Report detailing the responses to the CQC Consultation on How to Regulate NHS 111 Services

June 2015

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1. Introduction

About Quality Health

Quality Health is an independent healthcare consultancy, commissioned by the Care Quality Commission to support this consultation process. The consultation documents and the various processes for collecting feedback were designed and organised by the Care Quality Commission. Quality Health has reviewed, analysed and reported on the data collected from all aspects of the process. The conclusions reached in this report are therefore the conclusions of Quality Health based solely on the responses provided to the consultation; they do not necessarily represent our own views or the views of the Care Quality Commission.

2. Respondents

In total, 43 respondents contributed to the consultation:

23 respondents replied to the consultation questions via the webform:

- 10 healthcare professionals.
- 4 Providers of services
- 3 members of the public.
- 3 voluntary and community services representative.
- 1 Commissioner of services.
- 1 CQC staff member.
- 1 recipient of health or social care.

4 respondents, all stakeholders, submitted written responses to the some or all of the consultation questions.

4 respondents, all stakeholders, submitted written responses the consultations, as well as including responses to additional questions, not addressed by the webform.

Feedback was obtained from 12 providers of services during a consultation event.

3. Responses to consultation questions

1. Do you agree with our proposed approach for regulating NHS 111 services?

30 respondents replied to this question, the majority of who agree with CQC's proposed approach for regulating NHS 111 services.

24 respondents agreed:

- 9 healthcare professionals.
- 4 providers of services.
- 4 stakeholders.

- 3 voluntary and community sector representative.
- 1 CQC staff member.
- 1 commissioner of services.
- 1 member of the public.
- 1 recipient of health or social care.

3 respondents did not agree:

- 2 members of the public.
- 1 healthcare professional.

3 stakeholders submitted a more detailed response:

- We agree with the piloting and evaluation of your approach. However, the telephony system we use to handle our NHS 111 calls relaying a messaging during call waiting, at the immediate conclusion of calls, or using a call-back service may be seen as inappropriate, depending on the reason for the call. We have also found that on average last year NHS 111 calls were transferred over to the 999 service was around 10%. This demonstrates where not all calls to NHS 111 are non-emergency calls. During inspections we are unsure about the logistics of enabling inspections teams to speak with a random sample of patients e.g. Information Governance, using a true random sample. As stated before not all calls to the NHS 111 service are non-emergency calls, and some are even from frequent callers without legitimate healthcare requirements. We would suggest inspectors attend the local A&E departments, urgent care centres or walk in centres, where NHS 111 callers may have been directed. We feel that announced inspections are the most appropriate way to make sure inspections do not disrupt the care provided to people. We would hope to receive a six to eight weeks' notice of inspections. We would then assume the inspection lead and inspection planner will support and communicate with GP practices and out-of-hours services by letter, email and telephone to help them prepare for the day and know what to expect.
- Broadly speaking, the proposals for inspecting NHS 111 services are welcome. As specified later in this response, it will be necessary to give further consideration to how rating characteristics can be appropriately applied to NHS 111 care settings. Enabling inspection teams to constructively assess and monitor NHS 111 services in the most suitable way will play an important part in improving urgent, emergency and unscheduled care services. This should be done in a positive way, enabling the system to improve patient outcomes by becoming more integrated through experience and shared learning.

- No comment really - doesn't really seem to involve NHS P. Perhaps there should be some seeking out of information of systems used to support delivery of NHS 111 and how they maintain the license agreements. E.g. adherence to NHS P license agreement. Software support from software providers. What assurances they have in case the provider stops maintaining the product. Things like telecoms, hardware and software if not already included.

How do you suggest we gather people's views of NHS 111 services?

26 respondents replied to this question.

Three themes emerged and are shown on the following table:

Theme	Number of respondents
GP surgeries and out of hours services	4
Patient surveys	4
NHS 111/ provider survey data	4

Example quotes for each theme are given below:

GP surgeries and out of hours services:

- Placing feedback forms in GP surgeries shared with providers and available for CQC inspectors.
- You could also do the same (sample surveys) in GP surgeries to see if patients have used 111 when trying to get out of hours advice. Ask GP´s if they have evidence of 111 use by their patients and what the outcomes were.
- Seek views on NHS 111 services at out-of-hours centres that received NHS 111 referrals - via comments cards etc.
- GP practices may also be able to advertise the inspection and promote to their patients the option to go on the CQC website

Patient surveys:

- Do sample surveys of patients in A & E departments to see if they used 111 and what response they received.
- Patient survey to gather patient experience.
- People could be asked to complete an automated satisfaction survey at the end of the call or provide permission to be contacted at another time.
- Online Survey.

NHS111/ provider survey data:

- Some methods for gathering people's views of NHS 111 services could include using data collected by the provider on the Patient Experience Survey Questions.
- Reviewing intelligence that is already held - i.e., provider patient surveys.
- NHS 111 survey data.
- Providers have regular surveys – CQC could access the results.

Are there other things we could take into account?

25 respondents replied to this question.

Two themes emerged and are shown on the following table:

Themes	No. of respondents
Delivery models vary	3
Bad experience may not be only 111 service	3

Example quotes for each theme are given below:

Delivery models vary

- The 111 service is still embedding nationally. Health information models still developing. Service delivery model in call centres varies. SCAS call centre is combined with PTS/111/999. SCAS is not responsible for the DOS. NHS Pathways - revising Pathways is nationally led and can take time. The level of service provided by the provider- some will provide the entry point into 111 and some will provide this plus downstream services. Good opportunity to standardise assurance of the DoS.
- Services have been commissioned to meet the needs of local communities and therefore where differences exist there will be a need to take these into account. How will the CQC ensure that the inspection outcomes neither advantage nor disadvantage 111 providers as a result of commissioning decisions? Service developments are driven both internally and externally. Where these are the result of external requirements how will the CQC ensure these are considered.
- Workarounds. These are operational alterations in how 111 functions. This is a thorny area - currently not governed in a robust way. But it is my suspicion

that this is widespread and not easily identifiable or indeed likely to be volunteered by 111 providers. However it has potential to completely change the way a service works or is comparable to other 111 services.

Bad experience may not be just 111 service

- Clarification would be needed on how you intend to separate out the callers experience of the different urgent care services, for example the patients journey may involve the 111 Service, Out of Hours GP Service and the Accident & Emergency. The caller's view of the overall journey may be negative because of the influence from any of the three patient contact points but may only become apparent upon the 111 feedback request. We agree with the approach suggested to regulate NHS 111 services. Further clarification on who would be deemed as an "Expert" inspector for 111 services would be needed and we suggest that the team should include those previously or currently employed within the 111 service and have no conflict of interest to the service being inspected.
- NHS 111 awareness will be an important factor to consider (call rate per 1000 population) The local population demographic / health needs for the NHS 111 provider area NHS 111 is part of a patient journey and so the patient perception of the service may be influenced by other parts of the health system.
- The CQC's longer term intention to inspect the integrated urgent care system within a local area should be done in a positive way, enabling the system to improve patient outcomes by becoming more integrated through experience and shared learning. The present urgent and emergency care system may make it difficult for NHS 111 service providers to achieve 'outstanding' or even 'good' ratings because collaborative working, whilst absolutely necessary, is not always within their gift.

2. Our inspections ask five key questions that aim to assure the public on how safe, effective, caring, responsive and well-led services are. Do you agree that our proposed approach will do this for NHS 111 providers?

27 respondents replied to this question, the majority of who agreed with the proposed approach for regulating NHS 111 services.

22 respondents agreed:

- 8 healthcare professionals.
- 4 providers of services
- 4 stakeholders.
- 2 voluntary and community services representatives.
- 1 member of the public.
- 1 recipient of health or social care.
- 1 CQC staff member.
- 1 commissioner of services.

4 respondents did not agree:

- 2 healthcare professionals.
- 2 members of the public.

1 stakeholder submitted a more detailed response:

- All depends on knowledge and understanding of inspectors and the granularity of questioning whilst doing site visits!

Are the KLOEs, prompts, and ratings characteristics in the appendices appropriate for inspecting NHS 111 services?

28 respondents replied to this question, the majority of who think the KLOEs, prompts and ratings characteristics in the appendices are appropriate for inspecting NHS 111 services.

20 respondents said yes:

- 8 healthcare professionals.
- 4 stakeholders.
- 2 providers of services
- 2 voluntary and community services representatives.
- 1 member of the public.

- 1 CQC staff member.
- 1 recipient of health or social care.
- 1 commissioner of services

7 respondents said no:

- 2 healthcare professionals.
- 2 members of the public.
- 2 providers of services
- 1 voluntary and community sector representative

1 stakeholder responded in more detail:

- There is a question asking 'Has the service demonstrated that it is safe over time?' How will this be measured? Would be beneficial to set out objectives measures beforehand, of this key question.

If not, what is missing or needs to change?

17 respondents replied to this question:

Responses were very diverse and no themes emerged

What do you consider to be the best ways that we can observe NHS 111 services and gather evidence about the quality of care they provide?

22 respondents replied to this question.

1 theme emerged:

10 respondents mentioned call audits and observation/ listening to call-centres

Example quotes for the theme are shown below:

- Observation in a call centre for a mixture of shifts.
- "Call observation" audit - tools, application and use of finding. How is the quality and consistency of audit maintained. Quality and consistency of training and development. Observed practice. Patient survey results and other feedback.
- We would consider the following to be the most effective approach to gather evidence: Live call listening. End-to-End reviews of calls.
- Call audits by clinicians, call centre and NHS Pathways experts.

- Listen to calls that are consented.
- To actually view on a typical day what is happening in a 111 call centre and also to be present to monitor what happens on say a public holiday when demand is likely to be higher.
- The importance of auditing samples of telephone calls, clinical records and post event messages (PEMs) for quality during inspections cannot be emphasised enough.

Specific KLOE/ prompts were discussed in more detail at a provider event.

Do arrangements for repeat callers and out-of-area callers keep people safe?

- Agree importance but suggest addition of assessment of frequent callers which is more locally variable. An outstanding 111 service would be exhibiting considerable leadership in this field.
- How are repeat callers identified? Particularly if OOH/999 by different providers? How do you minimise the interfaces of care/handovers? How are out of area calls investigated if something goes wrong?
- Not sure how "safe" is measured

Are there arrangements in place to support the safe use of NHS Pathways, including reviewing its use and escalating any problems?

- Are providers involved and contributing to the national NHSP user network?
- A view that it is important to consider other 'systems' in addition to the clinical decision support tool either in this domain or elsewhere.
  In assessing providers, the interaction with Pathways is important - so, how are issues raised and responses tracked? How is the release cycle planned? Is there an implementation plan for each release with stakeholder involvement? Commissioner? DoS Lead? Providers?
- I.e. CQI.
- Call handler training, audit, clinician availability/floor walking, relationship with call handlers and clinicians, if call handlers and clinicians delivered by different organisations how does this work? How are staff keyed into the NHS

Pathways training supervisors? How do internal organisation clinical governance demonstrate safe sound effective clinical governance. What is their system for investigating issues which potentially involve NHS Pathways? What is their process to escalate to NHS pathways?

How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, including when there are peaks in demand, both expected and unexpected?

- Need to consider relationship between commissioner and provider and the success of joint planning for this function. Planning for downstream services is essential part of this. To what extent have commissioners supported NHS 111 in forecasting downstream services?
- Essential and an outstanding provider would be able to demonstrate that staffing levels and skill mix were well matched to demand so that KPIs were achieved not only on average but during peaks of demand.
- Staff rotas do not always equal what happens on shop floor. What is the real picture? How to clinician aspect operate? Floor walking v remote? What are procedures for call handlers to flag case to clinician? What is reliance on bank workers? What is staff retention like?

How do staff identify and respond to changing risks to people who use services, including deteriorating health and wellbeing or medical emergencies? This includes ambulance dispatch without delay or re-triage.

- This is a function of education. Ongoing education plans plus staff retention programme useful
- This is important and we have several suggested ways this may be assessed:
  1. Re-triage of second calls to assess deterioration
  2. Quality of pre-arrival instructions following high acuity ambulance dispatch? This is usually the weakest area in 999 service call handler audit and is much less frequent in 111 and hence less likely to be good quality. We are aware of at least 1 provider who offers call handlers BLS training in part to improve their ability to give telephone CPR advice.

3. Are arrangements for 999 to pass calls back to NHS 111 fit for purpose? Bear in mind clinical risk, timeliness, use of ITK .

- Training, supervision, audit, self identified learning, ability to defuse/debrief, random case analysis, systems for case sharing and learning, peer review groups.

How are potential risks taken into account when planning services, for example, expected or unexpected fluctuations in demand, the impact of adverse weather, or disruption to staffing? Are staff aware of how to escalate concerns about unexpected demand?

- CQC should understand the method of calculating demand and staffing which is now used by many providers. Arrangements to cope with peak demand (i.e. 9-11 am sat/sun) are important. How is home working arranged and how is it governanced? Does the provider understand the national telephony system and its limitations?
- This relates to prompt S4 above and feels like part of business continuity arrangements. Is there evidence of multi-agency business continuity planning?
- Contingency. And will vary wildly depending on breadth of services delivered by each provider. How is this process discussed - coal face experience that commissioners can sanction change but forget to include other organisations which need to be informed around escalation procedure.

How are relevant and current evidence-based guidance, standards and practice identified and used, including when callers' needs are assessed using clinical assessment tools?

- Important for CQC to assess system of ongoing education within provider organisations. This is linked to staff retention which is another marked of success.
- A provider should be able to show evidence of review of important guidance e.g. NICE which might impact on service delivery. Although NHS Pathways is responsible for incorporating updated guidance into its algorithms, this does not negate the provider role in doing likewise. It is particularly important in

identifying additional resources for the use of clinical advisors e.g. ToxBase eBNF.

- This is integral to NHS Pathways processes overseen by National clinical governance group.

Do staff have the right qualifications, skills, knowledge and experience to do their job when they start their employment, take on new responsibilities and on a continual basis, including when changes to processes or protocols are made?

- Important feature. But CQC should also take into account the pay bands and quality of staff recruited and the cost-per-call which differs markedly between services (range £7.50 to £24 per call). This enables different quality of staff to be employed.
- Staff retention I think is a good marker of quality of service. How are they supported, developed, progressed (and this feeds into the NHSE workforce programme
- I feel this needs more granularity. For example:
  - How are the training needs of staff recorded?
  - Where is completed training recorded?
  - Do all frontline staff have training passports?
  - Is all NHS Pathways training carried out according to the terms of the licence?
  - Do all new staff receive supervised practice at the required levels?
  - Have all staff engaged in coaching activities been through NHS Pathways Accredited Coaches training?
  - Have all staff engaged in the delivery of NHS Pathways Training been through Accredited Trainer's training?
  - Are coaches and trainers well supported, developed and monitored in their role?
  - Do all frontline staff receive call audit at the mandated levels?
  - Do all staff receive monthly feedback on audit?
  - Are any failed audits fed back face-to-face?
  - Are there action plans in place for all staff with performance issues?
  - Have all frontline staff been through the latest release training?
  - How is the competency of agency staff assured and monitored?
  - How are the learning needs of agency staff developed?

What are the arrangements for supporting and managing staff to deliver effective assessment and advice? (This includes ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, and supervision.)

4 respondents answered this question:

- Support entirely. CQC needs to note calibre of staff and ongoing training. E.g. safeguarding level 2 training should be mandatory for supervisors.
- Agree fully with this.
- What is required by the license agreements. And how much above and beyond does this organisation go to? How valued do staff feel?
- Is this CQI, call levelling etc. Do we need to provide them with an Ofsted style best practice, good practice, acceptable, below standard etc. so they can score the sites?

How is care and treatment delivered in a coordinated way when different services are involved, including between NHS 111, GP practices, GP out-of-hours, and ambulance services?

- CQC should consider arrangements for overlap of services. There will be problems when GPs stop at 1830 and GP OOH does not start till 1830. The same situation applies in the morning. Commissioning issue.
- Agree essential to assess how interoperability and referral processes are managed.
- Absolutely key. Interfaces of patient care and handovers. How do they minimise/mitigate particularly when different providers.

Do staff work together to assess and plan care in a timely way when people move between services?

- Interesting. Providers seem to become more insular as we approach re-procurement.
- Agree essential to assess how interoperability and referral processes are managed.
- System relationships, commissioner/provider, whole-system approach to urgent and emergency care.

Are there clear and effective arrangements for transfers to other services? Is the directory of local services up to date and used with processes in place to report issues?

- The DoS is held and updated by the CCG commissioners. It is not a function of NHS 111. That said, DoS governance should be a part of the local clinical governance process. How strong is DoS governance and how involved are CCG commissioners in this? What are the processes for updating the DoS for long term changes and in real-time.
- Although DoS governance and maintenance is a commissioner responsibility it is possible to assess how the NHS111 provider contributes to this through feedback mechanisms from call handlers and clinical advisors and how the provider develops and maintains relationships with DoS leads and service commissioners and providers.
- DoS provision is patchy. And if the DoS is poor then it doesn't matter how good NHS Pathways, your call takers, commissioner/provider relationships are - the system will drop to being very suboptimal. Is there a DoS lead? Is this available out of hours? How do they link regionally or centrally? How do they work with clinicians to decipher SG/SD codes to maximise local use of DoS? How do they hold local services to account for the services that they could provide? How do they manage under-provision of services? How do they manage overprovision of services?

Are there clear and effective arrangements for booking appointments for patients within other appropriate services, including GP practices, the GP out-of-hours service or urgent care centre?

- Again, this is very much based around what has been commissioned. Basic ITK should be a feature of all provider contracts to ensure seamless communication.
- What are technical limitations, how easy is it for call takers (without increasing call length which they are monitored on)?

Do staff communicate with people so that they understand their care or treatment, and any advice given?

- Yes. Internal feedback systems. Near misses, end of shift systems. Internal whistleblowing arrangements.
- Can be assessed through audit and call review with emphasis on care advice domain.
- They kind of have to with the supporting advice within NHS Pathways. Self-care however gets passed to a clinician to deliver, often in a call back situation rather than a warm transfer. Do they have any other expertise in the 111 service (e.g. pharmacist/dental/mental health) which facilitates expert advice in this way?
- Presumably they will get this from the patient questionnaires. It is a bit beyond the remint of a signposting service isn't it? Only exception would be about getting home care.

Do people have timely access to advice, including from an advisor or a clinician when appropriate?

- Plus is there a process in place to assess risk in the clinical queues which inevitably result.

- Absolutely critical, what evidence is there within the call centre of ease of access i.e. ability to warm transfer or seek advice and the willingness of clinical advisors to take responsibility for calls when advice is sought by call handlers. What is the culture in the call centre? Does it value the call handlers struggling on regardless or identifying when they are out of their depth? We have identified this as a possible issue in the causation of serious incidents during our reviews.
- It's my experience that a fluid system here means a good service overall.
- Is this about consistently meeting KPIs about warm transfer and call backs? This could come back on us if services say we generate too many clinician call backs….

Is the telephone system easy to use and does it support people to access an advisor or a clinician?

- Note: How many failures have occurred? How many ITK failures have occurred? How have national telephony issues exacerbated this?
- May wish to broaden this to assess access to 'floor-walking' support and if all interactions are recorded.
- I would say easy to use but potentially laborious at acute (Module 0 end). There are different models for accessing clinician support.
- what do they mean? You dial 111. How simple could it be? Unless you live in London and need to press 1 for this 2 for that, etc.

How is technology used to support timely access?

- Joint CCG responsibility.
- Could assess technical error message rate which can be supplied centrally. This measures the ability of the provider ACD system to cope with call volumes.
- What is the CAD that supports the system. What are the pros and cons? This might stray into commercial sensitivity but they vary a lot.

What action is taken to reduce the length of time people have to wait for subsequent care or advice? Are call backs for clinical advice minimised? When they are used, is this in a timely manner?

- How is clinical risk in queues assessed and minimised?
- As well as KPIs on call answering and warm transfer, call backs attempted within 10minutes are collected. In addition many services have adopted a clinical prioritisation process to manage any queue of patients awaiting a call back from a clinical advisor at peak times and also some stream calls from the 111 clinical queue to OOH by prior agreement to reduce delay to patients.
- SOPS, clinical conversations and agreement, escalation processes when backs up, ability and competency of clinicians who deal with these? What is there average disposal?
- This should be about appropriate use. The only element a 111 service could comment on is about internally. The question could be expanded to something about how they communicate and liaise with partner organisations across the system (e.g.999, GP OOH, A&E). Should be more about how do they monitor how appropriate transfer to clinician or how appropriately users reach a disposition. This question should be about CQI (how appropriate) and how they staff for clinician call backs. E.g. what special allowances do they make if they take on a new tranche of staff? Do they experience higher dispatch rates/higher dispositions/more clinician call backs and how do they accommodate for this, and how do they liaise with external partner organisations to ensure that they maintain a robust SYSTEM.

Are transfers to other services, including GP out-of-hours services undertaken in a timely way?

- CQC needs to understand how commissioners have facilitated this. Failure of downstream provision is a common cause of NHS 111 inefficiency particularly at peak times. e.g. is the GP OOH provider's bandwidth adequate. Are arrangements for call-backs from OOH providers adequate. Is their basic staffing on target? CQC needs to recognise when there is a failure of NHS 111 and when it is the result of failure elsewhere.
- This is difficult to assess simply but for those services where ITK is the norm you could assess rates of manual fax referral.

- Where does agreed responsibility for transfer of care end? Does that have all organisation sign up? (transfers is the most likely potential course for SI's in my experience).
- In 99.9% of cases this is electronic. There are two routes for this. OOH is by data transfer. In hours there are batched data transfers due to the IT system that is used being different. My view is that this question should be about checking what assurances are in place that the data is transferred to the right PLACE. Also about how they would know if there was e-transfer failure and do they have an SOP about what to do in that case.

3. We propose not to rate NHS 111 services for the six population groups and only focus on the five key questions. Do you agree with this approach?

28 respondents replied to this question, the majority of who agree with the approach of focusing on the five key questions and not the six population groups.

20 respondents agreed with this approach:

- 8 healthcare professionals.
- 2 voluntary and community sector representatives.
- 3 providers of services.
- 4 stakeholders.
- 1 member of the public.
- 1 recipient of health or social care.
- 1 commissioner of services.

5 respondents did not agree with this approach:

- 2 members of the public.
- 1 healthcare professional.
- 1 CQC staff member.
- 1 voluntary and community services representative.

3 Stakeholders responded in more detail:

- Your assessment should use your five key questions and ultimately focus on specific at-risk population groups - particularly children, adults with special needs, mental health, dental, use of catch-all dispositions.
- We have received mixed views from Fellows on this question. It could be useful to use one specific population e.g. the frail older patient as a guide on

how easy it is to navigate the service; as if this particular group finds the service easy to use then it is likely the other groups will too.

- Agree - ish. However we understand that some 24% ish of callers may be <16 which poses an unusual challenge. Also that elderly have complex helath needs and often sensory impaired and may perhaps find the modality of telephone assessment difficult. So actually some reference to young and old would be useful.

4. Where a provider delivers an NHS 111 service as well as other services, we believe that it is preferable to inspect the NHS 111 service during our inspection of that provider's other services using our combined provider approach. Do you agree with this approach?

24 respondents replied to this question, the majority of who agree with the approach of inspecting NHS 111 services during inspection of other services.

19 respondents agreed with this approach:

- 5 healthcare professionals.
- 4 providers of services
- 3 members of the public.
- 3 stakeholders.
- 2 voluntary and community sector representatives.
- 1 recipient of health or social care.
- 1 commissioner of services

5 respondents did not agree with this approach:

- 4 healthcare professionals.
- 1 CQC staff member.

<u>How do you suggest we develop our approach to inspecting combined providers in this sector?</u>

Three themes emerged and are shown in the following table:

Themes	**No. of respondents**
111 services should be inspected separately.	3
Should be rated and inspected at the same time.	3
Good services regardless of population/ location.	3

Example quotes for each theme are given below:

NHS 111 services should be inspected separately:

- 111 services should be inspected separately. There would seem to be a conflict of interest for example between an ambulance trust providing both a 999 and a 111 service.
- 111 should be inspected separately irrespective of other services provided to ensure that the focus is on ensuring a single unified standard nationwide that is not deflected by other issues with a specific provider.
- NHS 111 services are very different to, say, ambulance services and should not be inspected by the same team. It would be better to develop peer review rather than an inspection regime.

Should be rated and inspected at the same time:

- We believe this approach will allow the whole service to be inspected and rated at the same time and this is critical, as NHS 111 must be seen as part of joined up network and not in isolation.
- Overall we agree with the combined inspection approach outlined in the consultation document.
- It maybe that to start that for NHS 111 it is inspected separately but in time it will be beneficial to be combined.

Good services regardless of population/ location:

- With the new care act from April 1st 2015, this needs to be monitored closely across the country to ensure that the services are fit for purpose and not a postcode lottery. Local authorities gather information on their own services and that may be another mechanism for monitoring public feedback.
- We would be concerned if any population group were disadvantaged in terms of access to, use of or outcomes from 111 services, so if this approach is followed the assessment of prompt R2 will need to be particularly robust.
- To ensure that all evidence is reflective of patients' experiences across different boroughs.