NHS 111 and Urgent Care – Developing solutions
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Introduction

The British Medical Association (BMA) is the voice of doctors and medical students in the UK. We are an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year.

The BMA has been supportive of the principle of the NHS 111 telephone number as a single point of contact for patients in need of non-emergency triage. However, the General Practitioners Committee (GPC) was concerned about the Government’s proposals for implementation of NHS 111 as a standalone service, procured within a competitive tendering process and within an unrealistic and short timescale. The GPC issued many warnings about potential flaws in the proposed system prior to the formal launch date of 1st April 2013. One of the major concerns was the plans to divorce call handling from the provision of out of hours (OOH) services. Alongside the obvious economic problems this would cause existing OOH providers, the GPC felt this would in all probability lead to greater inefficiency within urgent and emergency care provision and place unnecessary risk on patient health.

Regrettably, many of the problems foreseen by the GPC became a reality. The notion that non-medically trained call handlers using an algorithmic software dispositions system could generate efficiency savings whilst maintaining timely good quality services has proven to be incorrect. Replacing the experience and expertise of clinical judgement with risk-averse software has led to greater inefficiency and use of more expensive care services, such as ambulance call outs and visits to A&E.

NHS England wishes to review the national 111 service specification and tendering process ready for a fresh approach to the way services are delivered beyond April 2014. This provides an opportune moment to consider a more detailed coherent case to abandon the current paradigm of 111 as a standalone provider subject to competitive tendering, with its own business interests. Instead, as suggested in the GPC’s paper on developing out of hours (OOH) care, the concept of GP-led locally integrated urgent care provision is now widely recognised as the way forward.

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1 http://web.bma.org.uk/pressrel.nsf/wall/BE3D1CDE6849FDF8802579A46004CC1CF?OpenDocument
2 An Ambulance Service Network factsheet published in 2010 indicated that ambulance call outs were rising by 6.5% a year, which equated to around 300,000 additional journeys at a cost of £60 million to the NHS. This would suggest each call out costs approximately £200.
According to the latest 111 minimum data set for February 2014 (published on 4 April 2014), 9.2% of all 111 dispositions in England were leading to ambulance dispatch. This amounts to 885,869 call outs at a cost of approximately £177 million.
3 When comparing A&E attendance dispositions within the January (527,160 attendances) and February (579,219 attendances) 2014 111 minimum datasets, these indicate that 111 dispositions led to an additional 52,059 A&E attendances in that period. Whilst an updated figure is yet to be published, in 2011-12 the Government indicated that the average cost of an A&E attendance was £108 (see page 8). This would suggest that the cost of the additional A&E attendances between January – February 2014 was approximately £5.6 million. The overall cost in relation to the February 2014 total of 579,219 111 recommended A&E attendances is approximately £62.5 million.
4 http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/priorities/out-of-hours-care
Professor Sir Bruce Keogh, NHS Medical Director, published the phase one report on his urgent and emergency care review, *Transforming Urgent and Emergency Care Services in England*, in November 2013. The five key elements he believes will ensure improvements are:

- providing better support for people to self-care;
- ensuring people with urgent care needs get the right advice when first contacting the NHS (through NHS 111);
- highly responsive urgent care services outside of hospitals, eradicating queues in A&E;
- ensuring people with serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise; and,
- connecting all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

**Purpose of this paper**

This paper provides a brief history of the problems that initially beset NHS 111 and sets out the GPC’s proposals for better integration of urgent and emergency care services. It is intended to provoke policy changes in the way NHS 111 services are commissioned, delivered and supported. Though the focus of this paper is England, many of the challenges facing the way patients access and receive urgent or emergency care are also found in Wales, Scotland and Northern Ireland.

The paper has been informed by members of the GPC who have many years of accumulated expertise and experience in organising, managing and delivering out of hours and urgent care provision, as well as acting in commissioning roles to develop specifications and tender for new services.

Appendix A (page 12) includes provider case studies from across England.

**Summary of the history of NHS 111**

*Prior to launch*

The BMA wrote to the then Secretary of State for Health, Andrew Lansley, in February and April 2012 warning of the dangers of rushing the implementation of NHS 111. The GPC repeatedly asked for the implementation of NHS 111 services not to be hurried, as a smooth transition was essential for patient safety. Concerns were expressed at an early stage about the decision to split call handling from service providers.

In addition, CCGs were asked to select successful contract bids despite the fact they had yet to take on full responsibility for commissioning services. In fact, many CCGs had not even been authorised or had fully formed Boards before procurement processes for NHS 111 were completed. It is unlikely that those CCGs would have been able to consider the planning, procurement or implementation of any service to a sufficient degree.

In November 2012, responsibility for NHS 111 was transferred to NHS England. The BMA considered the move of such a large initiative, to an organisation not yet fully staffed, to be an unnecessary risk. This contributed to a lack of clarity and transparency about the preparedness for the launch.

*Launch of NHS 111*

Serious problems were encountered with NHS 111 when the system was launched in a number of areas, which included Greater Manchester, parts of London, the West Midlands and the North East of England.

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5 See Appendix B (page 17) for the GPC’s submission to the national review of NHS 111
6 GPC report on concerns regarding 111 sent to the Secretary of State on 15 February 2012 - [http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/priorities/nhs111](http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/priorities/nhs111)
Data published by NHS England revealed that more than 425,000 calls to the NHS 111 service were abandoned up to and including April 2013\(^7\).

**Post launch**

The Government conceded that the launch of NHS 111 ‘did not go as smoothly as planned and that a number of providers have delivered an unacceptable service, especially at weekends’\(^8\).

In some areas, local GP cooperatives continue to triage all patients who ring NHS 111 due to the failures of providers who won 111 contracts. There were clear examples of patient safety being compromised due to a lack of clinical experience and capacity of call handlers.

Media coverage, including the Dispatches programme *Undercover in NHS 111*, demonstrated chronic understaffing, both by ‘Healthcare Assistants’ and clinicians, and patients were left waiting an unacceptably long time to receive advice.

Perhaps the most concerning development of all was the announcement that every 111 contract held by NHS Direct would have to be re-tendered, at great expense, less than a year after being awarded. Forcing through such a large scale project without first ensuring it was fit for purpose was at best unwise, and this was a profligacy the NHS could ill-afford.

**Concerns voiced by other organisations**

NHS Alliance also registered its disquiet both prior to and following the launch of NHS 111\(^9\); ‘the fallout [of the launch] has led to confusion, delays and frustration amongst patients using the service, and widespread concern in the national media’. It outlined several proposals for improving the service and building on the early failures of the soft launch, including a freeze on further implementation, which was not heeded. It also pointed out that ‘one of the original design principles for NHS 111 was the need for the service to sit on top of an effective and integrated urgent care system’. The lack of integration exacerbated the problems that occurred as a result of hasty procurement and chronic understaffing.

Urgent Health UK (UHUK), a federation of Social Enterprise Unscheduled Primary Care Providers, wrote to NHS England in April 2013, again highlighting issues ranging from lack of clinical staff to the time taken to process each call.

**Warnings from the past – NHS 24**

When NHS 24 was introduced in Scotland in 2001, it suffered significant problems. Much like NHS 111, there were not enough call handlers, not enough clinicians and, initially, no doctors other than the main clinical lead and a deputy. Following very adverse headlines not unlike those seen in England, patients experienced long waiting times, unanswered calls, unreturned calls and some high profile clinical catastrophes.

It was finally recognised that more call-centres were needed with local knowledge of the geography and the services. Originally, there were only 3 hubs. Now, NHS 24 answers calls in many more local centres and links with Health Board commissioned GP OOH services.

Since the start of NHS 24, the accepted levels of risk have been increasingly lowered, resulting in a massive increase in OOH consultations. This has lead to a change in public expectation. Self-care is much less likely and the response of the OOH services have contributed to the high demand and lack of self-care in the in hours period too.

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\(^8\) Earl Howe, Parliamentary Under Secretary of State for Health, Parliamentary Question on NHS 111 telephone service, 13 May 2013 [http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/130513-0001.htm#1305137000230](http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/130513-0001.htm#1305137000230)

Nurse triage follows rigid protocols, which results in a low-risk over triage environment. They cannot prescribe over the phone (or at all) and, therefore, need the patient to be seen at a face to face clinical consultation. They have rigid rules to follow and dispositions include too many unnecessary ‘must be seen in an hour’ conclusions and ambulance call outs. Patients have even said they knew they did not need to be seen, far less have an ambulance sent, just because they mentioned chest and pain in the same sentence.

There is concern in Scotland that the OOH service is unsustainable because of excessive patient demand, the pressure on A&E, the lack of acute hospital beds and the unwillingness of doctors to work in the OOH service. The reasons for the latter are poor pay, no pay increase since 2004, poor terms and conditions, no say on the running of the service and an already long, pressurised working week. In summer 2013, due to shifts not being covered, some Health Boards had to invest significant additional monies to ensure sufficient staffing.

It is easy to forget that many doctors, both north and south of the border, working in OOH services are doing so on top of what most would regard as an intensive working week.

If NHS 111 is to succeed, then it has to learn from the mistakes of NHS 24 and listen to the experience of the GPs who work or have worked within it. NHS 111 must also learn from the experiences of GPs who work in OOH services in England.
The General Practitioner Committee (GPC) position

The following principles reflect Professor Sir Bruce Keogh’s five key elements for improving urgent and emergency care in England:

1. providing better support for people to self-care;
2. ensuring people with urgent care needs get the right advice when first contacting the NHS (through NHS 111);
3. highly responsive urgent care services outside of hospitals, eradicating queues in A&E;
4. ensuring people with serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise; and,
5. connecting all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

Guiding criteria for the development of integrated NHS 111 and urgent care services

1. **Patients with urgent clinical needs** must be able to access quality clinically led call handling and out of hours care (key element three of the Keogh report).

   The GPC believes that the economic arguments for investing in this care are incontestable because of the potential savings to be made in acute care. Pressure to reduce secondary care admissions should lead logically to additional funding being made available to call handling and out-of-hours provision.

2. As populations, geography and healthcare providers vary so much across England, we do not envisage a one size fits all approach to improving call handling and out of hours care. The most appropriate solutions must be found by local clinical commissioners within an enabling national framework. Nevertheless, we believe there are some basic principles relevant to all commissioners (key element five).

3. **111 services should exist as part of an integrated paradigm** (key element five).

   We believe that urgent care services simply do not lend themselves to open tendering by default, though the option to do so would still be there for a CCG, e.g. if a local OOH provider was performing poorly or failing, as opposed to being compelled to do so.

4. A&E minor services, ambulance services, Darzi clinics, walk-in centres (WICs) etc, should be aligned. These services should be a commissioned ‘pathway’ and payment system of shared financial ownership, shared risk and shared incentives. This would mean ending the current tariff arrangements of payment by results (PbR) for A&E minor attendances and repatriating the entire budget for unscheduled care into a collective commissioning pathway approach. This would reduce bureaucracy, workload, cost shifting and buck passing (key elements three and four).

5. NHS 111 should be an integrated service, not something that is separately provided. It should mean that the patient receives a common initial assessment from whatever portal they seek their urgent care. Ideally, the local Directory of Services should be available via whichever provider is the portal on that occasion (key element two).

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Transforming Urgent and Emergency Care Services in England – Urgent and Emergency Care Review – End of Phase 1 Report
High level clinical triage

6. The cost of unnecessary ambulance call outs, A&E presentations and avoidable hospital admissions far exceeds the cost of investment in quality clinical triage and OOH services. **If triage and patient contact is with an experienced clinician, the presenting problem is managed in the most cost effective way.**

   This prevents more expensive ‘crisis’ responses, which can be caused by inexperienced triage activating more significant service resources and therefore cost. GPs can also play an authoritative role in educating the patient as well (key elements two and three).

7. In areas where services are strongest, the OOH organisations have been developed from GP co-operatives with high levels of GP staffing. This needs to be a core quality. **111 should act as a front door to the NHS, behind which are locally staffed and locally run GP-led organisations (key elements one and two).**

8. A recurring complaint is that the NHS 111 call handler ‘wasn’t listening - they just went through their list of questions’. **GPs know that if you listen intelligently, the patient will tell you what is wrong. (key elements two, three and five of the Keogh report).**

   East Berkshire Primary Care (EBPC) OOH service has had comments from patients saying the repetitive sequence of questions elicited by calling 111 is a waste of everyone’s time. This creates delays and a risk averse outcome, which, at worst, causes patients unnecessary time, treatment and has knock-on effects on the rest of the system, most pertinently ambulance services and A&E and during OOHs and in-hours GP services in the day.

9. In international surveys, the UK is praised for urgent and complex care11 - there is less waiting time than in other health systems – and it **achieves universal coverage for a modest cost** (see overleaf). This is UK general practice’s strength and it should be built upon, not destroyed (key elements four and five).

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11 2013 Commonwealth Fund International Health Policy Survey  
There are grave concerns that many problems will be perpetuated if we continue with a rigid commitment to NHS Pathways. Clinicians have been surprised at the level of ignorance of the management of minor medical problems and the risk adverse nature of Pathways algorithms. Some providers ‘drop out’ of Pathways during particular care episodes in order to appropriately triage (key element two of the Keogh report).

There are considerable concerns that NHS Pathways cannot deal with patients with multiple co-morbidities. The disposition regularly defaults to ‘refer to the clinician’ in these instances. Pathways is only currently suitable for straightforward conditions, which is why 111 call handling and GP OOH services should be integrated. OOH providers must have the flexibility to influence call handling in order to make the appropriate clinical judgement / decision at all levels (key element two).
12. **It may be safer and more economical in the long term to adopt traditional clinical triage.** This will not only provide a better service to callers, but will also improve efficiency as some calls are taking far longer using Pathways than would otherwise be necessary. Ensuring call handlers have instant access to live support from clinicians when necessary should be a minimum requirement (key elements two and three).

13. Exponents of Pathways are very clear that the reason for the clinician input is to assist in the more complex decision making. As part of the overall review in the West Midlands, it was questioned how, when and by whom clinical input is gained. **NHS Pathways may well be excellent for ambulance services where there are only 3 dispositions (‘transport’, ‘not transport’ or ‘call a GP’), but primary care is a different arena altogether (key element two).**

14. **Training issues and audit requirements for call handlers are significant.** Currently, call handlers are recruited, trained and then “thrown in at the deep end”. Some early auditing exists, but because of the volume of work and also retention issues, meaning yet more recruitment and training, then nuanced additional training is not as extensive as it needs to be (key elements two to five).

**Commissioning principles and considerations**

15. **CCGs must be free to commission their own integrated urgent care services without interference** from the centre, in order for this to be a clinically-led and owned service (key elements three and five).

16. **Competitive tendering should be removed as a procurement requirement for the provision of urgent and unscheduled care services** – commissioners must be assured that prospective providers can provide quality care to patients, whilst ensuring they are not placed at unnecessary risk (key elements three and five).

17. **Provider reputation is an important factor and profit should not be the main motivation.** Their approach to skill mix should not simply mean a ruthlessness that leads to cutting skilled (more expensive) staff (key elements three and four).

18. In order to be effective and to ensure true integration of services, **telephone triage must be linked with the other delivered services,** e.g. the Primary Care Centre(s) and home visiting and community nursing services. Without this connectedness there are substantial governance risks. Integration of these services also improves the knowledge and skills of the GPs who work for them (key elements three and five).

19. **OOHs services must be given the flexibility to innovate and adjust.** Some GP-led providers allow triage doctors to work from home via secure IT links. This is convenient, encourages uptake and allows for extra capacity at times of high demand, particularly as an increasing number of GPs have considerable family responsibilities (key elements three and five).

20. **OOH providers should offer a professionally rewarding quality extension to the in-hours work of GPs.** Younger GP colleagues are willing to work OOHs, but are much more likely to be motivated by working for organisations they can be confident offer a professionally rewarding experience (key elements four).

**Re-procurement of NHS 111 services**

21. In the areas where NHS Direct has withdrawn, there are numerous interim options agreed on a local basis. **Any re-procurement should be based on the historical success of those local options** (key element three).

22. Commissioners should support practice collaborations, e.g. **GP co-operatives, networks or federations,** to put forward a case for running 111 and OOH services (key elements two to five).

23. There should be a **requirement for prospective providers to produce evidence of managing and delivering a service** successfully. Contract bidders should be able to produce a
track record of success, not just simply say they can provide the service better, cheaper and quicker. Contracts should include provision for severe financial penalties should providers fail (key element three).

24. The process of due diligence must be followed rigorously, even if this means all bidders being rejected and contracts being re-advertised if there is any doubt about clinical or financial robustness, or the readiness of bidders to mobilise or deliver the contract specifications. Due diligence did not seem to be a priority with NHS 111 and the pace of health reform had much to do with this (key element three).

Quality assurance and monitoring

25. Although there are some disposal codes which are filtered out, GPs are being sent unnecessary information in the 111 post event messages (PEMs). Not only does this make reading the PEMs more time consuming, but the volume of information provided means important clinical elements could be missed. Furthermore, if a 111 call disposition leads to OOH attendance/advice/visit, GPs already receive information from the OOH service. Clinical governance risk caused by time pressures on already overburdened practices could lead to important bits of information about the patient’s care needs being missed (key elements two to five).

26. Quality assurance and monitoring needs to be based on end to end testing, with local 111 Clinical Governance Groups listening to random calls, feedback from health professionals, complaints and significant event reviews. This must not, however, be measured solely by response times, disposition or ambulance 999 activation rates (key elements two to five).

27. NHS call handling needs to demonstrate cost efficient outcomes, such as time of response, call abandonment rates, ambulance usage and referral to hospital. They should also be required to use audit and governance systems that assure commissioners, practices and patients. This will enable OOH work to be integrated into the appraisal and revalidation evidence of GPs who work in OOH settings (key elements three and four).

28. It is vitally important that a named 111 clinical governance lead is appointed for every CCG area to ensure local systems and processes are reviewed and kept up to date on a regular basis (key elements two, three and five of the Keogh report).

Directory of Services (DoS)

29. High quality local directories appropriately applied and kept up to date are vital to the signposting component of urgent and unscheduled care services. The critical importance of the directories was somewhat forgotten during the planning and implementation stages due to other issues, but they remain crucial to the scheme (key elements one to five).

30. Directories must be adequately resourced to support call handlers and clinicians by being comprehensively up to date (key elements one to five).

Innovation

31. Dedicated time must be spent looking at best practice not only in England but internationally too. Consideration and discussion of new and innovative ideas for making urgent health care more effective and efficient is vital (key elements two and three).

32. South Worcestershire CCG has commissioned the GPs with the Ambulance service scheme. The scheme supports paramedics when they respond to 999 calls and reduces the number of patients being admitted to hospital when they could be looked after at home by a GP. According to the
CCGs website, the service costs £21,000 a month but had saved the NHS £500,000 as of June 2013 (key element three).

**Patient demand and expectation**

33. **There is much variation in what patients want in terms of access**, i.e. the trade-off between immediate access and the desire to see a named GP, as well as that between austerity in the NHS and affordability for extended access and services.

34. **Patients and the public also want more information about health and their care.** Many wish for more involvement and engagement in shaping local services. The 2013 report from the Francis Inquiry stressed the importance of public and patient engagement and highlighted what can go wrong when this is not achieved.

35. **Patient input into the organisation and delivery of their 111 and OOH services should be strengthened** through the development or involvement of patient participation groups.

36. **The local patient voice within clinical commissioning group decision making should be increased** to give communities a sense of responsibility in terms of their own health and wellbeing.

37. **There should be investment in public education campaigns and better health education**, with the school curriculum being a particular focus.

38. **Patients should be empowered to self-care where appropriate**, avoiding the inconvenience of unnecessarily accessing healthcare services. This could be via consistent information that is easily available through, for example, electronic kiosks in public places, including in health care settings, and via accredited websites.

39. **Greater involvement of patients as partners**, providing longer consultation times where appropriate, would enable patients to share in decisions and the management of their care.

**Medical indemnity**

40. **Ever increasing indemnity costs are a real problem and must be addressed** if GPs are to undertake more sessions within urgent care settings. As reported by the British Medical Journal (BMJ)\(^1\), all three medical defence organisations (MDOs) have indicated sharp indemnity cost increases for OOH GPs.

41. **Rising expenses may lead to an insufficient GP OOH workforce.** This will become a problem for all unscheduled urgent care settings, including NHS 111 (key elements three and four).

42. As confirmed at a recent meeting involving the GPC, NHS England and the NHS Litigation Authority, the three main MDOs report a markedly adverse claims experience for GPs working OOH. This may be because of a greater willingness by patients to take legal actions against doctors that they do not know.

43. There is also a financial disincentive for GPs to work more than two sessions a month (which are covered by in-hours indemnity). **The costs of indemnity for working 40 hours OOH per week are twice those for in-hours** (circa £7,000 per annum) (key elements three and four).


The BMA General Practitioners Committee (GPC) Recommendations

1. The GPC believes that there should not be any compulsion for re-procurement of NHS 111 services via a competitive tendering process.

2. Clinical Commissioning Groups (CCGs) should be able to commission local NHS 111 services that are reflective of the need of their local populations, using tendering only where they feel this to be appropriate and necessary.

3. CCGs should be able to commission local NHS 111 services that are fully integrated with and provided by local unscheduled care providers including GP out of hours (OOH) services.

   This will align incentives and behaviour between stakeholders in urgent care, with local ownership and accountability. Such a local integrated arrangement should by definition not require an open competitive tendering process in keeping with Monitor’s guidance on procurement 14.

   See Appendix A (page 12) for provider case studies.

4. The GPC believes that standalone NHS 111 call handling service provision, disconnected from those that provide care services, leads to fragmented care.

   Combined with a lack of accountability for actions, this structure may have adverse consequences on other elements of urgent care provision, e.g. for patient safety and in terms of cost. NHS 111 call handling should therefore be operationally and managerially integrated with local unscheduled and urgent care provision.

5. Calls should be dealt with by clear, clinician-led triaging pathways, using an accurate, comprehensive local Directory of Services, which would be safer and more economical in the long term.

6. Triage details sent to GP practices must be replaced with succinct fit for purpose information. This should replace the current data sent, which is mostly irrelevant to ongoing patient care. The current excessive report poses a clinical governance risk of relevant clinical detail being lost in a mass of triage information.

7. If it is felt to be more appropriate for both patients and provides value for money, services could be provided for smaller geographical areas, allowing for integrated services with local out of hours providers as well as walk-in centres and A&E minor injury clinics.

8. One size does not fit all – commissioners must look at the particular qualities of successful / historical providers, some of whom have become current providers as a result of local service collapse.

9. The GPC believes that patients would benefit from greater clarity and information about the circumstances in which each unscheduled care setting ought to be used.

10. A framework for quality assurance and monitoring of local urgent care services would allow GP practices and other primary care services to provide useful feedback to commissioners.

APPENDIX A

Case studies: examples of urgent and unscheduled care provision across England

Shropdoc

Shropdoc is a not-for-profit limited company established in 1996. It currently has over 300 GP members, all of whom work in local general practice. The organisation provides services to 600,000 patients in Shropshire, Telford and Wrekin and Powys. It deals with over 200,000 calls and over 50,000 patients per year.

Shropdoc relies on clinical triage and has a 3% ambulance disposal rate, which is third best in terms of data from the best NHS 111 sites. This is against the 9% 111 ambulance disposal rate, which has previously been cited as the ‘gold standard’.

This GP heavy staffing means it is more expensive than other commercial providers, but it does significantly reduce A&E attendances and avoidable hospital admissions, which are far more costly to the NHS.

Shropdoc has consistently scored highly, not just in national and regional reviews that assess clinical care, but in patient surveys that speak of their satisfaction with the service.

Shropdoc monitors the percentage of patients dealt with on the telephone (70%), those brought down to base (15%), those visited at home (12%) and those who go to ambulance disposal (A+E or admission – 3%).

They also review telephone consultations, base appointment and visits with training sessions and peer review. Role-play (doctor v patient) is used for GP training sessions too.

http://www.shropdoc.org.uk/

The West Midlands adopts various integrated solutions

When NHS Direct failed in its contractual obligation to provide 111 services to the whole of the West Midlands, each area was asked to identify a local solution. An interim solution was agreed by each locality based on their local understanding of patient urgent and unscheduled care needs. These solutions began providing services from the end of October 2013. The interim solutions are (up to the end of March 2015):

- Staffordshire – Staffordshire Doctors Urgent Care (SDUC), providing integrated 111 and OOH service provision for 80% of Staffordshire. Use of NHS Professionals by call handlers and nurse clinicians with some support from GPs working in the OOH service.
- Shropshire – West Midlands Ambulance Service (WMAS), providing interim 111 services, but patients will continue to be encouraged to ring Shropdoc out of hours.
- Worcestershire – Care UK providing an integrated 111 and OOH service.
- Rest of West Midlands – WMAS has moved into former NHS Direct premises and provides the service with the same staff, following the use of TUPE protocols to formalise the transfer of employees.

The above approaches are extremely likely to prove that one size does not fit all. It is felt that integrating 111 with OOH is the only way to get the best from both services.

A review of these local interim solutions should take place before the revised national 111 service specification is published. The evidence from the reviews can then be used to aid the development of the revised specification.
FCMS (NW) Limited across the Fylde Coast

FCMS was established in 1994 during the cooperative movement for GP out of hours and is governed by an elected Board of Directors. It is a not-for-profit social enterprise organisation.

Local connections, operational knowledge and understanding patient footprint are essential to integration. In providing OOH GP service, FCMS is bonded with all urgent and emergency providers as well as a host of scheduled services. The additional management of the following local services creates the unification:

- NHS111
- 24/7 A&E/Urgent Care Service front end (using NHS Pathways) co-located primary care
- Care Coordination for regular acute service users and chronic patients
- Ambulance conveyance support scheme
- Same Day Centre call handling

FCMS provide these services in collaboration with urgent care colleagues. This depth of knowledge amongst 111 call handlers and clinicians enhances NHS Pathways with an optimal local care pathway.

The urgent care system operates on a single IMT platform. This allows cross referencing of cases and more effective management of patient care. This facilitates a holistic urgent care system, so if a patient enters at any point, they can be traced. For example, for an inappropriate A&E attendance, FCMS clinical staff are present and can provide tailored, onsite services to ensure appropriate treatment.

FCMS’ robust quality training ensures appropriate outcomes, which is a fundamental success factor. This coupled with an embedded clinical governance process has performance leading, high quality NHS 111 dispositions. This has safeguarded against the destabilisation of local health care provision through supported integration.

Patients are often encouraged to make choices and in urgent situations this often defaults to A&E. Due to the way FCMS manages integrated patient pathways, it guides and educates the patient to the most appropriate service for their need. This approach supports the patient in becoming more knowledgeable about their health needs, breeds confidence in the available services and helps to reduce costs to the NHS.

www.fcms-nw.co.uk

Suzy Layton, Chief Executive, FCMS
**Central Nottinghamshire Clinical Services (CNCS)**

CNCS are a not-for-profit social enterprise organisation providing urgent care services throughout Nottinghamshire, Leicester, Leicestershire and Rutland.

CNCS was heavily involved with the 111 project before the contract was awarded to the current provider. The organisation took part in several workshops and in particular the five stages of a 111 call, examining in detail all risks. Within the clinical governance group, there was an overall lack of expertise in the delivery of call centre type operations. The input of CNCS was therefore pivotal in the establishment of the initial risk register.

Once the provider had been selected CNCS stepped back a little, but remained involved in the development of the model and increased involvement as soon as the embargo was lifted.

The organisation has made significant changes to its operational delivery model to ensure that calls received from 111 are dealt with appropriately and as quickly as possible. An Interim Service Improvement Manager has played a significant role in the down-sizing of the operation and the implementation of new processes which have included changes within Adastra.

CNCS continues to be a member of the NHS 111 Project Group, which meets weekly and takes part in regular conference calls, which look closely at performance and staffing.

There has been major challenges regarding both clinical and operational resource levels and in particular the recognition that NHS 111 is not intended to replace services but to signpost people to the service best suited to their care needs. This has meant re-considering resourcing levels and submitting requests for additional funding to commissioners.

[www.cnscare.co.uk](http://www.cnscare.co.uk)

Anita Dixon, Chief Executive Officer, CNCS
IC24 provides an integrated service combining GP OOH and NHS 111 in Great Yarmouth and Waveney and South Essex. The feedback from GPs working shifts in these services is that 111 has assisted the OOH workload, although changing its character somewhat. There has been less ‘very serious’ cases and a reduction by 10% in patients needing phone consultations. However, there has been an increase in urgent two hour face to face contacts. This has been a consistent theme across the country. These services have proven successful, well liked by patients and well accepted by the GPs.

IC24 receives cases from NHS 111 in two areas:

- In Northamptonshire, NHS 111 is provided by Derbyshire Health United. Northamptonshire OOH was an OOH service with a very high contact rate and a great deal of routine same day GP type cases being dealt with in the OOH service. On shift stress levels were regularly high. After a short period of difficulty relating to the high demand in this county, the NHS 111 service has settled. There is a good relationship between DHU and NOOH, and shifts have become less stressed, and more in proportion to what was originally commissioned. This collaborative approach is as successful as the two combined services described above.

- In the South East, a unique model of 111 and process - in which the 111 provider is commissioned to do all the phone consulting usually performed in OOH - has altered the workload, with more time-consuming face to face appointments, a high percentage of cases rated as urgent and confusion over who phones the patient for what.

The number of cases referred to the ‘speak to’ element is around 10%. We understand the percentage closed by GP phone advice elsewhere, via the OOH service, is 35 to 40%. As well as this, there are also risks arising from the lack of note visibility between the two organisations, the “phone” doctor not able to see the face to face contact notes should the patient call again, and the face to face doctor not able to see any other calls closed as previous advice.

The total number of patients coming to OOH has reduced, but the work has become more complex and confusing. However, both organisations are committed to working together to rectify these problems.

www.IC24.org.uk

Dr Mark Reynolds, Medical Director, IC24
The benefits of the integrated NHS 111 and Out of Hours (OoH) service are evidenced through improved patient experience and clinical effectiveness. On the first phone call, the patients have a decision made on the urgency of the symptoms and the health care provider who will provide this.

An excellent example was a female patient calling Derbyshire NHS 111. The call advisor assessed her abdominal pain and transferred the call to a nurse clinician. The nurse called back within 8 minutes and she in turn escalated to a GP. Severe appendicitis was diagnosed and a Category A ambulance was dispatched. The total episode length was less than 30 minutes including ambulance arrival. The patient needed emergency surgery and credited the service with saving her life.

Appointments and home visits are made directly by call advisors in the integrated system and there is no delay or ring back to reassess the patient [as per non- integrated NHS 111] in the majority of cases.

If patients need to ring back to change an appointment or they have an enquiry as to how long the visit will be the call advisor can immediately answer the query rather than having to ring the OoH service and ask them to ring the patient.

There is greater clinical effectiveness and reduction of risk in an integrated service. For example, there is better communication and escalation of patient concern directly to a GP when required.

There is also further clinical effectiveness gained from increased flexibility amongst the clinical staff. For example, at times of intense pressure in out of hours, the call centre clinicians can assist with clinical advice calls. The opposite is also true when the Nurse Advisors are very busy. There is also instant constructive feedback for staff from more senior clinicians.

There are also advantages for commissioners through increased local ownership, care system buy-in to NHS 111 across the urgent care pathway and through improved patient pathways. There are further cost efficiencies gained from having only one organisation to liaise with, and improved expedience in service improvements identified in contract management, call review and clinical governance meetings.

Patient experience testimony:

  Very happy with 111 service, recognised he needed to go through a number of questions and then arranged an appointment for me. Pleased with efficiency / service.

http://www.derbyshirehealthunited.com

Lindsey Wallis, Chief Executive, DHU
APPENDIX B

Submission from the British Medical Association’s General Practitioners Committee (GPC) to the national review of the NHS 111 service

Executive Summary

- The BMA asserts that local NHS 111 services were subject to unnecessarily hurried procurement and implementation, without robust tendering procedures in place or due attention to patient safety.
- In many areas, the premature launch of NHS 111 has added further pressure on out of hours (OOH) services, ambulance services and accident and emergency attendances.
- The BMA calls for transparency on how the system is functioning and NHS England’s plans for the future of the service in the context of the national review of Urgent and Emergency Care.

Prior to launch

The BMA has always supported the principle of the NHS 111 as a single point of contact for patients in need of non-emergency triage15. However, the GPC issued many warnings about potential flaws in the proposed system. The BMA wrote to the then Health Secretary, Andrew Lansley, in February and April 2012 warning of the dangers of rushing the implementation of NHS 111. The BMA also wrote to the Health Minister Earl Howe, and NHS England Chief Executive Sir David Nicholson, urging them to delay the launch of NHS 111 beyond 1 April 2013 due to concerns that many areas were not ready for the transition16.

The BMA repeatedly asked for the implementation of NHS 111 services not to be rushed, as a smooth transition was essential for patient safety. Concerns were expressed about the decision to split call handling from service providers, which now appears to have been borne out. Although Andrew Lansley belatedly allowed areas to apply for an implementation deadline extension, there is evidence that at least one PCT Cluster pressured local CCGs not to do so. The Arden Cluster wrote to all CCGs in its area to ‘to highlight some of the potential challenges that an extension would cause for CCGs as commissioners and for the West Midlands project as a whole’. It enclosed a briefing detailing the negative impact delaying procurement would have on budgets and services and suggested legal action could be taken by potential providers. At a time when CCGs had yet to take on full responsibility for commissioning services, the threat of legal action is likely to have deterred shadow CCG Boards from applying for an extension. In fact, many CCGs had not even been authorised or have fully formed Boards before procurement processes for NHS 111 were completed. It is unlikely that those CCGs would have been able to consider the planning, procurement or implementation of any services at that stage.

The BMA wrote to Nick Hall, then Head of NHS 111, in September 2012, highlighting concerns over this rushed procurement and the lack of readiness. In response, the BMA was assured that “each NHS 111 service is put through a series of rigorous readiness tests prior to go live including:

- Service readiness tests, to check call centre staff and nurses have received the required level of training, and can deal with calls appropriately;
- Technical readiness tests, to ensure that the systems used by both the local NHS 111 provider and other local services, can communicate effectively on an interoperable basis;
- Clinical Governance tests, to ensure the service is clinical[sic] safe; and
- Mass-call event testing, to ensure the telephony infrastructure can handle a high level of calls from every possible means of calling (i.e. mobiles, landlines, and payphones, from every network), and to confirm the local routing works as planned.”17

However, as has since become clear, this did not happen and local NHS 111 services in many areas were not ready to be implemented when their ‘go live’ date was announced.

17 http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/priorities/nhs111
Until November 2012, the Department of Health was responsible for NHS 111. An evaluation report into the experiences of the four pilot sites was commissioned from the University of Sheffield’s School of Health and Related Research (ScHARR), prior to the full service implementation proposed for the 2013 Easter Bank Holiday weekend. The final version of the evaluation report was not published until November 2012, following a nine month delay. The conclusions maintained the pilots all met national quality standards for abandoned calls and for the proportion of calls answered within 30 seconds. However, the survey sample was very small for the basis of a nationwide multi-million pound project. Not only that, in the interim evaluation report, received by the national NHS 111 Programme Board, the authors recommended that ‘a reassessment of NHS 111 is needed to increase the likelihood of obtaining expected benefits and transforming urgent care as originally envisaged’. This sentence was missing from the final published report with no explanation for its removal.

In November 2012, responsibility for NHS 111 was transferred to NHS England. The BMA considered the move of such a large initiative, to an organisation not yet fully staffed, to be an unnecessary risk. The BMA felt this contributed to a lack of clarity and transparency about the preparedness for the launch.

Two months prior, the Department’s NHS 111 Programme Board, a group comprising DH officials, GP and patient representatives, pushed risk 31, ‘a lack of priority and resource’, to the top of the programme risk register. This was further exacerbated by the dissolution of the Programme Board and the cessation of the involvement of key stakeholders, including the GPC, in a central group overseeing the scheme.

Launch of NHS 111
Serious problems were encountered with NHS 111 when the system was launched in a number of areas including Greater Manchester, parts of London, the West Midlands and the North East of England.

- In Manchester, where NHS 111 was launched on 21 March 2013, patients reported waiting for several hours for call backs. Reports also indicate that the North West Ambulance Service was overwhelmed by 999 calls from patients because of an inability to get through to NHS 111 and long waiting times for responses to calls.
- South London also raised similar concerns about transition to NHS 111, with reports of patients experiencing delays before receiving call backs.
- NHS 111 was put on hold in Southwark, Lambeth and Lewisham until 9 April 2013 after problems with the service emerged in Bexley, Bromley and Greenwich.
- In Manchester, West Midlands and London, GPs and other doctors have taken back call handling because of safety concerns.
- Some out-of-hours providers who took over call handling following the collapse of NHS 111 in their area had to do so unresourced.
- Referrals to out-of-hours providers in areas where NHS 111 remained operational reported unusually low referral rates; this can only be satisfactorily explained by patients being referred to A&E or having ambulances dispatched to them unnecessarily.
- The risk-averse nature of the call handling triage can be attributed to the fact that without professional medical training, call handlers cannot be expected to exercise correct clinical judgement consistently.

The BMA notes recent data which reveals that more than 425,000 calls to the NHS 111 service were abandoned up to and including April 2013.

Post-launch
The Government has conceded that the launch of NHS 111 ‘did not go as smoothly as planned and that a number of providers have delivered an unacceptable service, especially at weekends’.

In some areas, local GP cooperatives continue to triage all patients who ring NHS 111.

The launch in Greater Manchester has been described as disastrous. There were clear examples of patient safety being compromised due to a lack of clinical experience and capacity of call handlers. Deloitte has

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now been called in to investigate the comprehensive failure of the service within 12 hours of it going live. This is not the only area that has seen problems of this nature.

The BMA is concerned that NHS England has not listened effectively to concerns raised by clinicians. In the West Midlands, a local cooperative who took back triage for 111 calls after concerns about the capacity of the provider was summoned to a meeting with regional NHS England staff to explain its actions. In the context of a post-Francis Report NHS, the need for local GPs to step into the breach in order to ensure patient safety and for that action to be seen in a negative light by NHS England managers is particularly concerning.

The BMA was not the only organisation to flag concerns about NHS 111. NHS Alliance also registered its disquiet both prior to and following the launch of NHS 111; ‘the fallout [of the launch] has led to confusion, delays and frustration amongst patients using the service, and widespread concern in the national media’. It outlined several proposals for improving the service and building on the early failures of the soft launch, including a hold on all further implementation, which was not heeded. It also pointed out that ‘one of the original design principles for NHS 111 was the need for the service to sit on top of an effective and integrated urgent care system’. The lack of this kind of integration has, in the BMA’s view, exacerbated the problems that have occurred as a result of hasty procurement and chronic understaffing.

Urgent Health UK (UHUK), a federation of Social Enterprise Unscheduled Primary Care Providers, wrote to John McIvor, the Chairman of NHS England’s NHS 111 Implementation Group in April, again highlighting issues ranging from lack of clinical staff to the time taken to process each call.

Both NHS Alliance and UHUK made suggestions to make NHS 111 safer and more responsive to patients’ needs. Recent media coverage, however, has shown that NHS 111 continues to be chronically understaffed, both by ‘Healthcare Assistants’ and clinicians, and patients are left waiting an unacceptably long time to receive advice. A recent investigation by the Channel 4 programme Dispatches saw call handlers being placed on calls with minimal training of pathways or the IT system used to triage patients. Some patients were left waiting 11 hours for a clinician to ring back, while there was an admission that not enough staff were in place over weekends to deal with the volume of calls.

The Department’s original plan for NHS 111 was to streamline patient experience and produce savings through a single point of contact. And yet now, all contracts awarded to NHS Direct will be re-tendered, at great expense, less than a year after they were originally awarded. The BMA queries the wisdom of forcing through such a large scale project without first ensuring it was fit for purpose and feels this is a profligacy the NHS can ill-afford.

Recommendations

- The BMA believes that there should not be any compulsion for re-procurement of NHS 111 services via a competitive tendering process.
- Clinical Commissioning Groups (CCGs) should be able to commission local NHS 111 services that are reflective of the need of their local populations, using tendering only where they feel this to be appropriate and necessary.
- CCGs should be able to commission local NHS 111 services that are fully integrated with and provided by local unscheduled care providers including GP out of hours services. This will align incentives and behaviour between stakeholders in urgent care, with local ownership and accountability. Such a local integrated arrangement should by definition not require an open competitive tendering process in keeping with Monitor’s recent guidance on procurement.
- The BMA believes that a standalone call handling service provision by NHS 111, disconnected from those that provide services, leads to fragmented care. Combined with a lack of accountability for actions, this structure may have adverse consequences on other elements of urgent care provision. The BMA therefore advocates that NHS 111 call handling be operationally and managerially integrated with local unscheduled and urgent care provision.

- Calls should be dealt with by clear, clinician-led triaging pathways, using an accurate, comprehensive local Directory of Services.

- Triage details sent to GP practices must be replaced with succinct fit for purpose information. This should replace the current data sent, which is mostly irrelevant to ongoing patient care. The current excessive report poses a clinical governance risk of relevant clinical detail being lost in a mass of triage information.

- If it is felt to be more appropriate for both patients and provides value for money, services could be provided for smaller geographical areas, allowing for integrated services with local out of hours providers as well as walk-in centres and A&E minor injury clinics.

- The BMA believes that patients would benefit from greater clarity and information about the circumstances in which each unscheduled care setting ought to be used.