

Q1 Do you agree with Ofcom's view that the proposed non-emergency healthcare service represents a justified use of a three-digit number? Please give reasons for your views:

Yes. The effectiveness of the three-digit number depends upon sound national and local strategies for non-emergency healthcare services and credible systems for directories of services. The three-digit number cannot be taken out of that context.

The Boards of County Durham PCT and Darlington PCT approved their joint Urgent Care Strategy on 3rd April 2008 following extensive stakeholder engagement over the previous six months. A central part of that strategy is the development of a local single point of access (SPA) communication centre using an accessible phone number for non-emergency healthcare services. This concept then became an action for the NHS North East strategy 'Our Vision Our Future' in response to the NHS Next Stage Review. We are now planning an 18 month pilot on behalf of NHS North East to operate a SPA communication centre across County Durham and Darlington, an area of 620,000 residents, to go live from 1st October 2009. The North East Ambulance Service NHS Trust will manage this service. We have a suitable eleven digit number for this service.

Non-emergency healthcare and the use of phone support are major issues for the NHS. Patients and carers routinely access inappropriate services or have frustrating journeys negotiating various organisations. There are clinical, social and financial implications of this ineffective service use. We calculate significant benefits from resolving these issues, particularly in avoiding unnecessary A&E attendance and admissions to hospital.

The ability to use a three-digit number will be of considerable value in communicating the new service model to the public, organisations and professionals. A three-digit number will give focus and clarity to awareness of the service and facilitate its use.

Q2 Do you agree with the DHs view that:

- A) a three-digit number is the best choice for the proposed service and
B) of the three-digit numbers available, 111 is the best option?**

Please give reasons for your views. :

a) Yes. Our work with a wide range of stakeholders over the last 18 months involved discussions on preferences for three and eleven digit numbers. There was a clear preference for a three digit number in terms of convenience for phone memories/speed dial and promoting public awareness. This was the case for both NHS staff and patient representatives. Many people highlighted the success of the 118 commercial campaigns and the simple impact of memorising that number.

b) Yes. Our work with a wide range of stakeholders involved discussions on preferences for a three digit number and examples used were 109, 111 and 119. The number 117 was never raised as an attractive option (see 4.87 in your consultation). Throughout these discussions, 111 was the favourite number with responses strongly supporting the Qualitative Research work by published with this consultation by the DH. The key reason was the ease of appliance of that number to public awareness campaigns. One slight qualification raised

regularly by our stakeholders re 111 was the possibility of mis-dials. The point made by you re mis-dials in 4.86 of your consultation document is therefore noted and appreciated.

Q3 What are your views on the tariff options selected by the DH? :

This is clearly a key issue and we found the consultative research published by the DH and conducted by COI Research to be useful in considering the options. We consider this to be an extremely important issue given our goals of reducing inappropriate use of the (free) 999 number and also supplying a single point of access (SPA) communication centre for urgent care. Our specification for the SPA advocates the use of NHS Pathways for assessing calls and then 'warm transfers' of callers between relevant agencies. This could lead to some calls being of extended length. Therefore the success of our integrated system will be reduced should callers consider the cost of calls outweighs the benefit of use.

Our consultative work suggests that the no cost use of 999 and A&E influences patient behaviour. Two further influences to consider are cost tariffs to NHS Direct and GP practices. Our strategy is led by a desire to address health inequalities and we believe tariff cost to be an important issue given our relatively high levels of deprivation and our need to influence the access behaviour of important groups such as parents of pre-school children.

Patient and carer feedback preferred a free to caller tariff as per Option 1 in your consultation. That is our preferred option given the emphasis our strategy places upon addressing health inequalities. A considerable degree of our support for this option is based upon simple pragmatism regarding the circumstances of those most likely to call 999, or walk into A&E, there should be no cost difference between 999 and 111.

Our ranked preferred options would therefore be Option 1, then Option 2 (10 pence a call) followed by Option 3 and then Option 4. We believe 10p per call would avoid the disincentive for callers to work within our warm transfer model. It would also be clearer and simpler to communicate publically. But, a 10p flat call rate would seem to provide little financial benefit over free calls given the likely cost of collecting and administering the income. In any option we advocate maintaining a tariff that is the same for landline and mobile phones. This is very important in our support to lower income users and younger patients.

Q4 Do you have any comments on the proposed notification of modification to the Numbering Condition in Annex 8 of this document:

We support the proposed notification of modification.