Publications Gateway Reference No.02919
Office Ref: BH/2015/155

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To: All NHS 111 Commissioners

23 January 2015

Dear Colleague,

Early Clinical Input into NHS 111 services

As you know, this winter local health services are responding to the highest ever number of NHS 111 calls, ambulance calls, A&E attendances and emergency admissions in NHS history.

Managing this demand requires us to respond as a whole-system to find solutions in out-of-hospital urgent care settings as well as the flow of patients through hospitals' A&E departments, in-patient beds and the provision of social care services to help manage the timely discharge of these patients.

As commissioners of NHS 111 services you are already playing a critical role in directing an unprecedented number of patients to the most appropriate care for their needs. However, I would like us to consider how we can use the work completed last year as part of the NHS 111 Learning and Development Programme, to do more.

Early clinical review of urgent (green) ambulance dispositions: All NHS 111 Learning and Development sites where this was piloted demonstrated that early clinical assessment of urgent (green) ambulance dispositions led to a significant number of changes, mainly showing reduced urgency or diversion to primary care, especially GP out of hours (GP OOH) and some diversion to A&E. The careful selection of clinicians undertaking the assessment was a pre-requisite for the success of the process.

Early GP and Support Clinician Involvement: The addition of GPs in contact centres has been shown to reduce the urgency of primary care dispositions, particularly for complex cases and for 'refused dispositions' following an NHS Pathways assessment by a Health Advisor. GP presence in the contact centre increased the knowledge and confidence of Health Advisors. In addition the introduction of other advanced practitioners, in particular pharmacists and mental health professionals could replicate the impact of GPs on changes to individual dispositions and on the overall development of the NHS 111 workforce.

Early clinical input – immediate action by all NHS 111 lead commissioners

The intention of the Learning and Development Programme has always been to influence and inform the next stage of the NHS 111 Commissioning Standards. However, with the wider system pressures we are experiencing, I feel it is important that we speed up this process and enact these changes as soon we can. I would be grateful if commissioners would work with their providers on the following priorities:

1. Early clinical assessment of green ambulance dispositions, where this is not already in place, and where there is significant pressure on local ambulance services. This will need to be coordinated with local ambulance services if the NHS 111 provider is not an NHS Ambulance Trust.
2. Early clinical assessment of complex cases and refused dispositions where this is not already in place. Commissioners will need to consider extending this if there are significant call volumes/ gaps in out-of –hours support which can lead to additional pressure on A&E for other services such as dental and pharmacy services.
3. A GP presence, or GP clinical advice available to NHS 111 Health Advisors and Clinical Advisors during the hours of peak demand – including at weekends and over bank holiday periods.

The pace at which these arrangements can be introduced will depend on the availability of clinicians with the requisite skills and the time taken for the provider to mobilise new and safe procedures. Clearly the changes need to be in place as soon as possible. For some this will become a permanent service, but we expect 111 services to put these in place to manage winter pressures until after the Easter bank holiday period at least. A minimum 3 month period is advised.

NHS England had previously requested further information from all Regions on the financial and workforce issues of implementing these changes. This work will need to be reviewed to meet the changes set out in this letter. Significant resources (£700million) have already been made available to commissioners this winter which can help to support the introduction of this enhanced service. In addition, some of the costs associated with this initiative should be offset by the reduced number of ambulance journeys and A&E attendances.

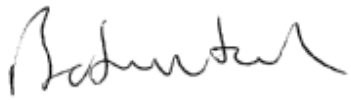
NHS England is currently developing a scheme, in conjunction with the main Medical Defence Organisations, whereby GPs, who commit to new or additional sessions in NHS 111 (and OOH) providers, can be invoiced individually for the additional indemnity cover for this period. Where such additional costs are incurred, the intention will be for these costs to reimbursed. Further details of this scheme, which is being led by NHS England, will follow shortly.

The impact of these changes on the quality of care, and in particular safe care, was considered as part of the Learning and Development Programme. There appeared to be no evidence of increased clinical risk in any of the interventions

undertaken (please refer to appendix 1). In addition the prospect of reduced calls to ambulance services potentially releases ambulance response capacity, as clinical assessors recommend an alternative (non-ambulance) disposition to callers.

I should be grateful if Lead Commissioners will now take urgent action to work with each of their NHS 111 providers to build on the achievements to date to improve the care provided by NHS 111 and to achieve better utilisation of local A&E and ambulance services.

Yours faithfully,



Dame Barbara Hakin
National Director: Commissioning Operations

Appendix 1

Learning and Development Programme

Clinical Assessment of Green Ambulance Dispositions

Findings: Re-triage of green ambulance dispositions resulted in 67% (range 61 – 70%) change to alternative disposition but note 2% upgraded to red response.

Recommendations 3&4 from the Pilot:

- The pilot evaluation has illustrated that there is a case for commissioners to consider including enhanced clinical assessment in their operating models.
- Further detailed work and on-going senior clinical audit of calls is required to confirm the clinical safety and effectiveness of this approach.

Patient safety

Was a key consideration of the service evaluation – it was clear that this had been considered at length during the local implementation of the process at the evaluation sites:

- Choice of green ambulance dispositions rather than all ambulance dispositions – to prevent delay to ambulance dispatch in potentially life threatening conditions (note x1 provider exception allowing discretion of HA).

- Hunt group process – max 72 seconds before being passed to auto-dispatch. This safety feature ensures that when a call is being passed to a clinician using a 'hunt for first free agent system, there will be no delay to ambulance dispatch if a clinician was not immediately available.

The evaluation process itself provided reassurance on the safety of the processes assessed and identified the following lessons:

- Clinical evaluation of green ambulance dispositions did not appear to increase call length compared to other calls passed to clinical advisors

- Detailed call reviews by clinical governance teams of 14 cases identified no inappropriate dispositions. A clinical outcome review by the Regional Clinical Governance lead of 17 cases from one pilot site confirmed the same finding.
- The four service providers participating in this pilot project were also contacted to confirm that there were no serious incidents related to the changed operational process of further assessment of calls with green ambulance disposition.

- In the pilot sites, only 53% of green ambulance dispositions were assessed during the pilot period. This was because clinical advisors dedicated to the task were unavailable during certain hours, or may not have been available within the 72 sec period as outlined above. It is important that sites do not compromise on this important safety feature until more evidence becomes available.

Additionally, WMAS have continued the process at scale and have reported no adverse incidents.