record if this was reviewed alongside a GP visit it may have avoided an ambulance call out.

LCW - Case study 4:

On the 12th January 2019, a telemedicine nurse received a call from a care home regarding a patient with a high temperature. The telemedicine nurse referred to a GP for a call back, but no time frame was given.

The GP called the care home back at 19:45 until 19:53pm. As the patient had already been seen by a GP, who ruled out a chest infection, a urine test was completed. The urine test came back as positive for Leucocytes and nitrites and the patient was diagnosed with a UTI.

The GP issued a liquid nitrofurantoin prescription and staff were advised to collect this prescription from a local pharmacy.

Nearly an hour later, at 20:47pm, the nurse from the care home called the 111star*6 care navigator to report that the pharmacy was out of stock of antibiotics prescribed and requested an alternative prescription. When the call handler answered the nurses call, they provided their name but did not explain their job role. They asked the caller whether they were a clinician, in which the caller confirmed and repeatedly had to explain why they were calling in the first instance. The call handler proceeded to carry out DST. The call handler told the nurse that they would receive a call back within an hour, not explaining this call back would be with a GP. Before the call terminated at 20:55pm, the call hander went through a checklist and told the caller to call back if the patient worsens.

At 21:13pm, the GP called back the care home to change the prescription. When the GPs call was answered, the GP provided an explanation of their role and asked to speak to the specific nurse who made the initial call using the star line, however they were not available at the time. Therefore, another nurse had to take the call who did not have all the information to hand and so, had to take time to collate all the details. By 21:22pm, following the nurse giving the GP all medical observations required, the GP had changed the prescription to co-amoxiclav and faxed it to the same pharmacy for the nurse to collect. The outcome was unclear at the end of the call as the GP was initially going to arrange a GP visit but then changed to collect from the pharmacy.

In conclusion, if it was possible to check the pharmacy stock in the first instance, calls three and four would not have been needed.

LCW - Case study 5:

On the 25th January 2019, a care home nurse called the crisis team seek advice regarding a patient with blood in urine and an infection. The crisis team instructed the nurse to call 111star*6 as they do not support care home patients. At 18:08pm, the care home nurse called the pathways clinician. As the nurse had all relevant information already to hand, they went straight into providing the call handler with symptoms of the patient, denying the call handler the opportunity of giving their name and role. The call handler does not take any observations, but went through the DST and tells the nurse that they will receive a call back within an hour; this call lasted three minutes.

At 18:22pm, a NHS pathways clinician, a nurse, called the nursing home back. The nurse provided their name, explained their role, confirmed the patients details and asked for the patient to be woken up to go through the assessment which required abundant questions. By the end of the call at 18:36pm, the nurse had advised that the care home nurse would receive a call back within two hours from a GP and a home visit was requested.

A GP called the nurse from the care home at 19:50pm where they explained their role, asked clarification questions regarding the patient and offered for a prescription to be raised. By the end of the call, at 20:04pm, an out of hours GP visit was arranged as the nurse at the home was not able to collect the prescription. The out of hours GP visited the care home at 22:05 until 22:38pm.

As the nurse was not able to provide a prescription this required a call back from a GP. It is not known whether the out of hours GP visiting would have the necessary medications on hand and so the nurse may still need to collect the prescription.

CareUK – Case study 1:

At 6:37am, a team leader from a care home made a call to 111star*6. The call handler, who did not provide a name, did not clarify whether they were a clinician, however described their role to the caller as a health advisor. The call handler asked the caller whether they were

calling regarding themselves or somebody else. Although the call handler did not ask whether the care home team leader was a clinician, the caller provided the call handler with the reason for the call. The call was regarding a patient who had a 2 x 2 inch deep cut on their left foot. The team leader did not want to take this patient to the emergency department as the patient was 93 years old. Following this information, the call handler asked clarification questions; such as if anything was stuck out of the wound and how the patient was feeling, medical observations were recorded and the call hander went through the DST. The call handler decided to put the caller on hold whilst they transferred the call through to a clinician.

When a clinician picked up the call they did not provide their name, state their role or ask for access to the patients records. The caller answered the clinician's questions which were very similar to those asked by the initial call handler. The call handler confirmed that they could not give pain relief to the pain and the clinician directed the caller to remove the wet cloth from the deep cut and replace with a dry cloth, adding pressure to the wound and to elevate it. The clinician then confirmed with the caller that they would be calling an ambulance out for the patient.

It is unknown to whether rapid response visited the care home patient and dressed the wound or whether the 93 year old patient was admitted to the hospital in the end.

CareUK – Case study 2:

At 2:40am on May 2nd 2019, a care home staff member used the 111star*6 service. The call handler who answered the call provided their name and, although they did not state they were not a clinician, they described their job role as a health advisor. The call hander asked for the callers job role and whether they were a clinician, in which the care home staff member clarified they were indeed a nurse. Following open ended and clarification questions, it was clear that the nurse was calling as a patient in the care home had fallen and hit their head. The nurse had all information to hand throughout this call and made it clear that they wanted the out of hours GP to visit this patient. During this call, the call handler did not ask for access to the patient records and did not go though the DST. The call handler told the caller that a GP would call them back (no time frame for call back was given) and if their concerns grew greater regarding the patients' health, then to call back or call 999. It was not possible to listen to second part of the call however the notes state that during the GP call back, the GP provided the care home nurse with advice.

CareUK – Case study 3:

A paramedic used the 111star*5 call line at 16:53pm. When answering the paramedic's call, the call handler provided their name and their job role. The call handler proceeded to ask the caller open ended and clarification questions regarding the purpose of the call and asked the caller whether they were a clinician. The caller confirmed that they were a paramedic. The reason for the call was that a SPINE check was needed so the paramedic could find out the name and contact details of a patients local GP as the patient could not remember. The call handler did not seek permission to access the patients' records, this call was resolved by the call handler giving the paramedic the GP surgery contact number and opening times. As the query was resolved, a clinician call back was not necessary in this instance.

CareUK – Case study 4:

At 5:49am, a paramedic used the 111star*5 star line service as they needed to make a referral for a patient and wanted to speak to a GP. The patient, was a mental health patient who had a skin condition and refused to go to A&E after calling out an ambulance. The patient was known to the services for being a frequent caller. The call handler that answered the paramedics call did not provide their name but informed the caller they were a health advisor. The caller also confirmed their job title, stating they were a paramedic. The call

handler did not ask what the purpose of the call was as the paramedic was proactive in telling the call handler the reason for calling initially. The call handler did not ask for consent to view the patients' records and did not go through the DST. They did however ask clarification questions in order to evaluate their options. The call handler told the paramedic that they would receive a call back from a GP within a 30 minute time frame and, following the worsening checklist, told the paramedic that if the patient worsens in anyway to call 999 or 111. The paramedic stated that they could not wait that long and so the call handler advised that the GP would contact the patient instead.

The handover of information by the paramedic was disjointed and unclear as they did not clarify why they needed to speak to a GP or what they expected them to do.