Summary: Intervention & Options

Department /Agency: Department of Health	Title: Impact Assessment of 3 Digit Number (3DN)	
Stage: Final	Version: 2.8	Date: 18/12/2009
Related Publications: Next Stage Review Final Report		

Available to view or download at:

http://http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyA Report ndGuidance/DH_085825

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What is the problem under consideration? Why is government intervention necessary?

Research has shown that patients often struggle to understand what health services are available and how they can be accessed, especially during the 'out of hours' period. Introducing a new national three digit telephone number would go a long way towards resolving this problem and it would be the route to more integrated local service provision. A new national number can only be secured from OFCOM by government working on behalf of the NHS.

What are the policy objectives and the intended effects?

The objective is to test the 3DN service through piloting. The 3DN service should fulfil three core functions, which are;

- Identify immediate life threatening emergencies and transfer to 999
- Respond to requests for health or service information
- Assess the clinical needs of all other callers and, where necessary, route them to a local service provider who is able to meet their needs with face-to-face consultation

The intended effect is to improve on current levels of patient experience by routing people to the right place first time.

What policy options have been considered? Please justify any preferred option.

We have considered two options: Option 1: "Do nothing" and Option 2: "implementing a pilot programme". The preferred option is option 2 due to its relatively small cost and significant long-term potential to improve level of patient experience

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

There will be an evaluation running throughout the pilot that will give its final report in Q2 of 2011

Ministerial Sign-off For final proposal/ implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister: ..... Date: 15/12/9

Summary: Analysis & Evidence

Policy Option: 2	Description: Implementing the 3DN Pilot programme

COSTS

ANNUAL COSTS	
One-off	**Yr**
£13.5m	3
Average Annual Cost (excluding one-off)	
£0.5m	

Costs relate to the implementation of the 3DN infrastructure and operational running costs for associated call centres. The range of costs relates to the range of possible call volumes and unit costs that are expected to occur during the pilot

Total Cost (PV) **£15.0m (£7.7m, £24.1m)**

Other **key non-monetised costs** by 'main affected groups'

BENEFITS

ANNUAL BENEFITS	
One-off	**Yr**
£ 0	3
Average Annual Benefit (excluding one-off)	

There are expected to be health benefits to deploying 3DN however working in conjunction with the NHS we have agreed to quantify these post evaluation. Previous theoretical work has quantified these at around £1.4m for the pilot areas and were in the areas of reducing time spent by the patient in pain and reducing the recovery time and seriousness of incidents through early detection.

Total Benefit (PV) **>0**

Other **key non-monetised benefits** by 'main affected groups'

Key Assumptions/Sensitivities/Risks The key sensitivities are unit cost, call volume and level of system saving achieved – discussed in section 5. The risk register is given in annex 10.2

Price Base Year2009	Time Period Years 3	**Net Benefit Range** (NPV) **-£15.4m to -£48.3m**	**NET BENEFIT** (NPV Best estimate) **-£30.0**

What is the geographic coverage of the policy/option?				England	
On what date will the policy be implemented?				April 2010	
Which organisation(s) will enforce the policy?				NHS	
What is the total annual cost of enforcement for these				£ 0	
Does enforcement comply with Hampton principles?				Yes	
Will implementation go beyond minimum EU requirements?				No	
What is the value of the proposed offsetting measure per				£ N/A	
What is the value of changes in greenhouse gas emissions?				£ N/A	
Will the proposal have a significant impact on competition?				No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large	
Are any of these organisations exempt?					

Impact on Admin Burdens Baseline (2005 Prices) (Increase -

Increase £ Decrease £ **Net** **£ 0**

Key:	**Annual costs and benefits: Constant Prices**	**(Net) Present Value**

Analysis & Evidence

Background

Lord Darzi's report, *High Quality Care for All*, described a vision for urgent and unplanned care in which commissioners would deliver an integrated, appropriate, convenient and accessible service 24/7, 365 days a year. There is also an expectation that they will promote these services widely to their local communities so that the public know what services are available, where they are and when they open. The commitment from the Department is to support the NHS implementing this strategy by exploring the viability of introducing a new national 3-digit telephone number (3DN).

There is no intention that the new number would replace existing numbers – people will continue to dial 999 in an emergency and telephone their GP practice to access routine primary care, as they do now. But where they are unsure what to do, 3DN would provide the public with prompt, easy access to safe, high quality, consistent clinical assessment and, wherever the assessment showed that this was necessary, a route to a face-to-face consultation, in a centre or in the patient's own home.

1. **Characterising the problem to be addressed**

The NHS *Next Stage Review* [2008], and other reports and research before it, have shown that NHS users and patients often struggle to understand what services are available to them. This is particularly true when people are away from home, with little or no knowledge about local NHS provision, but there is also evidence that many people are uncertain how to contact the NHS outside normal working hours, and the new 3DN service would be of real benefit to them as well.

Previously, the NHS has tried advertising campaigns, such as "A&E it's not anything and everything", and PCTs have used a variety of methods to publicise local NHS services. However, there is abundant evidence that none of this has worked particularly well, and the public continue to experience real difficulty in accessing urgent care, finding the current system confusing and frustrating.

Research carried out by the University of Sheffield revealed the stark limits of many people's knowledge about the availability of services, with some believing there was no out of hours care when the GP surgery was closed, and having to resort to *Yellow Pages* to try find what services were available. A recent study by the consumer organisation Which? found that 52% people did not know how that there was a primary care out-of-hours service. All of this evidence makes it clear that there is a real disconnect between the services that are in fact available and the public's understanding of those services and, given that most people only need to access unplanned care about once every five years, it is perhaps not surprising that they lack detailed, up-to-date knowledge about what services do exist.

Faced with this evidence, the Department commissioned social and market research to explore the extent to which 3DN would provide an effective solution to this problem. The research findings revealed that the public would

see real value in the introduction of a new 3DN for urgent care. It would significantly improve their access to urgent and emergency care and might, at the same time, deliver some secondary benefit of reduced demand for 999 and A&E services. This could result in real savings of scarce resources – although it should be borne in mind that previous introductions of new services (NHS Direct, Walk-in-centres) have sometimes led to claims of stimulating new demand rather than diverting it.

The introduction of a new number will not, in itself deliver the changes that are needed. The current provision of urgent and emergency care is fragmented across many different services, and it is only through the building of new partnerships and collaborative working across these many services that a better service can be delivered. 3DN will not deliver these all-important changes, but it can act as a lever to drive that wider integration.

In order to ensure a robust streamlined service it is recommended that pilot sites be implemented so that the uncertainty and the importance of getting this right first time would provide a strong evidence base from which to proceed. Piloting would also allow us to refine costings, test models and assess the value that each model would deliver.

2. Policy Objectives

The Department believes that there is a need to provide better access of urgent and emergency care services for the public. The policy aims to deliver:

- Clarity of access - ending the confusion around access will mitigate public uncertainty and may lead to a more appropriate level of care .
- Consistent clinical assessment –providing patients with a consistent assessment as they access urgent care will raise clinical standards and lead to greater patient satisfaction .
- Right place first time – better initial assessment linked to accurate knowledge about local services will lead to less shuttling of patients around the urgent care system
- Taking the best from local initiatives - developing a hybrid solution ensures that we empower the local NHS and build on the best of current practice

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3.0 What is the proposed change?

3.1 Scale of change

The Urgent and Emergency Care system covers around £10bn of public expenditure and at least 50m patient contacts. Further, there are approximately 340m patient contacts with in-hours primary care and dentistry, only a small proportion of which are likely to contact the new 3DN service. 3DN represents an opportunity to provide a simple point of access for patients unsure about how to access the system to get the most appropriate care. However, it is also the gateway to a large, high-pressure area of the NHS that patients access while in a vulnerable state. As such, we need to be confident that 3DN delivers a robust solution that enables quick and easy patient access and interacts well with the rest of the system.

Piloting will enable us to test the robustness of the solution and give assurance as to its likely impact on the system as a whole.

- 999 will continue to be the route to emergency care, and people will telephone general practice in exactly the same way that they do now. Equally, where people know the number of their local primary care OOH service, they will continue to call that number.

- A single, national 3DN will provide a new route to the NHS for all those who are unclear about which service is best placed to meet their needs or who are uncertain about how to contact the service they need. It will also become the route to the telephone services provided by NHS Direct (including health and service information).

3.2 Why pilot?

There are two main reasons for piloting the 3DN. The first is the scale of the change; the second is the level of uncertainty around key variables that could affect the viability of the 3DN. Given the uncertainty and importance of getting this right first time, piloting would provide a strong evidence base from which to proceed. Piloting would also allow us to refine costings, test models and assess the value that each model would deliver. There are three proposed pilot models within the pilot programme, which are described in annex 10.4 and referred to as site A, B and C.

3.3 Uncertainty & Risks

The programme has considered and captured strategic risks, and is maintaining a risks register - see Annex 10.2.

The strategic risk assessment incorporates input from the programme team and key stakeholders including the programme board, NHS in the pilot areas and other delivery partners such as CfH and NHS Direct.

The pilot areas have also considered risks specifically affecting the set up and operation of the 3DN pilot operation in their area. These have been shared with the programme team.

The DH 3DN team and pilot area teams have reciprocal governance arrangements whereby the pilot areas are represented on the 3DN programme board and DH are represented on the pilot area 3DN boards. Risks are regularly reviewed at the pilot area and DH 3DN programme boards

Subject to approval to proceed with the pilot phase, the programme team are working with pilot areas to establish detailed project plans and arrangements for progress reporting against risks and issues.

In addition, the programme has completed an OGC Risk Profile Assessment with a view to undergoing a gate 0 programme healthcheck review in Q1 2010. The programme is assessed as medium risk.

4. Coverage of the Impact Assessment

This IA outlines the proposed three pilots which cover 3.7% of the population in a range of urban and rural settings. We are piloting in order to gather evidence as to which option will be the best solution. The remainder of the IA covers the evidence so far for costs, cost savings and benefits, the evaluation plan and our conditions for full rollout.

4.1 Health Impact Assessment

We do not anticipate this policy having a wider health impact or significantly impacting on lifestyle related variables. However, there is likely to be a change in demand for these services caused by improving patient knowledge as to the most appropriate service to access for their need and enabling this to happen. We are recommending piloting so that the full impact of this change in demand can be assessed.

5. Evidence

Social and Market Research was undertaken with a series of focus groups, supplemented by in-depth discussions with hard-to-reach groups. The purpose of this research was to explore public attitudes towards the introduction of a 3DN and the work revealed that the public see real value in the introduction of the a new service. It showed that it could significantly improve access to urgent and emergency care and, may at the same time, deliver some secondary benefit of reduced demand for 999 and A&E services.

5.1 Costs – core assumptions

Implementing 3DN will provide consistent triage for those in urgent need of healthcare. It will advise them, using a directory of services, as to where the most appropriate service is and, where required, book the onward appointment. Necessarily, it will provide access to GP OOH, though GP OOH own phone numbers will be maintained in order to facilitate patient choice and not disrupt patient care for those familiar with that service. It will encompass the triage and health information services provided by NHS Direct.

There are several core assumptions driving the costing assumptions: call volumes, the call profile, the staffing mix deployed and the services included in the service.

Call volumes have been developed in conjunction with the NHS and the subject matter expert for telephony and have estimated the call volumes we are likely to receive during the pilot phase. The estimates are based on analysis of how patients currently access the urgent care system and making low, medium and high assumptions about what proportion of these patients will now access 3DN. The assumptions were developed with policy advisors and the ambulance service. The table below shows the assumptions made:

Urgent care service previously accessed	**Estimate of % of callers that will switch to 3DN**		
	Low	**Medium**	**High**
GP Out of hours	100%	100%	100%
NHSD	60%	75%	90%
GP in hours	2%	4%	10%

A&E attendances	1%	2%	5%
999 calls	3%	6%	13%

Table 5.1 The proportion of service users that will call 3DN first

We have also assumed that the volume of calls will be uplifted by 20% as a result of new demand and because the service is free to caller.

This process gives the following call volumes and population equivalents for the pilot :

Low	**Medium**	**High**
25% of population	37% of population	60% of population
371,000	**560,000**	**918,000**

Table 5.2 The call volume scenarios expressed as a proportion of the population (adjusted for go live date)

Pilot A is the development of an existing single point of access pilot, which is experience call volumes equivalent to 25 – 30% with minimal promotion. We would expect this to rise when 3DN is introduced due to the number being memorable and free to call taking.

5.2 Phantom calls

It has been identified that use of the number 111 will generate a large number of 'phantom' or 'ghost' calls due to calls being generated through pulse dialling. Phantom calls can be generated by wind on overhead wires, traffic noise on buried copper wire and misbehaving telephone handsets. These can all create 'clicks' which are recognised by the network as dialled digits. We have worked with BT who estimate about 30 million phantom calls a year will be sent to the destination network but we have developed a number of technical solutions to ensure that only a very small percentage of these will reach the 3DN call centres.

A number of technical solutions have been proposed which should prevent phantom calls being presented to an Advisor. These include:

- Use of a "4 second gap"
- Identification of calls which are pulse and DTMF dialled so that real DTMF calls can be passed through directly
- The screening of pulse dialled calls using "grunt detect" technology so that rotary phones can access 111.
- The identification of faulty devices that repeatedly dial the number so that users of such phones might e asked to "press 9 to continue"

The current estimate for the cost of phantom calls is between £70,000 and £100,000 a year when fully rolled out.

5.3 Cost of free to caller

Negotiations are in process with landline and mobile providers however it appears that costs are likely to be as follow:

Cost per minute from Landlines

- 1.3p evening and weekend
- 1.6p daytime

Cost per minute from mobiles

- estimated at 3.3p overall
- least expensive network 2.7p
- most networks about 3p
- smallest network (with 5% of volume) maybe 11p

Overall cost of calls based on 15 to 30 million calls a year and using the least to most expensive options together is £1.8 million to £5.2 million when fully rolled out

5.4 Costing the pilot programme

The estimated costs of setting up the pilot operations in three SHA areas are set out below. The majority of the set up costs will be covered by the Department to ensure value for money with respect to the national telephony service, development of the brand and an evaluation suitable to make a decision on national rollout. The NHS will pay for the implementation in each site – this covers staff training and non-recurrent infrastructure costs. It should be noted that the local costs to the NHS for implementation are relatively small.

Pilot	**09/10**	**10/11**	**11/12**	**Proposed funding source**
Programme, evaluation and national operations	£1m	£1.5m	£1.5m	DH
National telephony set-up	£2.0m			DH
Publicity and marketing		£3m	£3m	DH
National telephony support			£1m	DH/NHS
Implementation in pilot sites	£0.1m	£1m	£0	NHS
Total	£3.1m	£5.5m	£5.5m	

Table 5.3 The pilot programme implementation costs

The cost of running the service is set out below. The estimates are in line with previous theoretical work done by the Department. The cost of running the service has been estimated based on a unit cost for answering and triaging a call. The unit cost incorporates all staff and infrastructure costs, including telephony costs, IT costs and estates.

	Low call volumes	Medium call volumes	High call volumes
Low unit cost (£8)	£3,000,000	£4,500,000	£7,500,000
Medium unit cost (£10)	£3,750,000	£5,750,000	£9,250,000

High unit cost (£12)	£5,000,000	£7,500,000	£12,000,000

Table 5.4 The estimated operational costs of the pilots

Pilot A is currently running a single point of access pilot at a unit cost of between £10 and £11, indicating that the range of unit costs modelled is reasonable.

5.5 Do nothing costs – the baseline

The baseline cost of doing nothing has been calculated by estimating the cost of delivering:

- 75% of the 0845 service of NHSD, since health information calls and small volume of others would not switch,
- All GPOOH call handling and triage, since they can be switched through
- 30% of Category C ambulance calls, thinking that the less serious ones might transfer
- Pilot A's SPA at 25% population in that area for the time it was running

Those that are national costs have been pro rataed on a population based proportion of this, ie 3.7% – 2.5%, depending on whether the SPA is running. The table below gives the final breakdown of the baseline.

Item	Year 1	Year 2	Year 3	Unit cost
75% NHSD	126000	101000	101000	£23
All GPOOH	279000	225000	225000	£13
30% category C Calls	20000	17000	17000	£13
Pilot A's SPA	78000	155000	155000	£10-11
Total Cost	£7,500,000	£7,000,000	£7,000,000	
Total Call Volume	503000	498000	498000	

Table 5.5 The Baseline Call Volume and Costs

The total call volume in the baseline is similar to the "low" scenario for 3DN in a full year of live running. The average unit cost is above the "high" scenario for 3DN.

5.6 System effects

Patients who use 3DN would have previously entered the urgent care system at another service point such for example 999, A&E or GP services. This access point was not always the most appropriate point of entry; by using 3DN a greater proportion of patients will be sent to the right service first time.

We are expecting the 3DN to benefit the patient and previous work has attempted to quantify this using Quality Adjusted Life Years. However, we have identified evaluation issues with testing benefits in this form. The pilot sites have committed to piloting based on improving patient experience during an urgent care episode and shortening some care pathways in terms of time

and number of services access. Patient experience and health benefits will be identified through a population and 3DN user survey.

5.7 Cost savings – core assumptions

Areas of potential cost savings have been identified by the pilot sites in the following areas: Category C attendances by the ambulance service, A&E minor attendances, 0 bed day emergency admissions, GP OOH appointments.

Service	Possible cost saving in £		
	1% reduction in service volume	2% reduction in service volume	3% reduction in service volume
Ambulance Category. C attendances	66000	132000	198000
A&E attendances (minor cases)	68000	136000	203000
Emergency admissions (0 bed days)	405000	811000	1216000
GP OOH appointments	104000	208000	311000
Total	643000	1295000	1929000

Table 5.6 The estimated system cost savings of 3DN in the pilot areas

These savings are more specific than those identified in previous iterations of the IA and are those developed by the pilot sites.
We have still be reasonably cautious in terms of achievable cost savings and have excluded those that would be difficult to claim as a direct result of implementing 3DN (for example, emergency bed days which would overlap with the Long Term Conditions policy area). We have also focused on activity that is currently locally commissioned and/or covered by tariff in order to ensure that savings identified have a higher likelihood of becoming cash releasing. Examining whether these savings and others have been realised will form part of the evaluation a long with an examination of the effect of 3DN on the commissioning of urgent care services and whether the additional information made available through 3DN has allowed a greater degree of efficacy. The mid estimate has been used in calculations.

6. Options Considered

A 3DN service should fulfil three core functions, which are;

- Identify immediate life threatening emergencies and transfer to 999
- Respond to requests for health or service information

- Assess the clinical needs of all other callers and, where necessary, route them to a local service provider who is able to meet their needs for a face-to-face consultation.

6.1 National Rollout

Previous work considered theoretical options looking at whether to use NHS Pathways or not and what level of geography the 3DN should be organised at (nationally, locally (SHA level) or some hybrid of these two). We concluded that there was a clear case to approach Ofcom for the assignment of a number of non-emergency health care access. In this work, we have considered actual business models developed by the NHS and each of the pilots could lead to a different business model adopted in roll out. However, it should be noted that the models proposed by the pilot sites are not mutually exclusive.

6.2 Deploying NHS Pathways

NHS Pathways is an NHS owned and managed clinical decision support system designed to enable trained call handlers to offer safe clinical assessment of patients. It has been tested and piloted in both 999 and GP OOH settings and has been subject to rigorous clinical examination and independent academic evaluation. NHS Pathways can be used to assess the full range of unplanned needs (from life-threatening emergency through to minor illness), and to complete the majority of those assessments within the initial telephone call, without the need for a subsequent call back. .

At the heart of the wider policy for urgent and emergency care is the objective of delivering consistent, high quality clinical assessment across the NHS as a whole, and NHS Pathways is especially well-placed to deliver this. Its rigorous testing in an ambulance service has demonstrated its ability to identify and prioritise emergency calls at least as safely as the market-leading decision support system, and exactly the same system is used to assess less serious injury and illness in other NHS settings. Its robust integration with a local directory of NHS services enables NHS Pathways call handlers to identify the particular local service best equipped to meeting an individual's needs, ensuring wherever possible that they are met safely and appropriately outside the hospital and closer to home.

Whilst there are other decision support systems available to the NHS, there are four reasons why it is considered to be the option best equipped to deliver consistent assessment in urgent and emergency care:

- It is most aligned with the direction of travel for IT (Connecting for Health).
- It will provide commissioners with invaluable information about the demand for particular NHS services within their locality.
- It offers the most flexible staffing profile, with properly trained and supported call handlers completing the majority of the assessments.
- Finally, it is progressing toward clinical ownership by the Royal Colleges, which gives it the potential to secure real clinical credibility in the wider NHS.

In summary, implementing NHS Pathways is expected to increase credibility, increase information for commissioners, fit well with CfH, and reduce staff costs

Each of the pilot sites has decided to implement NHS Pathways as the consistent clinical assessment for the 3DN service in their area.

6.3 Role of evaluation in national roll out

The pilot phase evaluation will validate assumptions in a number of key areas including: demand for the service, resilience of the service, patient benefits and value for money. It will also provide learning about different operating models - the pilot areas are working with NHSD, Ambulance Trusts and OOH providers to design operating models that are appropriate for their region – and assumptions about improved integration of services and the consequent removal of duplication within the system.
The success of the pilots will be measured against the following criteria:

- Easier and quicker access for patients to the most appropriate service – health outcomes;
- More efficient use of resources across the entire non-emergency care system – value for money;
- Increased public satisfaction and confidence in non-emergency health care services;
- Improved management information regarding demand and use of services.

An independent academic lead are being commissioned to perform the evaluation including baseline measures prior to launch of the pilots and analysis of the impact of the pilots during and after a full year of operation.
A decision to roll-out the 111 service nationally will be taken based on the findings of the pilot phase. All procurements will include a necessary break clause to reflect this proviso.

7. Net Costs & Impact on implementation

	Option	Costs	Implementation Costs	**Net Present Value**
1	**Do Nothing**	20.4	0.0	0.0
2	**Pilot Low Scenario**	14.6	13.5	-15.4
	Pilot Mid Scenario	20.0	13.5	-26.2
	Pilot High Scenario	31.0	13.5	-48.3

Table 7.1 The two options for 3DN: 1 Do nothing and 2 The pilot programme under 3 different cost scenarios

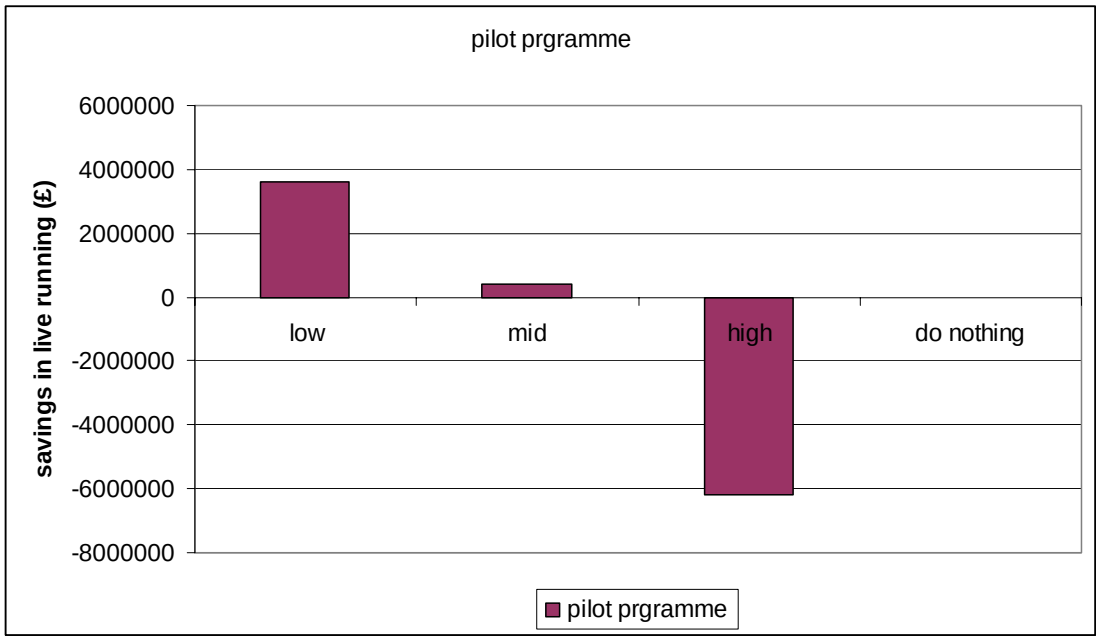
It should be noted that the pilot programme has significant implementation costs, which would be non-recurrent in a rollout situation. For example, the central project team and telephony procurement costs as well as the development of the 3DN brand.

Details on how costs have been phased for the pilot are contained in annex 10.5

The chart below illustrates the difference between the “do nothing” Option and the three scenarios for the pilot programme in live running. It can be seen from this that in live running both the low and mid call volumes will generate cost savings of between £0.5m and £3.5m for the pilot areas.

Considering all scenarios, the annual national saving on rollout is between -£165 and £95m, with an estimated rollout cost to the NHS between £40m - £80m. Spending around £15m on the pilot programme will reduce the tremendous uncertainty around the benefits and implementation costs and allow an evidence based decision to be made on national rollout. In addition, the pilot programme will result in lessons learnt that will be applicable in national rollout.

Chart 7.1 The cost savings in live running of the pilot programme



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8. Evaluation Strategy – update with evaluation plan and demarkation referring to Uni of Sheffield as “an academic lead”

The evaluation of the 3DN pilots will be an independent evaluation led by an academic institution in collaboration with Operation Research (OR) Analysts in the Department of Health.

8.1 Evaluation aims and objectives

The key aspects of the service that the evaluation will focus on are detailed below:

i) Monitoring trends in the service provided in each pilot site.

Using Pathways, telephony and HR data to monitor trends in who uses the service, referral patterns, call volumes and durations, abandonment rates and time to answer . DH OR analysts will undertake this work and will provide regular reports to the 3DN Stakeholders.

ii) Evaluating the impact of the introduction of 3DN on users of the emergency and urgent care systems

Population telephone surveys will be undertaken in each site before the first pilot site begins, and exactly 12 months later. The academic institution has developed a questionnaire that measures peoples experience and satisfaction with the service provided and also looks at confusion around how to access the system. The impact of the 3DN will be examined by measuring changes in the distributions of system use and satisfaction across each of the three pilot sites.

iii) Evaluating the impact of 3DN on patient experience and outcomes

A 3DN patient experience survey will be undertaken in each site. The questionnaire will ask a range of questions to gain an understanding of the overall patient experience of 3DN and compliance with the advice given. The questionnaire will be returned to the academic institution who will carry out the analysis of the responses.

iv) Evaluating the impact of 3DN on NHS staff

In each site the academic institution will undertake qualitative semi-structured interviews with a range of NHS staff. The interviews will explore the perceived impact of 3DN on system use and staff morale, and the safety and appropriateness of 3DN advice to contact other services.

v) Evaluating the impact of 3DN on other urgent care services and the costs and benefits of this

Services in the emergency and urgent care system may see an increase or decrease in use over time. DH OR Analysts will use routine data to develop a baseline of the use of urgent care services in the three pilot sites and three matched control sites. The costs, cost savings and benefits will be assessed in each site against the baseline data and control site data, analysing changes in activity and resources required for each service within the defined scope of the Urgent Care system

vi) Compare and contrast different models of provision to identify lessons on the best ways of developing the service and rolling it out across the country.

Documentation produced by each site for the DH will be used to describe the operating model. The University team will carry out a site visit to each pilot site in its first month of operation to describe the model in use. This will include observing at least one shift in the control room.

8.2 Reporting

The evaluation is being led by the academic institution in collaboration with Operation Research (OR) Analysts in the Department of Health, the University will have final say on the content of the report. The final report will be published in September 2011 with interim reports during the pilot phase.

8.3 Affordability

Each pilot site has separately considered the affordability of their pilot. This process has involved their local governance arrangements.
Programme funds for 2009/2010 have been identified covering. Programme funds for 2010/11 are still to be confirmed but are being secured as part of the normal business processes of the Department of Health**.**

9 Conclusions and Recommendations

There are many uncertainties in the costing, cost savings and potential benefits of 3DN including the uncertainty around the volume of calls a 3DN would receive. However the possible efficiencies that could be gained, the opportunities to lever integration across urgent care services and to benefit patients by providing a simple point of access lead us to point to considerable gains that could be made.

There is a clear case for improving patient access to urgent care services and the Next Stage Review points to a 3DN as a way forward. The evidence presented here suggests that 3DN pilot programme presents a clear opportunity to test and evaluate the feasibility, costs and potential benefits of introducing 3DN. The opportunities for co-production with the NHS system integration that 3DN leverages should be explored and the pilot programme is the best option for doing that.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

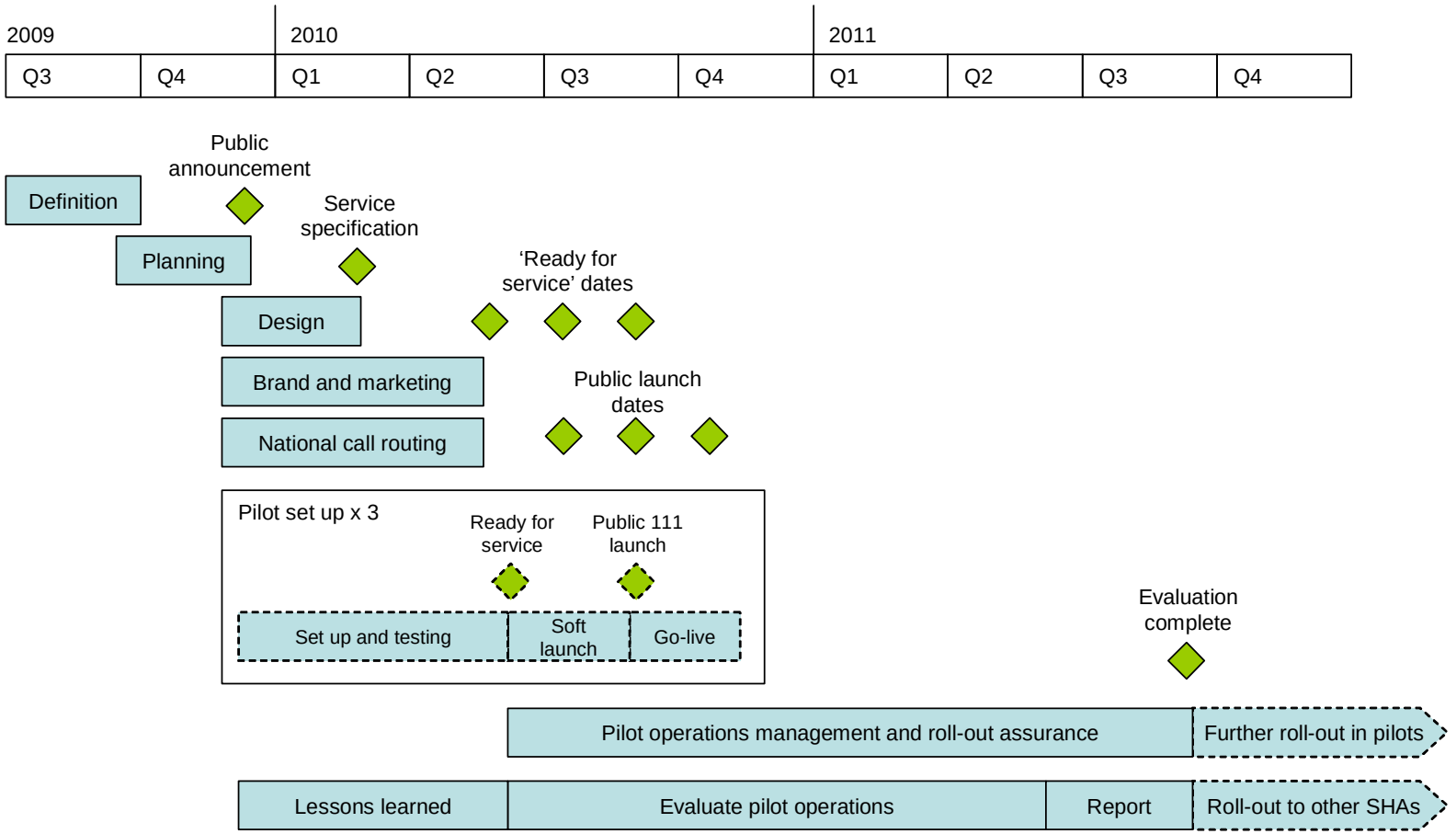
Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	***Results in Evidence Base?***	***Results annexed?***
Competition Assessment	No	No
Small Firms Impact Test	No	No
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	Yes	No
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	No	Yes
Rural Proofing	No	No

10 Annexes

10.1 High level Programme Plan
10.2 Programme Risk Register
10.3 Assumptions for cost savings
10.4 High level pilot business models
10.5 Phasing of costs assumptions
10.6 EqIA (tba)

10.1 High Level Programme Plan



10.2 Programme Risk Register

Ref	Risk	Prob	Impact	Status	Mitigation in place
2	Unknown demand – volume of calls may overload the 'system' or be unaffordable – potential 'tip' from GP in hours Free to caller effect	M	H	**H**	Demand assumptions agreed between DH and pilot areas assuming initial focus of brand on urgent health care 'Soft launch' principle established to ensure that service integration and new call handling capacity are fully bedded in prior to public announcement of the 111 number Plan to stagger pilot area launches to enable lessons learned to be acted on Piloting phase will be used to validate demand assumptions
3	Major dependency on NHS Pathways / CMS	M	H	**H**	CfH taking formal ownership of CMS DH working closely with CfH to establish robust plans for delivery of NHS Pathways and CMS
4	Key stakeholders do not support the programme	M	H	**H**	3DN Programme board members appointed to represent the clinical community, NHS in the pilot areas and CfH Stakeholder group established to engage wider group of stakeholders including NHSD, BMA, RCGP, Commissioners and the devolved administrations Key messages, lines to take and answers to FAQs developed to support stakeholder engagement activities Pilot areas have engaged key local stakeholders and delivery partners in their regions
5	Fit of with DH digital strategy is unclear resulting in sub-optimal brand, scope, patient experience	M	M	**M**	

Ref	Risk	Prob	Impact	Status	Mitigation in place
6	The patient experience is poor and/or inconsistent – eg what happens to a GP in-hours contact where practice is unavailable	L	H	**M**	The design of the service, initially captured in a high level blueprint takes a patient centric view of the process The evaluation will measure the patient experience
1	Insufficient funding available to set up and operate the 3DN service	L	H	**M**	DH funding secured to 'pump prime' the service set-up, covering programme team, marketing and telephony set up costs
7	Insufficient skills and resources available in DH and NHS to deliver the programme	M	M	**M**	Key lead roles in place including Prog Director, Pilot area leads, Evaluation, Service Design and Telephony
8	Lack of service integration beyond the single point of access results in poor service delivery and limits patient benefits	M	M	**M**	Pilot areas will work with service providers on a regional basis to populate directory of services and agree referral processes Pilot areas engaging commissioners of urgent and emergency care in the pilot areas in the set-up and operation of pilot services
9	The brand does not attract the right type of calls or set appropriate expectations resulting in poor patient experience / satisfaction	L	H	**M**	Plan in place to engage specialists in developing brand Piloting phase will be used to test the brand and validate assumptions
10	The wider impact of the programme on social care and community services is not fully considered and addressed	M	M	**M**	Pilot areas are focussing initially on urgent health care needs Pilot areas have engaged social care and community service stakeholders in their regions Piloting phase will be used to assess wider impact on social care and community services

Ref	Risk	Prob	Impact	Status	Mitigation in place
11	High volume of 'phantom calls' to 111 increase costs and necessitate technical workarounds which impair customer experience	M	M	**M**	Estimates of potential call costs are manageable within the existing business case Proposed technical solutions to filter out phantom calls are designed to have minimal impact on customer experience Piloting phase will be used to validate assumptions
12	Potential benefits resulting from reduced 'whole system load' and call handling efficiencies are not realised	H	M	**M**	Development of benefit profiles in pilot areas setting out the expected benefits over time and plans / ownership required to deliver them Piloting phase will be used to assess impact on call handling operations in pilot areas including NHS Direct
13	The pilots areas do not deliver the service on time or to quality, resulting in delays, additional costs and reduced benefits	M	M	**M**	Pilot areas are developing robust plans for setting up and operating the service Programme plan will include contingency to allow for slippages prior to public launch of the 111 number
14	The service is not clinically robust – a serious incident could irreparably damage the brand	L	H	**M**	Pilot areas have selected NHS Pathways to provide consistent clinical assessment NHS Pathways implementation approach includes robust accreditation and licensing arrangements for service provider and system supplier
15	Major change of scope or direction occurs as a result of general election or departmental / NHS reorganisation	M	M	**M**	Develop compelling case for the programme based on plans and evidence from the pilot areas
16	IT connectivity issues between Pathways and clinical systems	H	L	**M**	CfH plan in place to develop interoperability standards
17	National telephony infrastructure delivery is delayed	L	H	**M**	Active management of supplier throughout procurement and delivery Plan to establish effective joint working arrangements and formal escalation routes with supplier Build in contingency to programme timescales to accommodate slippages

Ref	Risk	Prob	Impact	Status	Mitigation in place
18	2nd wave of swine flu constrains call handling capacity in pilot areas	L	M	**L**	Pilot area launch window occurs over summer 2010
19	Lack of public involvement in pilots	M	L	**L**	Research undertaken about the potential demand for the service and choice of number
20	Lack of political support for the programme	L	H	**L**	MS(H) engaged and supportive of the initiative Opposition 'Plan for a better NHS' refers to a 3DN number for urgent care to sit alongside 999
21	Pilot area operational models are not scalable to whole SHA	L	M	**L**	Pilot areas working to secure regional involvement and buy-in to 3DN pilot and roll-out approach
22	Re-commissioning of OOH providers does not follow due process	L	M	**L**	Pilot areas to ensure that the procurement of wider roll-out of 3DN service within region is contestable
23	Boundary issues during the pilot phase are not managed resulting in patient confusion and exacerbating access issues in boundary areas	L	M	**L**	DH telephony SME working closely with pilot areas on call handling approaches

10.3 Assumptions for cost savings

Cost savings have been calculated as a % of system activity and have not been related to the call volume since there will be diminishing returns on higher call volumes and there is a probable step change that can be made in the system by implementing consistent assessment and the use of the directory of services.

10.4 Business models for pilots

10.4.1 Pilot A business model

The model for pilot A is based on their existing pilot of a Single Point of Access (SPA). The SPA pilot sits within a programme of urgent care integration and improvement is described as follows:

- The ambulance service operates the SPA located within its control room
- The ambulance service has developed and maintains the directory of service (DoS)
- NHS Pathways is used as the non-clinical triage systems and provides warm transfers to a number of organisations
- Calls are patched through to cover GP out of hours (OOH) calls and providing an integrated service linked to domiciliary visits from clinicians working out of the urgent care centres
- Callers can be referred directly to urgent care centre appointments
- The OOH and urgent care centre calls are enabled by a connection with Systm1 that provides significant future opportunities for integration
- NHS Direct will continue to provide health information, symptomatic advice and transfers to 999 and the single point of access
- It is intended to deliver warm transfers from the SPA to NHS Direct
- A possible future extension of the pilot involves primary care appointment booking from the SPA via Systm1

10.4.2 Pilot B business model

Pilot B is running pilots in two PCTs (B(i) and B(ii)) the business model for each pilot is outlined below:

B(i)

- The urgent care telephone access service will operate as a partnership between the ambulance service and NHS Direct (NHS D)
- The ambulance service provides the 999 and GP Out-of-Hours (OoH) call handling services located within its control room
- NHS D will provide its existing telephone access services via regional/national call centres
- Callers will be able to dial either 111 or existing service numbers for urgent but non-emergency health calls. The ambulance service will continue to operate the 999 emergency call system
- 111 calls (dependent on volume/demand) will be shared between the ambulance service and NHS D

- The Primary Care Trust and its partners will develop and maintain the electronic Directory of Services (eDoS)
- NHS Pathways will be used as the non-clinical triage system and can support warm transfers and/or signposting between the three main services (ambulance, OoH and NHS D) and other organisations
- The ambulance service, NHS D and the OoH service will have access to the eDoS. There will also be controlled access for other organisations
- Telephony systems and IT infrastructure will be in place to enable warm transfer of calls and management of call volume between the ambulance service and NHS D
- The scope of the service, including services featured in the eDoS, will be reviewed and expanded if appropriate as the service model develops.

B(ii)

- NHS Direct (NHS D) will operate the urgent care telephone access call handling service
- NHS D will provide its existing telephone access services via the regional/national call centres and also the call handling service for the GP Out-of-Hours (OoH) service
- Callers will be able to dial either 111 or existing service numbers for urgent but non-emergency health calls. The ambulance service will continue to operate the 999 emergency call system
- The Primary Care Trust and its partners will develop and maintain the electronic Directory of Services (eDoS)
- NHS D, the ambulance service and the OoH service will have access to the eDoS. There will also be controlled access for other organisations
- NHS Pathways will be used as the non-clinical triage system by NHS D and will be able to support warm transfers to the ambulance service and other organisations
- Initially, NHS Pathways will only be implemented for NHS D but there are outline plans to extend implementation to the ambulance service within the first year of operation
- Telephony systems will be in place to enable warm transfer of calls between NHS D, the ambulance service and the OoH service
- The scope of the service, including services featured in the eDoS and geographical coverage, will be reviewed and expanded if appropriate as the service model develops.

10.4.3 Pilot C business model

The business model for this pilot will be the similar to Pilot B with the exception of warm transfers between NHSD and the OoH service

10.5 Phasing of costing for pilot and baseline

Table costing the baseline

Item	Year 1	Year 2	Year 3
Pilot A Single point of access	0.5 year	1 year	1 year
Pilot A baseline estimate	0.5 year	0 year	0 year
Pilot A SPA saving	0.5% system saving 0.5 year	0.5% system saving 1 year	0.5% system saving 1 year
Pilots B and C baseline estimate	1 year	1year	1year

Table costing the pilot

Item	Year 1	Year 2	Year 3
Pilot A Single point of access	0.5 year	0 year	0 year
Pilot A baseline estimate	0.5 year	0 year	0 year
Pilot A 3DN Costs and savings	0 year	1 year	1 year
Pilot A SPA saving	0.5% system saving 0.5 year	0	0
Pilot B baseline	1 year	3/12 year	0
Pilot C baseline	1 year	4/12 year	0
Pilot B 3DN costs and savings	0	9/12 year	1 year
Pilot C costs and savings	0	8/12 year	1 year

Improving Access to Urgent Care Services (3DN)

Equality Impact Assessment (EqIA) – Initial Screening Assessment

December 2009

CONTENTS

EXECUTIVE SUMMARY

i. This Initial Screening for a full Equality Impact Assessment (EqIA) examines the impact of the introduction of a three-digit number (3DN) for access to non-emergency healthcare, on different groups in the community, to inform any possible final decision on nationwide roll-out. It anticipates and recommends ways to avoid any negative consequences for particular groups who may be subject to discrimination on the grounds of: race, gender, disability, faith, sexuality or age.

ii. In summary, the introduction of a new three-digit number for this purpose is likely to benefit all equality areas. Research commissioned to inform policy suggests there would be a high uptake for such a service.

iii. There is strong evidence based research to suggest that the number '111' could be particularly beneficial due to its memorability and ease of dialing to those with learning difficulties, sensory impairment or hand movement restrictions.

iv. The evidence also suggest that the hardest to reach group will be older people (+75) where the research suggests a strong connection with their GP and in parallel to this a lack of use of NHS services across the border, early on in the onset of illness. This will therefore be a challenge for communication of the service and will need to be targeted by individual SHAs taking forward piloting.

v. The more ambiguous research revolves around equality areas such as BME's, young people, LGBTs, faith and gender differences. Some assumptions about the likely benefits are made in this screening assessment and will be monitored carefully in the evaluation period that will inform a full EqIA and any possible decision on nationwide roll-out.

vi. A full EqIA will be undertaken following the completion of an evaluation project of the pilot sites and SHAs piloting the 3DN will be required to undertake their own EqIA on the service delivery element.

1 BACKGROUND

1.1 The principle aim of the 3DN Programme is to:

"consider options to introduce a new three-digit telephone number to help people find the right local service to meet their urgent, unplanned care needs."[1]

1.2 Following Lord Darzi's Review, 'High quality care for all: NHS Next Stage Review'[2], the Department undertook to consider the costs and benefits of a new national three digit number (3DN) to access non-emergency healthcare which would promote and drive forward the Government's commitment to integrated urgent health care.

1.3 The screening assessment looks at those benefits and their impact on the principle of equal access to all. Existing research demonstrated that people often find it difficult to know how to access urgent healthcare, who to call, where to go. A poll conducted by Which?[3] revealed 83 per cent of adults did not know the number to call for NHS Direct.

1.4 The public know the '999' number is an emergency number. It is important policy reinforces this and enables the public to contact other more appropriate health services, where their health need is not life threatening. By developing a more memorable non-emergency number, we will simplify the distinction. It will give the public, for the first time, a clear, simple choice, namely: "If the situation is an emergency, call 999; for all other urgent health needs, call 3DN and we will work out with you what is the best way of meeting your needs."

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[1] 'High quality care for all: NHS Next Stage Review' final report, Lord Darzi of Denham KBE, (June 2008)
[2] Ibid
[3] Out-of-Hours Care, Which?, June 2006. Only 17% of 1367 adults interviewed knew the number for NHS Direct.

1.5 The new 3DN will be able to:

- Identify immediate life threatening emergencies and transfer to 999;
- Respond to requests for health or service information;
- Assess the clinical needs of all other callers and, where necessary, route them to a local service provider who is able to meet their needs for a face-to-face consultation, and;
- Be free-to-caller.

1.6 It will provide a quick, convenient and accessible way for people to navigate their way around local urgent care services right across the country, at any time of day whether at home, at work or out of area but critically this would not replace existing local numbers.

1.7 The new number is not designed to replace access to services that are already familiar. For example, it is expected that people will continue to telephone their GP practice for (long-term) appointments in the same way that they do now. However, where they are unsure about what to do, or if they need information about a particular health condition or about a service provided by the NHS, this will be the number to call.

1.8 The new number is part of a wider programme of reform and it is anticipated it will act as a driver to help deliver the wider vision of integrated urgent care services.

1.9 Early in 2009, The Department of Health asked the Office of Communications (Ofcom) to consult on the use of the 3DN '111' for the purpose of accessing urgent healthcare needs. Ofcom published this consultation paper on 9 July 2009[4] and ran until 20 August 2009. Over 200 responses were received, both from members of the public and from bodies with a professional interest. The response was generally very positive, with 83% of respondents stating they were in favour of the

[4] Ofcom consultation, http://www.ofcom.org.uk/consult/condocs/three_number_non_emergency/main.pdf (July 2009)

concept of a 3DN for this purpose, and 68% of respondents stating they favoured '111' over any other number.

1.10 In undertaking preliminary research into the public, reaction to the use of a 3DN for this purpose over three quarters were positive[5].

> *"**Public opinion.*** Spontaneous responses to the 3DN concept were, on the whole, very positive, from both a personal and a societal point of view. Particularly appealing was the '999 style' memorable number, especially in light of the low recall of the current NHS Direct number in this sample and we understand generally. The service was expected to make for easy access to NHS care through a single number and it was anticipated that it would be easier to get through to a 'real person' in comparison to calling the GP's surgery. The 'call handler' was expected to possess useful local knowledge and to be able to help clarify situations. Overall, there was a feeling that the 3DN service would be an 'even better' NHS Direct. This in itself was expected to have societal benefits, reducing pressure on 999 and, to a lesser extent, GP services. Moreover, there was a feeling it would give permission to use the NHS and reduce any guilt pangs."[6]

[5] Three Digit Number For Urgent Care Concept Research, Qualitative Research Report, Diagnostics for DH (November 2008)
[6] Ibid.

2. PURPOSE OF EQIA

2.1. The purpose of the Screening Assessment is to examine the impact on different groups within the community of introducing a 3DN to access urgent and unplanned healthcare. It should be used to anticipate and recommend ways to avoid any discriminatory or negative consequences for a particular group, on the grounds of

- race,
- gender,
- disability,
- faith,
- sexuality or
- age

2.2 Equality Impact Assessment is an essential part of meeting the Department of Health's general duties towards equality. It considers what effect the Department's activities have on eliminating unlawful or unjustifiable discrimination, promoting equality of opportunity and meeting other requirements of the equality duties, such as promoting positive attitudes towards disabled people. It also enables us to show how positive effects can be maximised, and negative effects minimised or eliminated, by modifying policies and practices. [7]

2.3 Ensuring that all Strategic Health Authorities (SHAs) proposing to pilot the 3DN undertake a rigorous EqIA is an important requirement of the programme. As SHAs work with their local Primary Care Trusts to determine the nationwide expansion of this programme, a thorough EqIA of local service will be undertaken.

[7] Equality Impact Assessment: Guidance for policy makers, DH (2008)

3. METHODOLOGY

3.1 The approach to this screening assessment recognises a number of challenges and constraints in the analysis. For the purpose of this, a baseline of data, based on usage of NHS Direct services and qualitative public research, make up the statistical data.

3.2 The services accessed via the 3DN will be new and different to that currently provided by any healthcare or private sector equivalent providers. Therefore, this means equality data comparisons are constrained to the current nearest service provider.

3.3 The Department of Health and NHS will therefore necessarily be piloting the new 3DN in order to test amongst other things the effect of the new service on hard to reach groups and those with particular and specialised needs.

3.4 Within the evaluation period of the pilot sites there will be the following indicators which will be evaluated for their ability to meet different service users needs:

- What was the public/patient experience of using the service and did it improve quality, safety and health outcomes?
- Did it represent value for money?
- Did it improve access to services?
- What impact did the introduction of the service have on the local health economy?

3.5 During the development of the policy, the Department of Health sought the opinion of various stakeholders including minority groups and clinicians. These were all broadly supportive of the principle of a new 3DN for accessing urgent health care.

3.6 Following this research, two important aspects of the service were unknown: the most significant being the actual number and the cost-to- caller of accessing the service. These are two significant factors for equality and these will be evaluated in the pilot sites for their impact on BME's, older people and the disabled in particular. However, since the research was undertaken, the Department of Health has decided to make calling the three-digit number free to caller.

3.7 The research concluded:

- Qualitative research – The Number

  "On the basis of this research, 111 is by far the most popular of the candidate 3DNs: it was the clear first preference in every sample sector, despite a few individual dissensions. 111 is distinctive, basic and easy to use in its own right, and it benefits from associations

with 999 without losing its distinctiveness. As a result, it was almost universally expected to be the most memorable, most reliable to recall in urgent situations, and easiest of use of all the candidate 3DNs. It also has the additional benefit of conferring confidence in the quality of the service offered, and suggesting a vital public service as opposed to a useful private-sector one."[8]

- Quantitative Research – The Tariff

Four tariff options were originally under consideration[9]:

- Free to caller, including payphones and mobiles
- 10 pence per call, regardless of call length
- 3 pence per minute
- Local rate (which would vary in respect of different kinds of telephone provider).

"None of the tariffs have a major impact on likely usage but there is a significant increase in claimed uptake if the new service is free of charge – especially if alternative tariff is 3p per minute.

At least as many people expect to pay for the new service as expect it to be free. More likely to anticipate a charge if believe current services are charged for – especially in middle class, middle aged life stages.

Most people are at least fairly likely to use the new service regardless of what they might have to pay for it.

Most likely to use the new service if out of hours and/or away from home.[10]"

[8] Three Digit Number for Urgent Care: Qualitative Research to help identify the most appropriate number, Cragg Ross Dawson for COI Research and DH, March 2009

9 However, since the research was undertaken, the Department of Health has decided to make calling the three-digit number free to caller.

[10] Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009

4. EQUALITY AREAS

It is important to note that the separate equality areas set out below are a useful categorisation but are not separate from each other – e.g. an older black person with a disability may face multiple barriers.

Data cited in this report should be read along side the 'Methodology' section of this assessment. Any conclusions drawn reflect the possible impact of the programme nationwide. Local impacts will be assessed by SHAs piloting the scheme.

The Department of Health commissioned two major strands of research on the preferred number for the service and the potential tariff options. They both concluded that there was overwhelming support from all areas of society for a new 3DN, with an average uptake of the service likely in all scenarios at 82%[11].

4.1 Age

4.1.1 People at different stages in their life may have different healthcare needs. The programme is keen to encourage the public to access healthcare at an earlier stage in their illness. We know that particularly older people can be reluctant to contact health services, including '999' and other emergency services[12].

4.1.2 The programme recognises the challenges of providing services for different age groups and their particular sensitivities. These will be

[11] Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009
Three Digit Number for Urgent Care: Qualitative Research to help identify the most appropriate number, Cragg Ross Dawson for COI Research and DH, March 2009

[12] Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009 – of 87% of people surveyed who had not access any telephone health services in the last year this percentage rises to 90% for those aged 75+

monitored at a local level in the EqIA's undertaken by SHAs that will consider local service provision.

4.2 Young People

4.2.1 There is no evidence to suggest that introducing the 3DN would create an unequal provision for young people. Research commissioned did suggest that they would expect the service to be free as compared to other groups[13]; however, this does not worsen the current situation where a local rate tariff is paid for NHS Direct and most GP services.

4.2.2 The new service may well improve the provision given two factors. The memorability of the number may be beneficial for those accessing the service while away from home[14], perhaps at university and the anonymity of the service may encourage young people to access health information services.

4.3 Older People

4.3.1 Older people are often reluctant to access healthcare advice and assistance at the onset of illness through fear of putting unnecessary burdens on the system. A new 3DN would be a more memorable route ('111') into services and may 'give permission' to access NHS services.

4.3.2 However, research also suggests that older people maintain regular contact with their GP's and this is the preferred route to accessing healthcare[15]. The new 3DN service would not change this and people

[13] Ibid – of the 14% of respondents who said they were unlikely to use the service just 24% cited the cost as a barrier (36% of this was in the 16-24 bracket)
[14] Ibid – under each tariff option the uptake for the service increased in the scenario when 'away from home' – 81% average under each tariff, compared to 76% when at home
[15] Ibid – "compared to the average, older people are less likely to call NHS Direct in any of these scenarios and more likely to call their GP"

would still be able to access their GP where they know the number in the same manner.

4.3.3 The commissioned research suggests: "*particularly older age group tends to be lower than average, whether or not the 3DN is free or charged for. These groups also display a lower propensity to use current services. This suggests that price is less of a barrier than entrenched behaviours e.g. "suffer in silence*"."[16] The pilot sites will need to ensure that the service is considered comparable to 999 in quality in order to gain support from these more entrenched behavioural groups. This will be included in the evaluation and success criteria.

4.4 Disability

4.4.1 The focus of this screening assessment as regards to the needs of people with a disability or sensory impairment, has been on the ease of dialling and memorability of the number - a particular issue for those with learning difficulties or hand movement restrictions.

4.4.2 In general, the programme does not worsen the current service provision, provided by a sometimes confusing array of urgent healthcare providers. These will continue to exist and it is likely that the 3DN programme will assist people with a disability, or long-term condition, and those such as the disabled and those with learning difficulties that currently may be unsure how to access those services.

4.4.3 The Department of Health commissioned research to determine the best number taking into account:

- Memorability;
- ergonomic ease;

[16] Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009

- navigation for the partially sighted or blind; and
- most appropriate and resonance to the service[17].

4.4.4 The research consulted experts in dyslexia, dyscalculia, psychology and other fields. The researchers also interviewed individuals that were over 75, had a long-term condition, partially sighted or blind and those with restricted movement in their hands and their carers, as well as carers.

4.4.5 Across the research groups, '111' consistently emerged as the clear preference for health professionals but also for people with a learning disabilities or movement restriction. This was the number that would best meet the three objectives for the number (see paragraph 1.5).

4.4.5 The Department is currently liaising with the Royal National Institute for Deaf People (RNID) on technical options for deaf or hard of hearing callers. The Ambulance Services is currently piloting a text messaging service that may be a useful comparison for the 3DN programme.

4.4.6 The evaluation of the programme will also seek to address the broader access requirements of individuals with a range of other disabilities. More work will also be needed to consider the needs of people with sensory impairment and those with physical disabilities.

4.5 Race

4.5.1 Britain is a multi-cultural society. Historically, people from black and minority groups have suffered from poorer health, have reduced life

[17] Three Digit Number for Urgent Care: Qualitative Research to help identify the most appropriate number, Cragg Ross Dawson for COI Research and DH, March 2009

expectancy and have greater problems with access to health care than the majority white population[18].

4.5.2 There is now sufficient and increasing amounts of epidemiological data to assist public health agendas and preventative initiatives in tackling health inequalities[19]. In the case of BME communities rising rates of chronic diseases amongst some BME populations are concerning. We know, for example that:

- death rates from Chronic Heart Disease among the population of England and Wales born in South Asia are 50% higher than the average,
- The death rate for strokes amongst The African Caribbeans is 50% higher than average,
- Women born in India and East Africa have a 40% higher suicide rate then the general population,
- Prenatal mortality amongst Pakistani born women is double the UK national average.[20]
- BME populations are nearly six times more likely than the general population to report having diabetes, with risk ratios amongst Pakistani men and women being high[21].
- Pakistani/Bangladeshi men and women are three to four times more likely than the general population to describe their health as bad or very bad[22].

4.5.3 Equality of access, especially for BME communities is most significant in regards to memorability of the number and cost to caller. People from BME communities can experience particular difficulties accessing

[18] National Institute for Mental Health in England (NIMHE): Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England, London, DH, 2003
[19] Evidence of health Inequalities, Raleigh, S. V., Polato, G, M. 7Health Care Commission.
[20] Reaching Out to Black and Ethnic Minority Communities: Addressing Their Health Needs, S. Sharma, 2006
[21] Diabetes U.K. 2006
[22] Social Focus in Brief: Ethnicity, National Statistics, 2002

out of hours services where the wide range of different providers and numbers is sometimes confusing. The barriers range from practicalities such as the range of languages used for health information through to attitudinal challenges and the quality of health professionals understanding of cultural diversity. Currently, NHS Direct provides a translation service in over 100 languages. This will be a minimum requirement for the 3DN pilot sites.

4.5.4 In research commissioned by the Department of Health on the tariff for a new 3DN service consistently showed BMEs were more likely to access emergency services than their local GP[23] in an out-of-hours situation[24]. A 3DN has the potential to improve awareness of other services and improve integration. A new more memorable number could therefore provide better access.

4.5.5 In regards to price sensitivity, vulnerable groups such as BMEs displayed slightly higher price sensitivity than other groups[25]. However, over the four price ranges (see paragraph 3.7) BME groups on average displayed a high uptake of the potential new service at an average of 80% over the 3 priced tariffs in the out of hours and 77% away from home periods[26]. However, since this research was undertaken, the Department of Health has decided to make calling the three-digit number free to caller.

4.6 Religion and Belief

4.6.1 No specific work has been done to date on the potential impact of the 3DN programme with regard to religion and belief. There is no current

[23] Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009 – "compared to the average, BME's are more likely to dial 999 in any of these scenarios"
[24] Ibid
[25] Ibid – of the 14% of total respondents who said they were unlikely to use the service citing the cost as a barrier, 40% were of these were of BME origin.
[26] Ibid

data to suggest that the programme would have a negative effect on any particular religious groups.

4.6.2 In cases such as the Muslim community where a large proportion may not have English as their first language the service will provide a translation service in the same configuration as NHS Direct. NHS Direct currently provides its telephony service in over 100 languages.

4.6.3 The anonymity of the service may also encourage religious groups that are harder to reach due to cultural differences and embarrassment about certain health issues to access the service.

4.7 Gender

4.7.1 During the evaluation period, information will be gathered to determine whether the services are equally meeting the needs of both men and women. There is evidence that men are less likely to access healthcare early on in the onset of illness and have lower rates of attending their GP.

4.7.2 NHS Direct currently receives 15 percent of calls from men compared to 28 percent from women in the same age bracket[27]. The memorability of the service and anonymity may increase the likelihood of men accessing health care services earlier.

4.8 Sexual Orientation

4.8.1 No specific work has been done on the effect of the service provision on people from the Lesbian, Gay, Bisexual and Transgender (LGBT) community.

[27] NHS Direct dataset – February 2009 – in the age range 16-44 years old NHS Direct received 15% of calls from men compared to 28% from women in the same age bracket, in February 2009

4.8.2 Historically the unequal treatment of LGBT people by healthcare services has meant that they were often discriminated against. Previous research on the extent to which the LGBT community are confident of the understanding of their local GP services to their specific needs[28] suggests that the anonymity and improved integrated services of the 3DN service may encourage people to access healthcare information early. The NHS will need to engage with representative groups during the evaluation and piloting process to gauge the level of usage by the LGBT community and any specific deficits relating to this group in the service provision.

[28] "Count Me In" - Brighton & Hove Lesbian, Gay, Bisexual & Transgender Community Strategy 2001 - 2006

5. MONITORING AND COLLECTING INFORMATION

5.1 Under the Race Relations Act 1976 (Statutory Duties) Order 2001, every public body must *'monitor by reference to those racial groups, the admission and progress of students and the recruitment and career progress of staff.'* In the Commission for Racial Equality's Statutory Code of Practice on the Duty to Promote Race Equality, monitoring is defined as the collection of *'information to measure an institution's performance and effectiveness. The results may suggest how the institution can improve.'*

5.2 Equality monitoring is critical for the successful implementation of any policy or programme. Monitoring is a way of checking how well policies, procedures and practices are working; it can then be linked to policy development, implementation and evaluation.

5.3 It is an essential component of the 3DN programme that participating organisations:

- Undertake local equality impact assessments
- Collect a range of input and outcome measures, as stipulated by the programme's data set, in order to evaluate any success criteria.

5.4 This information is collected and reported at different levels to satisfy local service improvement, commissioning decision-making, regional, and national strategic planning. The 3DN programme has commissioned an academic institute to undertake such a study and the conclusions will inform a decision on nationwide roll-out.

5.5 The development of the 3DN service will be monitored by the 3DN Programme Board following OGC guidelines. The reporting structure is detailed at Appendix F. More detailed information regarding equality areas will be collected and monitored locally.

5.6 Responding to the national service provision across all equality areas will be important in informing future policy direction. Working closely with the 3DN programme board, a local evaluation of usage of the 3DN service by BME, older people and disabled groups will be undertaken. Understanding and responding to the needs of BME, older people and disabled communities has been identified as a priority with SHAs.

5.7 Each of the pilot areas trailing the 3DN programme has been tasked specifically to look at the equality agenda and the outcomes will be fully

reflected in a full EqIA scheduled for publication following the completion of the pilot schemes. This will contribute to any final decision on nationwide roll-out and the mode of any potential roll-out.

5.8 To support the embedding of equality issues into the pilot phase of the 3DN Programme, we have commissioned the SHAs to produce local EqIAs to inform their local service provision for a 3DN.