HSJ LOCAL briefing

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November 2012

NHS 111 THE ROLLOUT

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue The government has set a challenging timetable for the rollout of NHS 111. Most commissioners have had less than two years to design, procure and launch the brand new non-emergency telephone number by April 2013.
Context The government faced criticism from all sides for pressing ahead with a national rollout of NHS 111 before the evaluation of the pilot sites was complete. There are concerns the lack of clinical involvement will lead to an increase in pressure on emergency services.
Outcome All but two areas have awarded contracts to NHS 111 providers and are expecting to meet the deadline. The amount of variables in urgent and emergency care systems around the country means the impact of NHS 111 is likely to differ between areas but some increase in demand is likely, at least at first. In the longer term NHS 111 could provide opportunities to redesign services.

The story so far

The idea of an easily memorable three-digit number to help direct patients to the most appropriate service has been around since the 1990s when new telephone only services such as First Direct for banking were very much the zeitgeist.

NHS Direct, which launched nationally in 2000, was originally envisaged as a three-digit number. In 2006 a Department of Health consultation Direction of travel for urgent care identified confusion amongst patients about where to go if they had an urgent healthcare need and plans for a three digit number were revived. They began with the development of NHS Pathways, software that could be safely used by non-clinicians to direct patients to the most appropriate service.

In 2009 phone regulator Ofcom allocated the 111 number to the DH for nationwide use. The DH set up a programme board and commissioned Sheffield University to evaluate four pilot sites: County Durham and Darlington, Nottingham City, Luton and Lincolnshire.

When the coalition government took office in 2010 there was a step change in pace. In August that year then health secretary Andrew Lansley announced NHS 111 would be rolled out nationally by April 2013 but commissioned locally. However, it was not until the summer of 2011 that NHS deputy chief executive David Flory asked strategic health authorities to "start to finalise arrangements" to meet the deadline. At this point only five areas had plans to start a procurement process.

The essential components of an NHS 111 service are that calls can be "warm transferred" to another provider, such as GP out of hours, without the caller having to repeat details. The service must also be able to dispatch an ambulance if necessary without the need for a transfer.

How it works

The objective of NHS 111 is to direct patients to the "right place, first time". The government's expectation is that it will improve patient experience and drive efficiencies by reducing pressure on emergency departments and the ambulance service. The theory is that as a local service, NHS 111 can be more integrated into local health systems than NHS Direct.

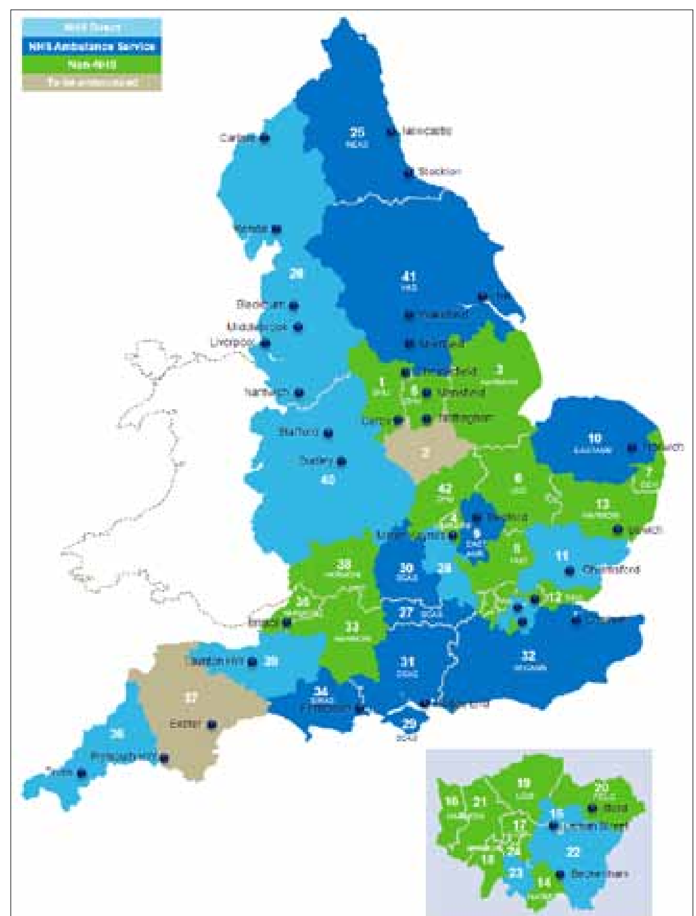
NHS Pathways works using a directory of services populated by commissioners. Call handlers triage calls according to the algorithm. This produces a recommendation for the most appropriate service based on the directory, such as to advise the patient to attend an urgent care centre, accident and emergency or to undertake self care. Commissioners can programme Pathways to encourage the use of certain services over others.

This local information is the key difference to NHS Direct. For example, in the Inner North West London cluster some local GP practices have agreed NHS 111 call handlers can book patients same day urgent appointments with their local GP, when clinically appropriate.

Data collected through NHS Pathways will highlight where patients have been advised to attend a more acute service than necessary because there is no alternative. It is hoped this "gap analysis" will be a valuable resource to commissioners. For example, if significant numbers of patients are being sent to A&E to have their catheter changed late at night this could identify a need for a 24-hour community nursing service.

Who will be providing NHS 111?

NHS 111 services could be commissioned at primary care trust level. However, very few services



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have been commissioned over such a small area.

The North East, North West, Yorkshire and Humber, South East Coast, and the West Midlands have all commissioned regional services. In the South West and South Central, contracts have been awarded across PCT clusters. In the East Midlands, East of England and London the picture is more mixed – there are 11 separate contracts across the capital, for instance.

NHS Direct won about a quarter of contracts covering a third of the country. Harmoni was the most successful non-NHS provider but a number of smaller not-for-profit out of hours services have also won contracts. Ambulance trusts are the main provider in three regions and have some smaller PCT cluster level contracts.

So far 42 contracts have been awarded. There are still two to be announced. Cambridgeshire and Peterborough chose not to go to procurement but opted for a default service provided NHS Direct in partnership with the local ambulance service and out-of-hours providers.

PILOT PERFORMANCE: change compared with control sites and adjusted for other variables

	Emergency attendances		Emergency ambulance calls		Ambulance incidents		Urgent care	
Area	Change	SS	Change	SS	Change	SS	Change	SS
Durham and Darlington	-2.3%	N	-11.40%	Y	1.60%	N	8.90%	N
Nottingham	0.60%	N	2.60%	N	2.30%	N	-0.50%	N
Luton	3.50%	N	-2.10%	N	-2%	N	-16.10%	Y
Lincolnshire	3.30%	N	10.40%	Y	4.80%	Y	-3.60%	N

SS = statistically significant

Why has NHS 111 been controversial?

The controversy has centred on four main areas:

- The cost and system impact and clinical involvement. According to the NHS service specification the cost per call for NHS 111 should be around £8, almost a third of what NHS Direct calls cost. This efficiency is achieved by using fewer clinicians, the safety of which is ensured by using NHS Pathways. However, critics claim the service is too risk averse and this will lead to more patients referred on to face-to-face services unnecessarily.
- The procurement process itself. There was confusion among bidders about whether they would be required to take on NHS Direct staff under transfer of undertakings protection of employment legislation (TUPE). Meanwhile, some potential bidders were also wary of signing a block contract on such an untested service when activity levels were hard to predict.
- The future of NHS Direct and its staff. Although not popular in all quarters NHS Direct's 0845 number is a well-established national service that the government decided to abolish without, unions claim, adequate public consultation. NHS 111 is not a like-for-like replacement and will not provide specialist health and information advice, including advice from dental nurses. This is also fuelling concerns NHS 111 will drive pressure on other services.
- The speed of the rollout. When Andrew Lansley announced 111 would be rolled out nationwide by April 2013 only one of the pilots was up and running. Unions including the British Medical Association and the Royal College of Nursing, representative bodies such as the Ambulance Service Network, NHS Direct and even some private sector firms interested in bidding for the contracts all called on the DH to await the outcome of the Sheffield University evaluation before pressing ahead with the rollout.

Cost and system impact

The Sheffield University evaluation published in October concluded:

"Although the four pilots in the evaluation operated differently to some extent, they seemed to produce the same lack of measurable benefit in terms of improving urgent system user satisfaction and reducing use of emergency care services."

The Durham and Darlington pilot was delivered by North East Ambulance Service Foundation Trust while the other three pilots considered by the research team were led by NHS Direct. In the North East pilot 17 per cent of staff were registered nurses, compared to 38 per cent in the NHS Direct sites.

The evaluation looked at the first year of operation of each pilot. It found that although calls in the NHS Direct sites were on average around twice as long as in the North East pilot the proportion of callers not referred on to another service was significantly higher – between 24 and 30 per cent, compared to 10 per cent in Durham and Darlington. It is likely many of these calls were closed with self-care advice.

NHS Direct chief executive Nick Chapman says it is disappointing that the service specification on which local procurements were based was set out before the publication of the evaluation. He believes the evaluation demonstrates the value of more clinical involvement. NHS Direct will use fewer clinicians in the sites where it has won contracts in order to meet the cost thresholds set out in the service specification.

Overall the evaluation found a statistically significant increase in emergency incidents attended by ambulance crews. However, the system impact was mixed across all four sites and complicated further by other changes to the urgent and emergency care system in both the pilot sites and the control sites they were compared against.

The report estimated there was a 21 per cent chance of NHS 111 saving the wider system money. The Sheffield researchers could find no international evidence relating to telephone triage by non-clinical staff so NHS 111 really is uncharted territory.

Durham and Darlington has continued to see a decrease in A&E attendances when compared to the control site Newcastle upon Tyne PCT. However, the Sheffield researchers said the comparison between the two sites "was particularly difficult to interpret" as a reconfiguration of emergency services in the control site had moved the A&E into the city centre leading to an increase in attendances.

The pilots in the Isle of Wight, Derbyshire and Cumbria and

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Lancashire which went live in 2011 have all seen increases in A&E attendances and ambulances arriving at the scene according to DH data since NHS 111 was introduced.

However, advocates for NHS 111 say the pilots will need much longer than a year to achieve results and that it was always intended the service be part of a wider reorganisation of the urgent and emergency care system. They question whether it is possible to pin the blame for increased activity on NHS 111 with so many other variables in the system.

DH national clinical director for urgent and emergency care Matthew Cooke says new services take at least three years to "bed in" and it should be viewed as a tool to help reorganise urgent and emergency care.

NHS Pathways, which is also used by some ambulance trusts and out-of-hours providers, has been blamed for a rise in demand on emergency services in some areas of the country, including Cornwall. A clinical review group convened by the Sheffield researchers to analyse a number of calls to NHS 111 triaged using Pathways found there were "lots of unnecessary/irrelevant questions" particularly for children.

NHS 111 providers can choose from three DH approved clinical assessment tools, including Capita's Clinical Solutions, which claims to increase levels of self care. However, it is thought most are using Pathways.

Simon Featherstone, chief executive of North East Ambulance Service Foundation Trust, describes the directory of services as "the engine" of NHS Pathways.

The trust has been working with the DH on the development of NHS Pathways since 2006 and had already set up a single point of access when it was designated an NHS 111 pilot.

Mr Featherstone expects the gap analysis provided by Pathways to allow the decommissioning of hospital services as alternatives are set up in the community. He sees NHS 111 as a tool to drive integration and hopes social care services can eventually be added to the directory of services.

He said: "NHS 111 is a long-term journey... there are going to be a lot of inappropriate referrals for a considerable period of time until the rest of the system, particularly services we need to develop outside of hospital, are ready to accept patients... The whole system needs to be built around this."

Pathways is overseen by a clinical governance group made up of representatives from the relevant medical and nursing royal colleges. It is constantly under development and may become more sensitive over time. Commissioners do have some control over where Pathways directs patients and can set up the "hierarchy of dispositions" within the directory of services to, for example, favour an urgent care centre over A&E where appropriate, even if it is not the closest setting to the patient.

However, John Horrocks, chief executive of Urgent Health UK, which represents social enterprise out-of-hours providers, said in many places the directory of services is not being treated with sufficient importance. He wants it to be made responsibility of the director responsible for the urgent care budget in recognition of its importance.

"It's the responsibility of commissioners to maintain the directory of services; the problem is they're all over the place due to the reforms," he said. "In a lot of areas the directory feels like it's falling through the cracks a bit and is often treated as an administrative task."

Members of Urgent Health UK are also concerned out-of-hours GPs will see more unnecessary work. A survey of members in areas where pilots are running found an increase in treatment centre visits and a reduction in calls closed over the phone.

The procurement process

All but two of 44 procurements are now complete. A few weeks ago DH lawyers confirmed that the Cabinet Office guidelines they had put in place in October 2011 had no legal basis with non NHS providers.

This has already caused problems in the North East where the contract was tendered and bid for prior to October 2011. Following a nine month row, in which NHS Direct asked the DH to intervene, the commissioners have agreed to pay the successful bidder – a partnership between North East Ambulance Service and Northern Doctors Urgent Care Ltd – extra to take on NHS Direct staff.

Elsewhere in the county, NHS Direct staff are successfully transferring to the NHS ambulance trusts that have won contracts. Although 111 providers are under a contractual obligation to the commissioners to offer NHS Direct staff the same terms and conditions, including pay and pensions, they do not have any legal obligations to the employee.

Mr Chapman said: "Somebody who is transferred under COG who started employment with one of these providers could in theory be unfairly dismissed on day one and have no right of redress through to an employment tribunal. Unlike TUPE there is no underpinning legislation."

As a result staff are being asked to transfer voluntarily but without protection more staff are likely to opt for redundancy, particularly those with a long length of service in the NHS. This has implications for the cost of decommissioning NHS Direct's 0845 number.

The original impact assessment for the introduction of a three-digit number to access NHS services identified likely call volumes as between 15 and 30 million a year. Mr Chapman said volumes received would be influenced by the scale of the national publicity as well as the quality of the service, particularly the online aspect.

The 101 number, introduced for non-emergency calls to police last year, was not very highly publicised. There has reportedly been a lower call volume than anticipated.

Mr Chapman said commissioners were being flexible and recognised they may have to get back round the table if volumes differed widely from those predicted.

Professor Cooke accepts it is difficult to predict how much the switchoff of NHS direct will change the volumes and profile of the calls. However, he said national publicity will encourage people to use NHS 111 before they go to A&E or call 999, which could lead to less demand for these services.

The future of NHS Direct

NHS Direct will shrink from an organisation with a turnover of £144m to around £46m. This figure may increase slightly if the NHS Commissioning Board commissions national complex health and medicines information, dental nurse advisers and online health and symptom checkers with nurse callback, which will be included on the new website.

Mr Chapman said NHS Direct was currently waiting "to agree the final model" for those services but was clear NHS Direct's role would not be to run the new NHS website.

NHS Direct is in the foundation trust pipeline but with such a small

turnover and short-term contracts it is unlikely to pass Monitor's tests. Its board has previously said it would consider a social enterprise but this could leave it at a disadvantage in future bids for NHS 111 when competing against ambulance foundation trusts and private providers such as Care UK which bought Harmoni earlier this month.

Mr Chapman said the social enterprise option was still on the table, along with merger and a private sector partner, but he declined to speculate about which organisations could be appropriate. Unions are hoping for a change in government that would lead to a relaxation of the requirement for all NHS trusts to become foundation trusts or failing that some kind of special arrangement will be made that allows it to remain an NHS organisation.

The speed of the rollout

In June this year the DH agreed to allow clinical commissioning groups to apply for an extension to their go live date of up to six months. The fact that only three clusters took this opportunity probably reflects the fact that most were well advanced in the procurement process by the time this announcement was made. What critics really wanted was a pause in the procurement process to await the evaluation.

London has taken a different approach and has only commissioned short pilots of around two years. This approach was driven by concern that NHS 111 did not just add another layer of confusion to the already complex urgent and emergency care system in the capital.

The plan is to begin a full capital-wide procurement in 2014-15 once the best 111 operating model has been identified, which could be smaller services for PCT cluster areas or one or two providers for the whole city.

The work will be co-ordinated by the NHS London team, which has been leading on NHS 111 so far but as of April they will be based in the commissioning board's local area team.

They have combined the introduction of NHS 111 with the introduction of an end of life care record that can be viewed by call handlers, London Ambulance Service, district nurses and out-of-hours GPs in order to improve patient experience and increase the number of patients who achieve their wish to die in their own homes.

Elsewhere most other contracts are for five years with a three-year break clause. NHS Direct's 0845 number will be replaced by NHS 111 everywhere except Devon, Plymouth and Torbay and Leicestershire and Rutland clusters, areas which requested an extension, until 30 June.

Areas are planning a soft launch before 21 March but nevertheless Mr Chapman admits it is "much more of a big bang than we would have liked". "Any slippage of mobilisation would give rise to problems. We are being asked to provide contingency support in the event of problems; we're planning for the worst but hoping for the best."

The DH Service Readiness guidance sets out a mobilisation process of nine months between the award of a contract to a provider and the public launch which puts a lot of areas on an extremely tight timescale.

Providers will be required to demonstrate to the DH robust clinical governance arrangements, service readiness and a test of their directory of services. The service will then be soft launched before a decision is taken on whether to proceed to the public launch.

NHS Direct has been asked to provide contingency support in the event that some areas are not ready to go live. The situation is complicated by the fact NHS Direct staff will be transferring into 111 services but the organisation has been making a lot of use of agency staff in the past year so has established flexible working arrangements in place.

Mr Featherstone said the NHS 111 programme board had been "well run" and has been putting organisations through their paces in terms of clinical governance. He is confident the North East will go live on time. Both Mr Featherstone and Urgent Health UK stress the importance of making sure patient transport arrangements are agreed.

Other issues cited frequently as likely to cause problems on go live are the interoperability of systems, including the Adastra system used by many GPs, and sharing of special patient notes which are used for patients with long term conditions or at the end of life and can help avoid admissions.

Will it work?

Despite some of the early rhetoric around the potential of NHS 111, it is not a quick fix. If it works it will be a valuable tool for commissioners that helps to identify unmet need and inform service redesign as a result. If it does not there is a real risk it could put additional pressure on already stretched systems as it beds in.

There is no doubt the rush to roll out NHS 111, particularly at a time when the commissioning system is in flux, has caused problems. It has not allowed for the detailed conversations about urgent and emergency care pathways which NHS 111 needs to bring about the most significant potential benefits and has generated opposition that may have been avoided with a more phased and inclusive approach to the roll out.

The Sheffield evaluation ultimately proved inconclusive as to the wider system impact, complicated as it was by other changes in local health economies, but it seems to suggest the service may generate more demand rather than redirect existing demand. The DH argument is that until you get a national rollout with the accompanying publicity it will not be possible to realise the full benefits.

With less than four months until the national go-live date when the Christmas break is accounted for, there are currently only 10 areas of the country live and reporting into the DH minimum data set. More are coming online all the time but there is still a significant amount of work to do before 21 March.

The procurement process could also have been improved with more time, particularly in relation to the workforce issue. But although the timetable may have been driven by political imperative there is still an opportunity for the introduction of NHS 111 to provide a catalyst for change.