111 2014

NHS 111 Commissioning Standards : Comments from Barry Silverman : Attachment to e-mail dated 7/7/14 to Malcolm Alexander

- Weaknesses are self evident and fundamentally relate to the original D of H decision to devolve commissioning to 212 CCGs and make this near autonomous level of commissioning responsible for commissioning the 111 Service in its area (although most have formed groupings – as in other areas of Commissioning – such as those for (NHS 111 London, of which, as an example, SE London is one.

  The effect is that there is a Local Service not a National Service which delivers the whims of local Practitioners as long as they deliver the specified Commissioning Standards – **note that the standards have a forword from a CCG Chair.**

- Thus from the outset, some CCGs refused to allow obsolescence of their OOH Service (which can relate to financial interest and/or Practice GPs delivering OOH Service – albeit, there is a competitive process of tendering that has had to recognise that OOH providers exist. So, there can be differences in operation between CCGs and clusters of CCGs.

  Note : that Para 1.4 on page 7 says that the service does not constitute a detailed specification for NHS 111; it describes the core requirements and standards (which may be enhanced but not reduced).

- The differences between the local/cluster services should not be recognisable by the user.....**the service is seamless.....** but may become evident if described to a patient who then moves to a different area or is acting for a patient from one area but not the same area in which they themselves live. This is especially so when comparing the London offer with that, say, in the North of England.

  Note : since the specification is the same, the differences may be only enhanced and not visible to the user....not seeking to compare are one area with another.

- The fact that the services are locally Commissioned means that there has to be monitoring and accountability which creates a layer of work (absorbing financial resources) to assure a consistent National Service

  Note : recently it has emerged that key information ***-highly relevant to Patient Safety*** *– is not entering the service from transfer of records (for example Adult and Children's Safeguarding; allergies)*

- In such a situation, although responsibility is defined for action, there is stipulation that NHS 111 must enter into Information sharing Agreements (for example with PHE). But, who is responsible for making it happen, what sanctions are available to the monitor, how is action enforced in the patient interest, does the CQC have a role in this process