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NHS Alliance Discussion Paper

From the Clinical Commissioning Federation and the Urgent Care Network

NHS 111: getting lost in translation?

Overview

There is widespread support for the principle of developing one easy access national telephone number for patients who have an urgent, but not life-threatening, health problem. But there are increasing concerns that this initiative is being lost in translation as the NHS moves towards a rapid implementation of a national 111 number by April 2013.

At the NHS Alliance Annual Conference in early December, delegates were pleased to hear the Secretary of State confirm his commitment to the principles of local commissioning, local control and local ownership for his health care reforms. Despite this, there was a general sense of concern expressed amongst the new clinical commissioners about the national specification and roll out of the NHS 111 programme and, in particular, the lack of engagement with Clinical Commissioning Groups (CCGs).

We decided to explore this further. We designed a survey drawing on the experience of two of the NHS Alliance Networks, the Clinical Commissioning Federation and the Urgent Care Network. An invitation was sent on 9th December to all members of the NHS Alliance Clinical Commissioning Federation, including the majority of CCGs across England, to take part in a survey asking 12 multiple choice questions about the implementation of NHS 111. It was made clear that we were looking for responses from clinical leaders across CCGs and that we were looking to understand their local experience of introducing NHS 111. By the end of December, 51 responses were received on a specially designed website. We need to be clear that this not a representative sample but it is, at the very least, a 'straw poll' of some of the new clinical leaders who will be responsible for commissioning this service locally. It also needs to be remembered that CCGs are going through a difficult period with multiple challenges as they move towards becoming fully independent organisations.

Despite these reservations, the overall message is striking – suggesting that while there is support in principle there are substantial concerns about the speed and style of implementation. Although the central message from ministers and DH has emphasised the importance of local engagement and encouraged local diversity and innovation, this is not what people are hearing on the ground. Whatever local health systems can do, local leaders do not see it this way. Too many of them appear to feel they have had little say and that the introduction of 111 is unlikely to lead to all the benefits that everyone wants.

The main findings from the poll are that currently clinical engagement appears to be poor (23% saying 'I knew what was happening but had no say' and 34% saying 'No real engagement, the decision was out of my hands'). At the same time, clinical leaders feel that this is another example of top down policy rather than local innovation (79% said 'There is little scope for local clinicians to shape this service to meet local needs' and all respondents agreed with the statement that 'This roll out is top down politics not local empowerment'). Finally, there is little confidence that the 111 programme, in its current form, will offer the desired improvements in

patient care (74% are not confident that 'the introduction of 111 in my area in April 2013 will be a success').

The full results from the survey are included at the end of the paper as an Appendix. The main body of this discussion paper looks at what the results might mean and what can be done to address the concerns raised, as well as highlighting the potential for local flexibility within a national framework.

Moving forward

We are keen to work with partners across the system to address some of these concerns. The NHS Alliance has already produced an extensive resource for local urgent care commissioners in December 2011 '*Breaking the Mould*' which emphasises the importance of finding local solutions for improving integrated care for patients. We also produced an earlier paper in June 2011 '*A new approach to 111: re-establishing general practice as the main route in to urgent care*' calling for greater flexibility in the way 111 was being implemented and exploring the opportunities for a new model that put General Practice at the centre of 111.

It is clear that without proper ownership from the bodies responsible for commissioning there is a high risk that the service will flounder. There is a need to reinvest CCGs with ownership of the 111 program by offering genuine choice in how it is delivered, taking advantage of local innovation and pre-existing developments in the urgent care arena. Below are a number of suggestions for taking this forward.

- Support the Department of Health in its plans for an objective peer learning exercise amongst existing providers of current NHS 111 pilots, that seeks to understand the benefits and constraints of the current system 'on the ground' and without prejudice.

- Offer opportunities for whole system support for everyone to discuss and agree on a way forward. This could involve setting up sessions for all key stakeholders to come together for a facilitated workshop designed to look at the current health care system, how it should be developed to achieve integrated 24/7 urgent care and what this means for the effective introduction of NHS 111. Some areas have already done this very successfully; others need to resolve differences and agree a shared way forward.

- Encourage local CCGs to take more active leadership of the process for introducing 111. If leaders feel blocked, or that they are simply being directed to support a regionally determined solution that doesn't meet their needs, they need to speak out. In the evolution from core principles around 111 to the more detailed specification, there may be aspects of the 111 roll out that are stifling innovation at local level. These need to be fed back to the centre, which in turn needs to demonstrate a willingness to address these issues wherever possible, within the spirit of the core 111 principles. As an example, it would be helpful to clarify the uncertainty around whether downstream providers are 'allowed' to complete more detailed clinical telephone assessments on patients designated for face to face consultations and visits by 111. A central point of access is already available at nhs111@dh.gsi.gov.uk and it would be helpful if local systems could seek further advice and support if they feel unable to make progress in implementing local solutions. The new health agenda requires a new culture where local clinical leaders determine what is best for their communities rather than perpetuating old behaviours in a highly managed system.

- Ensure that we make the best possible use of all information coming out of the formal independent evaluation of the first four pilot sites, as well as other intelligence from pilots and procurements across the Country. We need to rapidly share emerging data so that everyone can learn in real time from what is happening on the ground. Early reports from the pilot sites suggest a mixed picture, with positive findings in some areas, but more negative findings in others. So, for example, the first data in November on the crucial indicator of the impact on unscheduled admissions showed an increase compared to control sites of between 5 and 9% across all pilot sites. It is important to understand whether this is an early blip, or whether 111 could lead to substantial extra costs to a health system already focused on making substantial financial savings.

- Allow CCGs to 'pause' current procurement processes that have not yet been concluded if they feel that they have not yet built in enough local flexibility to existing specifications. This might be one option following a session bringing together all partners in the local health community, as described above.

National or Local: is it one or the other?

Our recent survey suggests that there is a substantial gap between the understanding of local leaders and the way the programme is designed to work. Our respondents were wary of top down implementation, but in reality, any national initiative needs to find the right balance between a clear common framework and local implementation. NHS 111 does this by asserting four core principles:

– Completion of a clinical assessment and information on the first call without the need for a call back;
– Ability to refer callers to other providers without the caller being re-triaged;
– Ability to transfer clinical assessment data to other providers and book appointments where appropriate; and
– Ability to dispatch an ambulance without delay.

CCGs are encouraged to work with their PCT Cluster and Strategic Health Authority leads to use these principles to develop their local service specification.

There are already examples where local systems have decided to vary the way 111 is to be implemented locally as part of a clear view of how to develop integrated 24/7 urgent care. These include:

- Many CCGs are supporting individual practices to improve the speed and effectiveness with which they respond to calls, which in turn reduces pressure on the rest of the healthcare system (as highlighted in our paper in June 2011 *'A new approach to 111'*). It also improves continuity of care which has been shown to reduce unscheduled admissions.

- Other CCGs are also looking at aligning NHS 111 and the GP clinical dashboard so that practices can track the overall use of urgent services by their patients, ensuring there is greater visibility of NHS 111 activity at practice level.

- In Devon they have chosen to take GP OOH calls out of the local specification, helping to manage the risk as 111 is introduced, especially as their local out of hours provider, Devon Doctors, is currently completing 66% of calls with phone advice from a doctor.

- Some systems are introducing 'Call before you go' so that patients, who for whatever reason choose to visit A&E can be offered a community based alternative, when appropriate. Encouraging patients to call NHS 111 rather than just turn up at A&E and, if suitable, directly setting up an appointment with their practice is another option for local commissioners.

- In London CCGs are working together to develop a single electronic end of life register for London as part of a project called 'coordinate my care' (CMC). Once NHS 111 is live in London, patients or carers calling 111 will be flagged as having a CMC entry, the entry will be opened and the agreed care plan can then be implemented. The plan would then be to extend this to other patient groups over time, for example, for the care of patients with long term condition or patients with a mental health crisis.

The clinical NHS 111 leads are currently producing a list of potential service innovation that moving to an NHS 111 service offers and they will be sharing this soon.

These examples highlight the potential to use local flexibility within the national framework. But at the same time we need to acknowledge that many CCGs are reporting that they are facing considerable pressure to sign up to models that offer very little room to develop and use these flexibilities. Too many feel that this is top down politics, implemented by an NHS management system that is required to meet tight timescales on central priorities, even if this is not the government's intention.

APPENDIX ONE

Results from a Survey: How engaged do local clinical commissioners feel in the implementation of NHS 111?

Background to this Survey

At the NHS Alliance Annual Conference in early December, delegates were pleased to hear the Secretary of State confirm his commitment to the principles of local commissioning, local control and local ownership for his health care reforms.

Despite this, there was a general sense of concern expressed amongst the new clinical commissioners about the national specification and roll out of the NHS 111 programme and, in particular, the lack of engagement with Clinical Commissioning Groups (CCGs).

We decided to explore this further. We designed a survey drawing on the experience of two of the NHS Alliance Networks, the Clinical Commissioning Federation and the Urgent Care Network. An invitation was sent on 9th December to all members of the NHS Alliance Clinical Commissioning Federation, including the majority of CCGs across England, to take part in a survey asking 12 multiple choice questions about the implementation of NHS 111. It was made clear that we were looking for responses from clinical leaders across CCGs and that we were looking to understand their local experience of introducing NHS 111. By the end of December, 51 responses were received on a specially designed website.

Results

The survey included 12 multiple choice questions as well as an opportunity to express more general views about the implementation of 111.

Clinical engagement

Few of the clinical leaders who responded to our survey are actively engaged in the process for establishing NHS 111. In answer to 'How would you describe your level of clinical engagement with the process for establishing NHS 111?' only 11% said 'Good engagement, my view was taken into account' with 32% answering 'Some engagement, but no real ability to affect decision' 23% saying 'I knew what was happening but had no say' and 34% saying 'No real engagement, the decision was out of my hands'.

Perceived Quality & Outcomes for 111

We asked four different questions that tested out opinion on how clinical leaders feel 111 will impact on the quality of the local service.

We first asked about the quality of the current urgent care system available to support calls to 111. We described how 'The Department of Health have described 111 as 'the icing on the cake' as the 111 number is designed to sit on top of a well integrated urgent care system.' and asked them to agree with one of four statements. 29% said that they have 'a well integrated urgent care

system with good co-operation across all agencies', 39% agreed that 'Our local urgent care services are good but are sometimes difficult to navigate', a further 23% said 'Our local urgent care services are variable and are often difficult for patients to understand' and only 9% opting for 'Our local urgent care services are fragmented and difficult for patients to understand'.

We next asked whether they agreed or disagreed with the statement 'NHS 111 will ensure that patients get to the right service for their needs more quickly'? Only 2% strongly agreed, 30% tended to agree, 48% tended to disagree with a further 20% strongly disagreeing.

We also asked if they agreed or disagreed with the statement ''NHS 111 will reduce the overall workload of our local urgent care system'? Only 2% strongly agreed, a further 2% tended to agree, 50% tended to disagree with a further 46% strongly disagreeing.

Finally, we asked 'How confident are you that the introduction of 111 in your area in April 2013 will be a success?' On this key question, no-one was very confident, 23% were quite confident, 49% were not very confident and 28% were not at all confident.

Collectively, these answers suggest that at the moment clinical leaders are far from convinced that NHS 111 will deliver the clinical and patient benefits predicted.

Centrally or Locally Driven?

We asked 'NHS 111 is described as being nationally defined but locally driven. What do you think of the balance between Central and Local decision making?' Just 9% of respondents answered that 'We need more support and direction from the Centre' and 14% felt 'The balance currently is about right' with 77% responding that 'There is little scope for local clinicians to shape this service to meet local needs'.

Do you agree or disagree with the following statement 'this roll out is top down politics not local empowerment'? Remarkably, all respondents agreed with this statement, with one third (33%) tending to agree and two thirds (67%) strongly agreeing. This may highlight a wider danger that CCGs feel that they have limited control at this point in the reform agenda.

Why are CCGs choosing procurement rather than piloting 111 locally?

Currently, all CCGs have either agreed to pilot, procure or establish a service around existing providers, as we prepare for the service to go live across England by 1st April 2013. We specifically asked those who chose to go down the procurement route for the main reason for their decision. Of those who answered just 5% *'felt the procurement process would give us more choice'* while 79% selected '*We had no choice. The decision was made by the SHA/PCT cluster*' and a further 16% answered that *'Our procurement advisers recommended that the risk of legal challenge was too great to pilot first'*. One respondent added that they saw it as a *"national dictat - procure or be procured for (and charged more)"*. Another described how "We started by considering a local pilot, but have been told it's too much of a risk. The timetable for implementation is clearly driven from the top. We now must devote resource to ensuring its not going to destabilise our local urgent care strategy."

It is also far from clear that local CCGs are making procurement decisions based on good information about the impact of 111 on wider local heath economy. We asked 'How confident are you that you know enough about what 111 will bring to your local health economy (e.g. in terms of cost, volume of calls, and downstream effects) for your CCG to commit to a 3 - 5 year

procurement at this stage?' Only 11% were quite confident, while 31% were not very confident and 58% were not at all confident.

The specification for the national 111 service

We asked 'Given that 111 is a national requirement, would you commission it as currently specified if you had the choice?' Only 4% answered yes, 73% said no, with 22% not sure.

Is it time to pause on 111?

Given that the Government took the step of pausing and reflecting on the wider Health Bill, we asked clinical leaders whether there might be a similar case for pausing and slowing down the implementation of NHS 111. We asked whether they agreed with the statement '111 roll out should be paused and await full evaluation of the pilots first'? 58% strongly agreed, 37% tended to agree, 5% tended to disagree with no-one strongly disagreeing.

Other Comments

About a third of respondents chose to add further comments at the end of the survey – all of them either amplifying concerns raised by the earlier questions in the survey or highlighting other criticisms.

A substantial number of comments related to the clinical process underpinning NHS 111, including the "need to simplify the process of assessment of patients". One respondent added "for the majority of patients the service works well. For complex cases it is less good and pathways needs to develop to allow these to go straight to triage by clinician. Clinicians should be able to re-triage cases if they believe this to be appropriate. It is not clear that it is cost-effective. There is no evidence of reduction in workload for primary care." There was further criticism of the new approach to call handling "A simple call handling service would seem sensible with local providers linking their telephone systems would seem a cheap workable option. The current proposals will cost our local health economy significant set up costs with little evidence of benefit." Similarly, "urgent care needs calls to be triaged as early as possible by an experienced clinician with access to the patient's medical record." And there was another concern how visits are organised under the new system "visit triage by 111 is done by non clinicians and unnecessary visits allocated, putting more workload on clinicians in out of hours". There were concerns that this might mean that the overall impact would be to "increase the volume of work presenting at Emergency Department". Finally, one respondent highlighted that "feedback from service users is that assessments are cumbersome and prolonged and can delay care."

Many of the comments returned to the theme of the programme being too centrally driven. "I have strong reservations about 111 - the whole of the NHS reforms are being managerially-led and the clinically-led proclamations seemed to have been purely an aspiration which has now been all but sadly lost." Another respondent said "We started by considering a local pilot, but have been told it's too much of a risk. The timetable for implementation is clearly driven from the top. We now must devote resource to ensuring its not going to destabilise our local urgent care strategy." Another respondent focussed on a specific aspect of the programme "the centrally-defined governance arrangements and assurance processes are horrendous, and the lack of local flexibility is antithetical to the supposed local freedoms of the new NHS".

One respondent, although critical of the lack of local ownership felt that some aspects need more central guidance "there needs to be more guidance about the contracts and who can have one and for how long. There seems to be a tendering process with lots of differing potential providers but little co-ordination of CCGs to decide best option. How big does it have to be without losing the local feel and responsiveness?"

Others were concerned about the speed of implementation. "It's too rushed; we have a good OOH service which 111 is going to put at risk." Another commented "we should look at the experience of the pilots -it replaces NHSD at best and fuels demand for urgent care and acute admissions. We need to be able to change the national specification".

There were also concerns raised about the financial impact of NHS 111. One respondent described it as "a terrible waste of money totally undermining the governments claim about local empowerment within the changes". Another felt that "a large regional service will take vast funds from our local service detrimental to local patient care. The 111 number idea is fine but local call handling is essential." A final comment questioned the whole business case for this initiative "we have not actually agreed to pilot - we reviewed the business case for the pilot and rejected it on the grounds that it is not affordable. The key issue is not the clinical model around 111, it is the affordability of the programme. Specifically there is no commitment from the centre to redirect the NHS Direct funding to commissioners to fund 111 locally, and without this the system is unaffordable. CCGs need to have a strong collective voice refusing to proceed with the implementation of 111 without a commitment from the centre to redistribute the NHS Direct funding."