The BMA’s General Practitioner’s Committee (GPC) supports the principle of developing an easily accessible national telephone number for patients who have urgent health problems. We are however extremely concerned that the new NHS 111 service is being rolled out without full, truly independent and thorough evaluation of pilots and without adequate input from local clinicians. We have been made aware of a number of problems with the pilots, examples of which are included as case studies at Appendix I.

The GPC calls on the Government to slow procurement of NHS 111 services to allow for proper evaluation of the pilots and to adopt a flexible deadline for full implementation of the service to ensure that fledgling clinical commissioning groups can play a full role in procurement decisions.

Further procurement of NHS 111 services should not take place without full evaluation of the pilots

The University of Sheffield’s final evaluation report of NHS 111 pilots is due to be published imminently1. This should provide the proper basis for further consideration of any problems encountered and refinement of service specifications prior to roll out. Indeed, it is our understanding that the Department of Health has asked for the publication of a minimum dataset to help local commissions determine what model of call handling would be most appropriate for their circumstances.

Yet procurement of NHS 111 services is being rushed ahead without careful reference to the pilots and subsequent analysis of what has happened to them. The Department’s Stocktake and Stabilise Project within PCT clusters appears to be being used as an opportunity to bring forward or renegotiate contracts with existing out of hours providers. Instead contracts with existing OOH providers should really be extended to allow proper evaluation of the pilots to take place and to give local commissioners the opportunity to make appropriate procurement decisions.

The introduction of NHS 111 requires considerable changes to be made to existing services. Others have already voiced their worries.2

Evaluation of the pilots must include consideration of the all of the following factors:

- **Fitness for purpose of the new service** Before full implementation of NHS 111 we must be confident that the service will offer more than a memorable number and that well-trained call handlers will direct patients to the appropriate services and offer good advice on self-care for minor ailments. We are not confident that single triage is a worthwhile objective. As medical defence organisations always point out, clinicians should not rely on information elicited by others without testing its veracity for themselves. On the whole, clinical triage should be based on:
  a. a single complete assessment by the same team that actually delivers the frontline care if required
  b. clinical assessment by a doctor or senior clinician with direct access to a doctor who can see the patient themselves if necessary.
  c. seamless transfer of clinical data between providers

- **Impact on existing services (urgent, unscheduled, emergency, out of hours and GP services)** The new services will inevitably change patterns of consultation across local health economies. Before NHS 111 is fully implemented, the Department should be confident that overly risk adverse call handlers will not place unnecessary and costly

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1 The University of Sheffield is undertaking an evaluation of the NHS 111 pilot sites, which is due for publication in Spring 2012. The interim reports were published in May and October 2011
   www.shef.ac.uk/polopoly_fs/1.108894!/file/NHS111Interim2final.pdf
burdens on ambulance services and GP and nurse practitioner appointments. NHS 111 must not dictate inappropriate or unrealistic deadlines for other services. It must not inappropriately increase the workload of local emergency departments, nor result in inappropriate displacement of OOH work to GP practices. The principle that OOH services are for urgent matters only should remain. Doctors must retain clinical autonomy when deciding what is best for the patient and must continue to have the ability to refer to another provider where they consider this to be necessary.

- **Smooth transition for patient safety** The transition from existing arrangements for urgent, unscheduled, emergency and out-of-hours care must be well handled and not result in unreasonable pressure on already stretched services. In some areas, the procurement of NHS 111 could financially and operationally destabilise existing out-of-hours services. If this happens at the same time that they are called upon to provide additional support to the new service, patient care could suffer.

- **Value for money** Experience of NHS Direct and NHS 24 Scotland suggests we might expect NHS 111 to lead to increased demand for healthcare services and higher referral rates. If this happens, we must be sure that those extra referrals are a cost-effective and appropriate use of NHS resources. NHS 24 in Scotland costs £64 million a year and serves fewer than 5 million people.

- **Local sensitivity** NHS 111 services must be locally appropriate. We suspect large remote call centres will struggle to deal with rural areas, where local knowledge is particularly important. Particular attention should be given to patients living near the English borders to ensure their care is not compromised by the introduction of NHS 111.

**Procurement must be driven by clinical commissioners**

It is clinical commissioners, not PCT clusters or SHAs, that should shape the future of local urgent and emergency care services. Decisions should be based on local circumstances and existing services so the solution is locally appropriate.

Local experience of NHS 111 implementation varies widely. In some cases, shadow clinical commissioning groups are being asked to make procurement decisions despite not yet being authorised bodies themselves. Elsewhere clinical groups are not even being engaged in specification design for NHS 111 services in their area. This is of course entirely contrary to the principles of clinical commissioning.

We believe there is a real risk that costly, ill-conceived and unalterable arrangements for urgent and out-of-hours care will be imposed upon or inherited by clinical commissioning groups, which will ultimately have to deal with the consequences.

Procurement should give every type of provider a fair chance to bid to host the 111 service and not allow contracts automatically to be awarded to the cheapest provider without regard to quality and local experience.

Consideration should be given to extending the contracts of existing OOH providers until CCGs are fully established, have assumed commissioning responsibilities from PCT clusters, are in a position to advise on the development of the NHS 111 specification, and can make informed commissioning decisions.

**Roll out of NHS 111 should be subject to a flexible deadline**

A comprehensive NHS 111 service is currently expected from April 2013. A more flexible deadline for full implementation should be adopted to give fledgling clinically led commissioning groups a chance to become fully established and ready to drive local procurement decisions at a pace that will ensure that the right decisions are reached.
APPENDIX I

CASE STUDIES

Case Study One – Lack of clinical engagement with Shropshire County and Telford & Wrekin CCGs

GPs in Shropshire pride themselves on the high quality of their OOH service, known as Shropdoc. They believe one of the reasons for its success is that they use local clinicians to triage urgent calls. However, GPs believe this quality of care is now in jeopardy because of the changes being proposed due to the implementation of NHS 111 in their area.

To date, NHS 111 Service procurement has continued in Shropshire without any of the Shropshire County and Telford & Wrekin CCGs’ concerns being addressed. These were expressed at a meeting in November 2011 with representatives from the two CCGs, the LMC, the OOH provider, the NHS 111 Procurement Team and a patient representative.

The key concern is that the triage function is to be taken over by NHS 111. The CCGs believe that replacing triage that uses highly trained and experienced local clinicians with an algorithm process handled by non-clinicians would be extremely detrimental to urgent, unscheduled and emergency and OOH services.

They are opposed to introducing a major new urgent healthcare system that has not been properly evaluated, will have a significant cost attached to it and is being installed at a time of financial constraint. In addition, the change over between two very different systems will have a significant effect on neighbouring patients in Powys, Wales, who use the Shropdoc OOH service.

Local CCG leaders have shared some experiences of similar disruption that has occurred in the past. Shropshire went through a comparable process when NHS Direct took over call handling for GP OOH care. The results were chaotic and put patients at risk of real harm. Clinical triage was re-instated and has been the back-bone of the high quality OOH care in Shropshire ever since. Local clinicians are determined that this episode will not be repeated.

The CCGs believe that whatever the merits of the NHS 111 Service as a single point of access for urgent care, it makes no sense for it to be introduced in a ‘one size fits all’ manner that removes the very thing that makes GP OOH care in Shropshire of such high quality - a highly trained and experienced team of OOH triage clinicians. Any change to urgent care should surely build on what is excellent. Replacing it with something untested will not only be costly financially, but could be costly in terms of patient health.

The West Midlands NHS 111 Service Specification covering the Shropshire area is unreferenced, and there is no evidence base for the claims it makes for improving care. It makes no mention of the results of the NHS 111 Service pilot evaluation studies, and the impression the CCGs have from reading these is that the best feedback is from areas with previously poor OOH services.

Shropshire wants to retain clinical triage for GP OOH care and wishes to address the issues around quality and equity of access to urgent care with the Shropshire Unscheduled Care Strategy. If this strategy is to develop in a manner that truly represents the local commissioner-led evolution of health care for urgent problems, then the introduction of a single point of access must be properly evaluated and seamlessly adopted into the local urgent care strategy.

The national specification for the NHS 111 Service is that it must be able to dispatch an ambulance and there are only two software packages that have a UK license for this, namely NHS Pathways and the old 999 software that has been superseded. The CCGs suggest that they could find a way to adapt the Service Specification and NHS Pathways to achieve the best from NHS 111 and incorporate clinical triage. However, to do this it is essential that the procurement for the NHS 111 service is paused in order to give time for a local solution to be found.
The Secretary of State has confirmed, in letters to local Shropshire MPs, his intention that local GPs should have input into the process. At present the tendering date is the end of February 2012. Conforming to such a tight deadline may result in a repeat of the NHS Direct problems.

Case Study Two – Nottingham City

GPC has received reports from Nottinghamshire LMC that clinical commissioners have not been engaged in the procurement, implementation and governance of the local NHS 111 service. In addition, the PCT recognises that removing funding from existing OOH services may result in gaps in urgent, unscheduled, emergency and OOH care for patients.

The PCT’s response to a Freedom of Information (FOI) request stated that the Department of Health allocated an extra £50,000 to NHS Midlands Strategic Health Authority (SHA) in September 2011 ‘to support clinical engagement’ with the pilot. This immediately suggests that, prior to this date, the PCT/SHA had failed to engage clinicians sufficiently to ensure the local NHS 111 Service could be designed and established in a safe, cost-effective way. This further investment clearly demonstrates that the Department was concerned about the lack of engagement with clinicians, and recognises the need for local clinical commissioners to shape local NHS 111 Services. Indeed, the Secretary of State for Health is absolutely clear that CCGs must be signed up to NHS 111 locally. He has insisted that it is for local commissioners to make judgments on local procurement, implementation and governance.

The PCT’s FOI response goes on to say that ‘in the short term, there is no increase in costs to the PCT associated with more people needing to be seen by our OOH provider, although it will clearly impact on their costs’. We can deduce from this statement that the PCT is aware that destabilising health economies in this way may well lead to OOH providers struggling to survive and potentially having to stop operating. Regardless of whether this is an unintentional or intentional side effect of implementing the NHS 111 Service, this could result in incomplete urgent, unscheduled and emergency and OOH services in many regions and has the potential to seriously jeopardise the safety of patients.