TRAFFORD COUNCIL

Report to:	**Health Scrutiny Committee**
Date:	**12 September 2013**
Report of:	**Gina Lawrence, Chief Operating Officer - Trafford CCG**
Report for:	**Noting**

Report Title

NHS 111: Update

Summary

Following recent media reports, the Committee's Chairman requested an update on the 111 service.

Recommendation(s)

1. To note the update;
2. To consider any further action as appropriate.

Contact person for access to background papers and further information:

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Background Papers: None

NHS 111

INTRODUCTION AND BACKGROUND

1. NHS 111 was introduced to make it easier for the public to access urgent healthcare services. It was considered that patients in England were confused about where they should turn for medical care when GP surgeries were closed, or when they were away from home, and almost a third of people who needed out of hours care went straight to A&E.

2. The NHS 111 service was co-designed by the NHS and Department of health and specified nationally so that a consistent identity and quality of service would be maintained across the country. It is commissioned and (will be) delivered locally by the NHS in a way that is most appropriate for any given area. Calls are answered by trained advisers, supported by experienced clinicians, who assess the caller's needs and determine the most appropriate course of action, including:

    - Information, advice and reassurance
    - Referral to a service that has the appropriate skills and resources to meet the needs of the caller.
    - Ambulance dispatch where the caller is facing an emergency
    - Signposting to an alternative service where out of scope of NHS 111

3. NHS 111 operates on 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
    - Ability to dispatch an ambulance without delay.

4. NHS 111 is an urgent care phone line and was always intended to replace NHS Direct's 0845 4647 service. However, it has also become standard to incorporate GP out-of-hours (OOH) telephone access too. While this has never been centrally mandated, local commissioners felt it appropriate to avoid unnecessary duplication of services, and to simplify the route to NHS care for patients.

5. NHS 111 also has a clear clinical governance regime based on meaningful and effective local clinical leadership. Coupled with this is the principle that NHS 111 clinical governance is about the whole patient journey and not just the telephone call at the outset.

6. NHS 111 was first launched as a series of four small-scale local in August 2010, run either by the North East Ambulance Service NHS Foundation Trust or NHS Direct. In December 2010, the former Secretary of State announced a deadline for a full roll-out of April 2013.

7. Local commissioners were given the responsibility for commissioning and procurement of NHS 111 services, supported by a small subject matter expert team (telephony and call-centre) hosted by the Department of health. The North West was identified as a 'site' and NHS Blackpool were identified as the lead commissioner. Clinical leadership was provided by Dr Jerry Martin of NHS Bury.

8. The proposal was once the commissioners and the central Department of Health team had signed off a site as being ready to go live it would enter into a 'soft-launch' phase where out of hours numbers would be routed into 111, so the service only had to cope with existing demand. This was proposed to last between 2 – 4 weeks at which point the service would be advertised locally, with leaflet-drops. Radio adverts, and information in GP surgeries.

SOFT-LAUNCH OF NHS 111 IN NORTH WEST

9. NHS 111 went live in the North West Region via a 'soft launch' on 21 March 2013, following authorisation by the Department of Health. This authorisation followed assurance from the new provider, NHS Direct (which won the contract all three NW clusters) that staffing levels were correct.

10. During the evening of 21st March it became very clear early on following the switch-over that the system was failing with patients waiting up to forty minutes to have a call answered. In order to ensure patient safety a decision was taken – where possible – to switch calls back to local Out of Hours (OOH) providers.

11. Mastercall were the OOH provider for Stockport and Trafford and were able to take back calls.

12. An Emergency Contingency Planning meeting was held on 22 March comprising NHS Stockport, NHS Trafford and Mastercall where it was confirmed Mastercall could get back staff made redundant to cover the call handling and clinical triage and ensure a safe service over the Easter period.

13. Following this meeting all Trafford GP practices were contacted to switch phone systems back to Mastercall or amend answer phone messages asking patients to ring the Mastercall number. A briefing was issued by NHS Trafford to all GPs/Practice Managers.

14. Trafford and Stockport CCGs further agreed that Mastercall would continue to deliver the OOH service for a further three months and this was later extended until a new clinical model has been agreed for the NW and a procurement process completed to identify a new provider. This is consistent across the North West where OOH providers have taken back calls.

15. Across the whole of the NW 70% of calls were taken back from the new service to other providers, in most cases the OOH providers. In Greater Manchester it is only Salford CCG which is still currently using NHS 111 with NHS Direct as the provider

16. The issues that arose during the soft-launch impacted across the North West and also the West Midlands, where NHS Direct was also the provider. NHS Direct won a number of contracts to deliver NHS 111 nationally but the NW and West Midlands were the largest.

17. As a consequence Deloitte were commissioned by NHS Direct, NHS England and the National Trust Development Authority to undertake a review of the launch issues. Their report has been published and summarises the main failures as lack of capacity in the provider (NHS Direct) to manage the demand. This was caused by:

- A shortage of fully trained staff
- Calls taking longer to manage than had been expected
- Some difficulties with managing onward flows for calls

18. NHS Direct were required to produce rectification plans; however, these were considered to be unaffordable when also considered alongside the major credibility issue. North West Clinicians did not feel this could be re-gained and it was subsequently agreed that a new clinical model would be designed and the service re-procured.

19. As reported recently in the media, NHS Direct decided to pull out of the contracts rather than continue until the procurement of the new provider. As a result a stability partner needed to be found and North West Ambulance Service NHS Foundation Trust was identified locally. The decision to ask ambulance services to provide an interim service was made nationally by NHS England.

20. While Trafford patients have been advised to contact the out-of-hours service, some patients will still be using the 111 service as the number is in the public domain. These patients will continue to be handled as required by the specification.

21. There have been no serious incidents involving Trafford patients as a result of the issue with the NHS 111 service.

THE NEW CLINICAL MODEL

22. It was agreed by all CCGs that a new clinical model for NHS 111 should be developed for use across the North West.

23. Having received confirmation from the government that they remain committed to the NHS 111 concept, clinicians from across the North West met to consider the model of NHS 111, working within the framework of the national model. The North West NHS 111 Clinical Group was established to lead this piece of work and identified the mandated elements of a NHS 111 service as:

    - Number is 111, available 24/7/365
    - Electronic data transfer to enable ambulance dispatch, without the need to transfer/re-triage the call
    - Capture of patient demographics, as a minimum, and pass these on to any provider the caller is referred to
    - Offer of a clinical assessment (although this does not have to be a definitive clinical assessment)

24. The North West Clinical Group further identified the following elements of NHS 111 that are not mandated:

    - Calls to GP OOH services do not have to be routed via NHS 111; this is a commissioner decision.
    - Appointment booking is for local determination 9for all providers)
    - The NHS 111 service does not have to include assessment by clinicians. Cases that cannot be completed by a call handler (because of the complexity) could be referred to another service for that element of the assessment to be completed.

25. The Clinical Group met three times and subsequently defined a new clinical model. However, at the Association of Greater Manchester CCGs meeting in July, an exercise was requested to estimate the costs of potential clinical models for the NHS 111 service to be re-launched by September 2014.

26. As a result, a paper on NHS 111 was presented to the GM Association of CCGs Association Governing Group (AGG) on 8th August 2013. The paper set out the potential options for the new NHS 111 clinical model with comparative costs – the existing service design costs £6.9m for the North West.

27. NHS Direct has now given notice to withdraw from the contract and the stability partner during the transition has been agreed as NWAS. There is the possibility that the stability partner may request additional resources particularly if there is additional clinical input although savings from the stepping down of NHS Direct could mitigate the additional costs.

28. The AGG felt there were benefits of joining up 111 with Out-of Hours (OOH) which would also benefit from joint procurement arrangements.

29. The North West model, proposed by the clinical group is as follows:

- NHS 111 calls would be received by the new service and through initial triage, calls requiring a 999 disposition would be identified and an ambulance dispatched; calls requiring health information would be completed and information supplied; and those needing sign-posting to other services would be so directed. This mirrors the existing service.

- However, the recommended model provided the option for those calls with a primary care disposition to be sent on for definitive clinical assessment and management within Out of Hours providers (an alteration to the original model where all dispositions were part of the NHS 111 service). It would remain possible for a mix of handling the final primary care disposition at CCG level if CCGs required a mix of the 2 options for final definitive clinical assessment.

- In hours, the definitive clinical assessment would be performed by a senior clinician (this being defined as nurse practitioner, senior paramedic or doctor) A variation of this is for the assessment to be performed by a doctor although this option was considered by the North West Clinical Group but discounted as likely to be both unaffordable and unachievable with the need for large scale doctor appointment.

30. The AGG noted that some clinicians from Greater Manchester hold strong views that this doctor-only option needs further consideration and the AGG queried whether the corresponding reduction in A&E costs had been analysed against the cost of more senior clinical input.

31. The costs have yet to be discussed by the Chief Finance Officers and there are still questions regarding value for money, affordability, what the 111 service replaces (what is stopped because of its introduction) and the impact on out of hospital plans.

32. The AGG recommended that the model described above is progressed with the doctor-only variable to available as an option.

33. The AGG agreed the importance of alignment of 111 and Clinical leadership with the Urgent Care networks, especially the Local Clinical Assurance Groups.

34. A GM commissioning foot print was agreed, to be procured as part of the North West umbrella.

GOVERNANCE

35. The current and future GM organisation and governance structure for NHS 111 is attached in Appendix 1.

36. The Local Clinical Advisory Group (LCAG) covers Trafford, Stockport and Tameside & Glossop CCG's. Dr Chris Tower from Trafford has agreed to be the Interim Chair of the group. Dr Tower has recently been appointed Associate Director of NHS Trafford CCG for Urgent Care.

37. The LCAGs have continued to meet to fulfil their clinical governance assurance function for the service. This remains an important role in terms of assuring the quality of the current service and also learning lessons to inform the future model. Investigation and analysis of complaints remains important and this is done via the use of Health Professional Feedback forms. There have been no serious incidents recorded involving Trafford patients.

PROCUREMENT

38. The indicative procurement timeline assumed an invitation to tender in September; however, this has been delayed as debates over the clinical model have continued.

39. The contract award is now expected to be early 2014 with a phased mobilisation proposed to be completed by end of September 2014.

UPDATE

40. As the situation with regard to NHS 111 continues to develop a verbal update will be provided to the meeting by Gina Lawrence, Chief Operating Officer for NHS Trafford CCG on any changes to the proposals detailed in the report.