James Smith  
Provider Engagement Officer  
Care Quality Commission  

By email  

1 May 2015  

Dear James  

CQC consultation – How we regulate NHS 111 services  

The British Medical Association (BMA) is 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 Association welcomes the opportunity to respond to the CQC’s consultation on how you will regulate NHS 111 services. Please find enclosed the BMA’s submission.  

We believe that inspection teams should play an important part in improving NHS urgent, emergency and unscheduled care services. Positive assessment and monitoring of NHS 111 services will enable the whole care system to improve patient outcomes by becoming more integrated through experience and shared learning.  

Further careful consideration is also needed to ensure that inspection assessments are suited to telephone triage care settings, and this should include ensuring staff receive ongoing high quality training and that disposition software is receptive to the needs of patients.  

We hope that our submission is useful – please do not hesitate to contact us for more information if required.  

Yours sincerely  

Alex Ottley  
Senior Policy Executive  
NHS Primary Care Division  
Policy Directorate  

Chief Executive: Keith Ward  
Registered as a Company limited by Guarantee. Registered No. 8848 England.  
Registered office: BMA House, Tavistock Square, London, WC1H 9JP.  
Listed as a Trade Union under the Trade Union and Labour Relations Act 1974.
CQC consultation - How we regulate NHS 111 services

1. Do you agree with our proposed approach for regulating NHS 111 services?

Broadly speaking, the proposals for inspecting NHS 111 services are welcome. As specified later in this response, it will be necessary to give further consideration to how rating characteristics can be appropriately applied to NHS 111 care settings.

Enabling inspection teams to constructively assess and monitor NHS 111 services in the most suitable way will play an important part in improving urgent, emergency and unscheduled care services. This should be done in a positive way, enabling the system to improve patient outcomes by becoming more integrated through experience and shared learning.

How do you suggest we gather people’s views of NHS 111 services?

This could be undertaken in a number of ways. We would recommend seeking feedback from a wide range of people to see exactly how NHS 111 fits in with the rest of the system. This will only be possible by speaking to all the parties involved, e.g.:

- Clinicians and staff – emergency departments, GP out of hours services, GP practices, ambulance services, dentists, pharmacists, opticians, care and nursing homes, mental health services, local authority social care services, other local providers that work in collaboration with 111 services, call handlers, NHS Pathways technicians etc
- Commissioners – clinical commissioning groups, area teams, Local Authorities etc
- Patient / staff representative groups – e.g. HealthWatch, Local Medical Committees (LMCs) etc

Are there other things we could take into account?

The CQC’s longer term intention to inspect the integrated urgent care system within a local area should be done in a positive way, enabling the system to improve patient outcomes by becoming more integrated through experience and shared learning. The present urgent and emergency care system may make it difficult for NHS 111 service providers to achieve ‘outstanding’ or even ‘good’ ratings because collaborative working, whilst absolutely necessary, is not always within their gift.

Nevertheless, the outcomes from the implementation of the recommendations from the national urgent and emergency care review¹, led by NHS England Medical Director Professor Sir Bruce Keogh, should lead to improved collaboration as service governance, contracts and funding are consolidated to enable integrated person-centred pathways of care. This is likely to lead to a significant shift in the ways urgent and emergency care is paid for and delivered², and this will impact on the way in which the CQC will need to inspect providers and the local systems within which they exist. However, in the absence of detail about how the reformed system will look, it is hard to comment definitively on how regulation should work.

It will also be important to take stock of any changes of policy direction following the election of a new government in May 2015. Reducing A&E attendances, ambulance call-outs and avoidable hospital admissions will remain a priority. Making use of appropriately funded GP out of hours services that are fully integrated with front-end NHS 111 call handling services will be important.

in making sure demand for services is managed effectively and in partnership with patients. This will assist in alleviating pressure on the urgent and emergency care system, particularly during winter time, and preserving the NHS' sustainability in the future.

Inspections should include assessment to ensure individuals working for 111 services and combined providers are appropriately trained. The national NHS 111 commissioning standards only specify minimum training requirements for call handlers, but we believe all NHS 111 providers should supplement this with regular ongoing training as well.

Finally, from a clinical perspective, assessing the quality and validity of the IT systems in use by 111 providers will be crucial. Inspection teams must be able to look at how these systems are used in practice. For example, a sample of telephone calls, clinical records and post event messages (PEMs) should be audited for quality during inspections.

2. Our inspections ask five key questions that aim to assure the public on how safe, effective, caring, responsive and well-led services are.

*Do you agree that our proposed approach will do this for NHS 111 providers?*

Again, broadly speaking, we agree with the proposed approach, but it is important to recognise that inspections will need to be adapted to ensure they are practical for NHS 111 telephone triage services and are suitable for this particular care setting.

*Are the KLOEs, prompts, and ratings characteristics in the appendices appropriate for inspecting NHS 111 services?*

In general, we believe they are. However, some of the areas suggested may not be practical to apply to NHS 111 settings or appropriate to measure in the ways suggested. This is because staff within 111 call centres will only be speaking with patients on the telephone. Some further clinical and non-clinical input from appropriate staff, such as nurse practitioners, GPs, call handlers, NHS Pathways technicians etc, is needed in terms of the practicalities of measuring services against the key lines of enquiry rating level characteristics.

*What is missing or needs to change?*

The key lines of enquiry (KLOE) for safety are comprehensive but they do not yet include reference to integration with other services locally. Integrated NHS 111 services have an essential role to play in addressing the considerable pressures on the urgent care system. This will ensure system resilience, which has a major part to play in patient safety and the quality of services delivered.

In relation to effective care, treatment and support, patient referral, care and treatment outcomes should be audited to ensure they are appropriate. It is important that NHS 111 dispositions are reviewed by providers and commissioners, and this should include appropriate use of self-care advice or referrals to a pharmacy.

For example, as specified in paragraph 3.9 of the national NHS 111 commissioning standards, call handlers must undergo a continuous process of audit as part of the requirements of any clinical decision support system (CDSS) licence. Inspection teams could monitor this assessment to ensure it is taking place.

---

Variation in the Directory of Services (DoS) can have a significant impact on care provision, and, if it is not monitored and reviewed regularly, the DoS can quickly become inaccurate. The accuracy of the DoS could be assessed by inspection teams.

Universal appointment booking by NHS 111 providers could currently affect patient access. Significant numbers of inappropriate call dispositions advising patients to see their GP within 1 to 2 hours, for example, can have a drastic impact on access for routine patients and those who simply call their GP for an appointment. This is because they will either have their appointment cancelled / rearranged to enable the practice to see the patient referred by the NHS 111 service, or there will not be any available appointments within a timeframe acceptable to the patient. In order to regulate the use of directly booked appointments, urgent care IT systems would need to be truly integrated to avoid booking conflicts.

In terms of the information staff need to deliver effective care, it is also important to monitor systems for ensuring confidential information is not shared inappropriately. The Information Governance Statement of Compliance (IGSoC) process is the procedure by which organisations, including GP practices, enter into an agreement with the Health and Social Care Information Centre (HSCIC) for access to its services.

Inspection teams could monitor 111 providers to ensure they are signed up to the Information Governance Alliance (IGA), which is a group of national health and care organisations that are working together to provide a joined up and consistent approach to information governance. The process includes completing the IG Toolkit, which contains a requirement to agree to the IG Assurance Statement. The Statement contains the terms and conditions of access to HSCIC services. The IGSoC process is completed only once, but compliance is reconfirmed through the annual publication of the IG Toolkit and annual acceptance of the IG Assurance Statement.

Capacity to consent to care and treatment is not always easy to obtain over the telephone, particularly for non-clinicians. BMA member feedback has highlighted that in at least one instance a care home has made an urgent call on behalf of a patient, but the call handler has refused to take the call any further without having explicit verbal consent from the patient even though this was not possible. The caller was advised to dial 999 instead. A more appropriate response from the call handler would have been to transfer the call to a GP or nurse, who could then speak to the caller about the patient’s condition and decide on an appropriate referral.

Part three, paragraphs 75-76 of the GMC’s Good Medical Practice guidance includes a section on making decisions when a patient lacks capacity. Doctors must consider which options for treatment would provide overall clinical benefit. Patients should also be treated with respect and not discriminated against.

This should be no different for a parent or carer calling on behalf of a child or young person in urgent circumstances, and may indeed be an issue for patients that need additional support to help them understand or be involved in their care and treatment. In monitoring call dispositions, inspection teams could check to ensure consent issues did not result in callers having to make a second urgent call to another unscheduled care service.

In order to manage demand and minimise inappropriate and costly referrals from NHS 111, patients using 111 must be empowered and supported to manage their own health, care and well-being to maximise their independence. Providers should monitor referrals regularly and inspectors should inspect monitoring systems and processes.

To achieve a rating for the safe KLOE, providers should have a comprehensive induction scheme if using agency or locum staff (where this may be appropriate), as recommended in outcome 14, ‘supporting workers’, in the CQC’s Guidance about compliance Essential standards of quality.

---

A supportive working environment / organisation should greatly reduce any risk associated with temporary staff.

The characteristics for a good rating under the effective KLOE should include reference to collecting feedback from other stakeholders and using the learning from this to improve services. This may be particularly pertinent to other stakeholders / providers where appointments are booked directly. Outcome 16, ‘Assessing and monitoring the quality of service provision’, in the CQC’s Guidance about compliance refers to collecting feedback from service users in order to effectively manage risk.

Empowering patients to self-care should be a high priority for NHS 111, as acknowledged in NHS England’s urgent and emergency care review update report in August 2014. This will ensure patients who need referrals to other parts of the urgent care or in-hours system get access and treatment in a timely fashion and that NHS resources are used efficiently. This will contribute to the future sustainability of the NHS. It also seems appropriate that the characteristics for an outstanding or good rating under the caring KLOE should take into account what the patient needs and the treatment they received. This could be done, for example, by reviewing calls, post event messages and patient notes.

Adequacy, reliability and effectiveness of NHS Pathways algorithms should also be a priority for providers when considering the characteristics for an outstanding rating under the responsive KLOE. In addition, maintaining, assessing and developing the DoS should be in both the outstanding and good rating characteristics. However, it is currently the responsibility of clinical commissioning groups (CCGs) to ensure the DoS is kept up to date by local providers, as confirmed to the BMA by the NHS 111 Medical Director, so it would be inappropriate to rate an NHS 111 provider against this characteristic without first being sure that the commissioner is coordinating the efforts of all local providers. How CCGs interact and involve NHS 111 services in unscheduled care planning and provision should be assessed, as this might be a major constraint to success and effectiveness.

What do you consider to be the best ways that we can observe NHS 111 services and gather evidence about the quality of care they provide?

Inspection teams should include experienced in and out of out of hours GP, emergency department and ambulance service clinicians that interact with NHS 111 regularly. It will also be necessary to have social and mental health care experience to draw upon, since this expertise will be important in monitoring interactions across all urgent and emergency care services.

The importance of auditing samples of telephone calls, clinical records and post event messages (PEMs) for quality during inspections cannot be emphasised enough. Consideration should also be given to the level of support call-handlers receive from managers and how easily they can access clinicians when required.

3. We propose not to rate NHS 111 services for the six population groups and only focus on the five key questions.

Do you agree with this approach?

Since NHS 111 is an urgent care service available to all the population groups at any given time, and one which aims to offer consistent quality to all callers, it seems reasonable to focus on the five key questions.

---

4. Where a provider delivers and NHS 111 service as well as other services, we believe that it is preferable to inspect the NHS 111 service during our inspection of that provider’s other services using our combined provider approach.

*Do you agree with this approach?

This is difficult to answer bearing in mind the need to ensure that services are integrated and work collaboratively for the benefit of patients. There is also a risk of bias with this approach, since the inspection outcome for one part of the combined service may negatively impact on the other. Inspection teams will need to assess all NHS 111 service providers fairly and consistently.

*How do you suggest we develop our approach to inspecting combined providers in this sector?*

It should be noted that the differences suggested in rating services provided by ambulance and standalone services may cause confusion, since the rating will form part of the ambulance services overall combined provider rating.

It may be more appropriate to assess and rate combined providers on the 111 component separately, otherwise other aspects of their service may raise or lower the overall rating. It will then become unclear how the 111 component is performing. The ratings system should show how NHS 111 is performing, but also be judged on how well integrated it is with the rest of the urgent and emergency care system.