A Three-digit Number for Non-Emergency Healthcare Services

Proposals for the number and tariff; including notification of a proposed modification to General Condition 17

Consultation

Publication date:	9 July 2009
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Contents

Section 1

Executive Summary

1.1 Ofcom (The Office of Communications) is undertaking this consultation in order to meet a request from the Department of Health ("DH") in England for the designation of a three-digit telephone number to access NHS non-emergency healthcare services in England. The aim of the service to be provided via the number is to act an entry point for patients seeking NHS services: trained call-handlers will respond to requests for health or service information (whether urgent of not) and assess the medical needs of callers to identify which NHS services are best place to meet those needs.

1.2 The three-digit telephone number will initially be piloted in a number of Strategic Health Authority ("SHA") areas in England from spring 2010 but the intention is for the service to be fully rolled out across England in the long-term, subject to a positive evaluation of those pilots. The DH has decided on the underlying policy behind the service and this consultation relates only to the communications' issues, for which Ofcom has responsibility.

1.3 The devolved administrations may also consider whether to introduce the three-digit number with a similar or comparable service in Wales, Scotland and Northern Ireland respectively. However, given that this consultation is based on a DH initiative, we have focussed on the proposed service as envisaged in England and have referred to the devolved administrations where appropriate.

1.4 As the regulator responsible for communications matters in the UK, including the administration of the UK's numbering resource, we have been asked by the DH to make a three-digit telephone number available for the delivery of its proposed non-emergency healthcare service. In order to make such number available for use by all communications providers, we would need to add it to the list of numbers in General Condition 17 of the General Conditions of Entitlement, which covers the allocation, adoption and use of telephone numbers (the "Numbering Condition").

1.5 The DH has chosen 111 as its preferred number for the service. We advised the DH on available number options, including full length numbers from existing ranges in the National Telephone Numbering Plan (the "Numbering Plan"). The DH considered these options and decided that a three-digit number (similar to the 999 and 112 numbers used by the emergency services, and the 101 non-emergency number initiated by the Home Office) would be the most suitable choice. It concluded that, of the possible three-digit numbers available, 111 was its preferred option.

1.6 While the DH is committed to the provision of the proposed service on a three-digit number, other options are available. The purpose of this document, therefore, is to seek stakeholders' views on the DH's preferred and alternative numbering options, and to set out why the DH has chosen the three-digit number 111 for its proposed service.

1.7 As regards to the tariff for the number, three-digit numbers have no inherent tariff structure. The DH plans to implement the tariff for the number through negotiation with the selected service provider and communications providers. The DH has drawn up potential tariff options and we have set out these options on behalf of the DH. We do not propose to intervene in setting the tariff for the number and this consultation does not therefore propose regulatory measures on the matter of call

charges. As the tariff will not be regulated, each tariff option could vary depending on the operator, and the price will depend on the commercial arrangements of each operator. The DH has pointed out that experience with 101 (the three-digit number initiated by the Home Office) showed that negotiation with telecoms providers can result in the same call charge across virtually all operators. Nevertheless, as the call charge will be a commercial decision by each provider, we will keep open the option to revisit the tariff issue at a later stage if it proves appropriate. If it is necessary for us to consider regulatory measures on the tariff in the future, we would need to carry out a further consultation on the specific issues and proposals.

1.8 The main body of this document sets out the background of the proposed service and a discussion on the options for the number and tariff. Section 4 also contains an impact assessment which evaluates the different options for the number. In addition, Annex 8 contains a draft notification of the necessary modification to the Numbering Condition in order to designate 111 for "Access to NHS Non-Emergency Healthcare Services" (Type A Access Code).

1.9 We invite comments on the draft notification, the specific consultation questions we have set out, as well as on the issues raised generally in this consultation document, by 20 August 2009.

Section 2

Introduction and Background

Introduction

2.1 Telephone numbers are a critical national resource for consumers, businesses and the delivery of key public services. Ofcom, as the regulator responsible for communications matters in the UK, including the administration of the UK's numbering resource, has the responsibility for deciding how this resource can be used in a way that maximises benefits to citizens and consumers.

2.2 As part of this function, we set aside specific telephone numbers for use or adoption by any communications provider in accordance with their service designation and without further application to Ofcom. Such numbers are listed in the Annex to the Numbering Condition. These numbers, which include, for example '100' for access to operator assistance and '112' for access to emergency services, are different from the numbers we allocate uniquely to communications providers in accordance with the Numbering Plan.[1] Numbers from the Numbering Plan can be used for any purpose within a broad service designation, whereas these numbers can only be used in accordance with the specific service designation attributed to that number.

2.3 To perform our duty of ensuring that the best use is made of the UK's numbering resource, it is sometimes appropriate for additional numbers to be made available for use by communications providers. In order to do this, we may be required to modify the Annex to the Numbering Condition or the Numbering Plan. The Communications Act 2003 (the "Act") provides for modifications in accordance with set procedures, including consultation.

2.4 In 2005 we undertook a similar consultation after a request from the Home Office for a three-digit number to provide a service giving access to advice, information and action for community safety matters, including non-emergency crime, policing and anti-social behaviour.[2] Following that consultation, we designated the three-digit number 101 as "Access to Non-Emergency Service (Type A Access Code)".[3]

2.5 On the basis of the reasoning set out in Section 4 of this consultation, the DH has requested a three-digit number for access to NHS non-emergency healthcare services. The aim of the service to be provided via the number is to serve as an entry point for patients seeking NHS services: trained call-handlers will respond to requests for health or service information (whether urgent or not) and assess the medical needs of callers to identify which NHS services available locally are best placed to meet those needs – the patient would then be advised appropriately as to the next steps.

2.6 In order to meet the DH's request, we must consult on adding the number to the Annex in the Numbering Condition and explain how the proposals would make the best use of the UK's numbering resource and promote the interests of citizens and consumers in relation to communications matters.

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[1] Available at: http://www.ofcom.org.uk/telecoms/ioi/numbers/numplan170608.pdf.
[2] Ofcom, *National Single Non-Emergency Number: Proposals for number and tariff*, 27 October 2005, available at http://www.ofcom.org.uk/consult/condocs/snen/snen.pdf.
[3] Ofcom, *National Single Non-Emergency Number; Designating number "101"*, 8 March 2006 available at: http://www.ofcom.org.uk/consult/condocs/snen/snen_statement.pdf.

2.7 As indicated above, the proposed service is intended to help direct the public towards the most suitable clinical response for their situation, including in instances where their need is urgent but not life-threatening.[4] It would offer access to the most appropriate care, providing an easy and convenient source of advice and information, and help the public navigate around their local healthcare system. It is expected that the service would lessen the demand on existing front-line services such as 999/112 or accident and emergency units ("A&E"). This is because a significant number of people automatically default to these services even when their healthcare needs are not life-threatening, whereas alternative services available locally may be more appropriate or convenient. In England, the three-digit number would, in the longer term, become the single number to access urgent care services, including NHS Direct.

Scope of the consultation

2.8 The purpose of this consultation is to set out proposals to make a three-digit number, specifically 111, available for use by communications providers, for access to NHS non-emergency healthcare services. Section 3 provides a description of the service, and Annex 5 includes the DH's more detailed background information and description of the service in England. The service is a DH-led initiative, which the DH has researched, found public and stakeholder support for, and is committed to launching in spring 2010 in a number of SHA pilot areas. Its intention is to roll out the service across England in the future (subject to a positive evaluation of the pilots). It is not, therefore, the purpose of this consultation to examine the underlying policy and proposals for the service. While we accept that this service could deliver real benefits to consumers, we have not evaluated the intricacies of the service or the Government's underlying policy in introducing it.

2.9 The devolved administrations may also consider whether to introduce a similar or comparable service on the same three-digit number in Wales, Scotland and Northern Ireland respectively. However, given that this consultation is based on a DH initiative we have focussed on the proposed service as envisaged in England and have referred to the devolved administrations where appropriate.

Ofcom's role

2.10 Our role is to consult on the communications matters for the delivery of the proposed service. Primarily, this means making a telephone number available for use by communications providers in order for their customers to access the proposed service. This is, therefore, the focus of this consultation.

2.11 There are also additional communications matters that need to be considered, including the tariff, interconnection arrangements and access from communications providers to the service. A discussion of the tariff for calling the number to access the service is included in Section 5. We are not proposing to intervene in setting the tariff for the number or taking any action with regards to communications providers providing access to the service. We will, however, keep open the option to revisit these issues at a later stage if it proves appropriate. If it is necessary for us to consider regulatory measures on these in the future, we would need to carry out a further consultation on the specific issues and proposals.

[4] In situations which are life-threatening, i.e. in emergencies, the emergency number 999/112 would continue to be the appropriate number to call.

2.12 In order to designate a three-digit number for a specific service we would need to make an amendment to the Numbering Condition. The legal framework and tests for making this modification are set out in Annex 7 and a draft notification of the necessary modification to the Numbering Condition is set out in Annex 8.

Impact assessment

2.13 In this document, we have conducted an impact assessment on the various numbering options. Impact assessments provide a valuable way of assessing different options for regulation and showing why the preferred option was chosen. They form part of best practice policy-making. This is reflected in section 7 of the Act, which means that generally we have to carry out impact assessments where our proposals would be likely to have a significant effect on businesses or the general public, or when there is a major change in Ofcom's activities. However, as a matter of policy, Ofcom is committed to carrying out and publishing impact assessments in relation to the great majority of our policy decisions. For further information about our approach to impact assessments, see the guidelines, "Better policy-making: Ofcom's approach to impact assessment", which are on our website: http://www.ofcom.org.uk/consult/policy_making/guidelines.pdf

2.14 The analysis presented in this document, in particular in Section 4, therefore represents an impact assessment, as defined in section 7 of the Act, on the proposal to make the three-digit number 111, available for use by communications providers to provide access to the proposed service.

2.15 Section 5 of this consultation covers additional policy issues regarding possible tariff arrangements for the three-digit number. We have included discussion of tariff arrangements at the DH's request, as this consultation provides an opportunity for it to gather stakeholders' views. However, we have not conducted an impact assessment on the tariff options selected by the DH, because any decisions on the tariff arrangements would fall to the DH in negotiation with communication providers.

Section 3

The Three-digit Number Non-Emergency Healthcare Service

Introduction

3.1 The DH has requested a three-digit number for its proposed non-emergency healthcare service in England. The DH remit extends to England only, and the devolved administrations will decide whether to use the three-digit number for a similar or comparable service in Wales, Scotland and Northern Ireland respectively. However, as Ofcom has responsibility for the numbering resource across the UK, if a three-digit number is reserved for the proposed service, it will be reserved across all regions in the UK (because the numbering system covers the whole of the UK). We have therefore engaged with the devolved administrations to discuss their intentions and develop a service description which is most likely to suit their future needs. This service description is set out in paragraph 3.11 below.

3.2 The DH description of the proposed service in England is outlined in more detail in Annex 5. In this section, we have summarised the DH proposed service, and the reasons behind its introduction, as well as outlining the position of each of the devolved nations with respect to the proposed service.

Background and DH commitment to offering the service

3.3 The DH has been exploring the creation of a single number and contact point for access to non-emergency healthcare in England for some time[5] and more formally since 2007, when the concept was first introduced in the publication of the NHS Next Review Interim Report, *Our NHS, Our Future.*[6] It was proposed as a way to simplify access to urgent, non-emergency care, which research revealed was a priority for the public. In addition, research by the consumer organisation, Which?, in 2006 revealed that three quarters of people surveyed in England did not know the NHS Direct number, and as a result it also proposed that the number should be changed to a three-digit number to aid recall.[7]

3.4 Following a major review of NHS services in 2007/8, the NHS Next Stage Review Final Report, *High Quality Care For All* committed the DH to explore the viability of introducing a new three-digit number to 'front end' local urgent care services and help people find the right local service to meet their urgent, unplanned care needs

[5] See the DH paper at Annex 5.
[6] Department of Health, *Our NHS, Our Future: NHS Next Stage Review – Interim Report,* October 2007, available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079077
[7] Which?, *Which Way? – Negotiating the Out of Hours Maze*, July 2006, http://www.which.co.uk/about-which/press/campaign-press-releases/health/2006/07/which-calls-for-shake-up-of-out-of-hours-care.jsp.

(outside the 999/112 framework which relates to emergency, life-threatening care needs).[8]

3.5 Subsequently, in November 2008, the DH commissioned a series of focus groups and in-depth discussions with 'hard-to-reach' groups to explore whether there would be support for the idea of three-digit number as a way of accessing NHS healthcare services.[9] The research found that there was widespread support for the concept, with the idea of a 999 style number found to be particularly appealing (see Annex 6).

Reasons for the introduction of the single number for non-emergency healthcare services and benefits to consumers and other stakeholders

3.6 The proposed service in England is intended to give the public a new, simple route of access to NHS non-emergency healthcare services. This is intended to simplify (but not replace) access to the most appropriate care, by helping people navigate around their local NHS healthcare system.

3.7 The public currently have available the NHS Direct service in England on the short-digit number 0845 4647 and a range of numbers for contacting GPs, out-of-hours services, walk-in centres and A&E departments. The variety and general lack of memorability of these numbers often results in consumers calling 999/112 or going to A&E, which may be unnecessary, inappropriate and inefficient. The ambulance service is dealing with more emergency calls than ever before. The number of calls increased annually by an average of 6.5 per cent between 1997/08 to 2006/07[10], with a total of 7.5m emergency and urgent calls in 2008-09.[11]

3.8 Currently, approximately 37 per cent[12] of visits to A&E in England are 'minor attendances' (i.e. non-emergency). Similarly, of the 7.5m calls per year handled by the ambulance service, 2.2m (29 per cent) are classed as 'Category C' calls, which are the lowest category of response required.[13] These are non-emergency calls where the ambulance service is not required to dispatch an ambulance and may choose to resolve the call by referring the caller to an urgent care service.

3.9 The three-digit number for the proposed service in England would be available 24 hours a day, 365 days a year. The number would give the public a clear, simple choice, namely: "If the situation is an emergency, call 999 or 112; for all other health needs, call 111 and we will work out with you what is the best way of meeting those needs."

3.10 The DH's paper at Annex 5 sets out the rationale for the three-digit number and the service behind it in England, including a more detailed discussion of how the service would operate and options that are under consideration for providing the service. The DH envisages that in the long-term the three-digit number would become the single

[8] Department of Health, *High Quality Care for All. NHS Next Stage Review Final Report*, 2008, p. 40. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

[9] Diagnostics Social & Market Research, *Three-digit Number for Urgent Care; Qualitative research report*, November 2008. See Annex 6.

[10] NHS Information Centre for Health and Social Care, *Ambulance Services England 2008/2009.* Figures from 2007/08 onwards include data for urgent calls in addition to emergency calls and are therefore not directly comparable with earlier figures.

[11] NHS Information Centre for Health and Social Care, *Ambulance Services England 2008/2009.*

[12] *DH Reference Cost Data 2006-07.*

[13] NHS Information Centre for Health and Social Care, *Ambulance Services England 2008-2009*. "Category C" calls are the lowest category of response required.

number to access urgent care services, including NHS Direct. During the pilot stage, anyone ringing the NHS Direct number from the pilot areas would be re-routed through to the new 111 service. Similarly any calls made to 111 from non-participating areas will be routed to NHS Direct). In the long term 0845 4647 could be switched off. All services currently provided by NHS Direct would be accessible through 111.

Core description of the proposed service

3.11 The proposed service description set out below will reflect the designation of the three-digit number 111 as "Access to NHS Non Emergency Healthcare Services" that will appear in the Annex to the Numbering Condition (see Annex 8 of this document). This description details the scope of the services that could be used for the three-digit number 111 across the whole of the UK. We have ensured that each of the devolved administrations are aware of this service description and have no concerns with it.

"The proposed service will help direct members of the public towards the most suitable clinical response for their situation, in particular in instances where their need is urgent but is not life-threatening. It will:

- *respond to requests for health or service information (whether urgent or not); and*
- *assess the medical needs of callers and identify which NHS service is best placed to meet those needs*

999/112 will continue to be the number to call in an emergency and people will continue to be able to phone their local healthcare provider in the same way they currently do."

The devolved administrations

3.12 The Scottish Government has confirmed that (depending on the outcome of DH pilots and this consultation) it will consider using the 111 number to serve the same function as the current NHS 24 number in Scotland, which is 08454 242424. The service offers health information and self-care advice, as well as being able to advise patients what services are available in their local area. During the out-of-hours period, NHS 24 also supports patients in accessing services appropriate to their clinical needs. This may mean, for example, arranging an appointment with an out-of-hours GP or other healthcare professional either at a primary care centre or via a home visit. If the three-digit number was adopted in Scotland, it is intended that all callers resident in Scotland who called 111 would be routed to the NHS 24 service.

3.13 The Minister for Health and Social Services in Wales has not formed a view on whether to offer the three-digit number at present and will await the outcome of the proposed pilots in England before considering the issue further. Wales currently has its own NHS Direct service which is also available on 0845 4647 and the Department of Health and Social Services ("DHSS") has confirmed that the core service description for 111 broadly describes the core service provided by the existing NHS Direct service in Wales.

3.14 The Department of Health, Social Services and Public Safety ("DHSSPS") in Northern Ireland has indicated that it supports the DH proposal in principle but it has not made a decision on whether to offer the three-digit number and the proposed

service behind it in Northern Ireland. The DHSSPS is monitoring the progress of its own proposed NI Direct service (which offers a single point of contact for public service enquiries) in developing the scope of a three digit number for public services within Northern Ireland. Currently Northern Ireland does not have a service similar to NHS Direct or NHS 24. The DHSSPS has confirmed that it agrees with the service description set out above should it decide to use 111 for those services in the future.

Timetable for implementation of the proposed service

3.15 The DH has committed to launch pilots of the (number and) proposed service in a number of SHA areas in England from Spring 2010 with the intention to roll-out the service across England after the results of those pilots have been evaluated.

3.16 As indicated above, the Scottish Government will decide whether to introduce the three-digit number for its NHS 24 service after the results of the three pilots have been evaluated. The DHSS in Wales will also consider the issue further after the outcome of the pilots. The DHSSPS in Northern Ireland does not have a timetable for its decision on whether to offer the three-digit number for the proposed service in Northern Ireland.

Section 4

The Number and Evaluation of Proposals for the Number

Introduction

4.1 The DH has made a request to Ofcom for a three-digit telephone number for the delivery of its non-emergency healthcare service initiative in England. It wants the number and the service behind the number to become as much part of the public's consciousness as the 999 emergency number. It is important, therefore, that the number is memorable and can be used as a strong brand for the proposed service.

4.2 In this section, we have evaluated the three-digit number option and other numbering options. We conclude that the most suitable option would be a three-digit number. We go on to discuss the DH's preferred three-digit number, 111, and its rationale for choosing 111. Our proposal in this consultation therefore is to designate the three-digit number 111 for the access to NHS non-emergency healthcare services.

4.3 As explained in paragraph 2.14, the analysis presented in this section, when read in conjunction with the rest of this document, represents an Impact Assessment as defined by section 7 of the Act. Impact assessments provide a valuable way of assessing different options for regulation and showing why the preferred option was chosen.

Ofcom's duties

4.4 Three-digit numbers are a scarce resource. There are only 15 'Type A Access Codes' (see paragraphs 4.15 to 4.18) available for designation. We are therefore clearly limited in the amount of three-digit numbers that we can designate for specific services and we need to ensure that they are used for the best purposes.

4.5 Ofcom has a duty under section 63(1) of the Act to ensure that the best use is made of telephone numbers and to encourage efficiency and innovation for that purpose. We also have a general duty under section 3 of the Act to further the interests of citizens and consumers in relation to communications matters.

4.6 Our duty is to decide whether making a three-digit number available for non-emergency healthcare services makes the best use of the UK's numbering resource, while promoting the interests of citizens and consumers. The main criteria for assessing the different numbering options are therefore the promotion of citizen and consumer interests and the best use of telephone numbers.

4.7 We consider that by providing the most appropriate number for the proposed service we can help support the provision of a service which will promote citizens' and consumers' interests.

4.8 Our duty relates only to the telephone number itself; while we accept that a public interest is service by the proposed service, we have not evaluated the intricacies of the service of the Government's underlying policy in introducing it. We have therefore confined our analysis in this section to the different numbering options available.

Eligibility criteria for a three-digit number

4.9 In 2005, Ofcom consulted on the designation of the 101 number for the Home Office's non-emergency service (related to issues such as non-emergency crime and anti-social behaviour[14]). As part of that consultation we requested views on what desirable or essential characteristics a service should have in order to be eligible for the designation of a three-digit number.[15] In our final statement we concluded that four criteria in particular should be considered when making future decisions on the designation of a three-digit number.[16] These were that:

i) there is an overwhelming public interest argument;

ii) the proposed service has a national impact and/or national provision;

iii) the proposed service is not only for the public good but also used only where there is high demand based on high call volume; and

iv) the proposed service provision benefits everyone or at least a very wide part of society.

4.10 The statement also made clear that any assessment of eligibility should be made on a case-by case basis, although the four criteria above would be of great assistance to Ofcom when making its decision. We will therefore also consider the present application for a three-digit number against these criteria.

The available options

4.11 The numbering options for the proposed service are:

- **Option A:** no change (i.e. maintain existing NHS Direct 0845 4647 number for the proposed service);
- **Option B:** three-digit number;
- **Option C**: number from the Numbering Plan; or
- **Option D:** Harmonised European six digit number starting with 116.

DH preferred choice of number

4.12 The non-emergency healthcare service is a DH initiative and the choice of the preferred number rests with the DH. Our role has been to provide advice and consult on available options. The DH wants to ensure that the service has the best support, which includes the best available number in terms of memorability, consumer perception and reduced risk of misdialling. The DH has considered the possible number options above and also discussed these with the devolved nations. It has concluded that the most suitable choice would be Option B, a three-digit number.

[14] See the 101 website: http://www.101.gov.uk/.
[15] Ofcom, *National Single Non-Emergency Number: Proposals for number and tariff*, 27 October 2005, available at http://www.ofcom.org.uk/consult/condocs/snen/snen.pdf.
[16] Ofcom, *National Single Non-Emergency Number; Designating number "101"*, 8 March 2006 available at http://www.ofcom.org.uk/consult/condocs/snen/snen_statement.pdf.

4.13 We provide an explanation of the options A, B, C and D below before assessing the relative costs and benefits and wider impacts of each option.

Option A: no change

4.14 In assessing policy options we usually consider an option that would maintain the status quo. In this case, the 'do nothing' option would mean NHS Direct would remain on its existing 0845 4647 number and no new number would be allocated for the proposed service. Although the DH has specifically requested a new memorable number, we have considered a 'no change' policy option because it can provide a reference point from which other policy options can be assessed.

Option B: Three-digit number

4.15 The Annex to the Numbering Condition contains, among other types of numbers, a list of telephone numbers available for use in accordance with their specific service designation. Such numbers are known as Type A Access Codes. Type A Access Codes are used by consumers to reach commonly used services such as 100 for "Access to Operator Assistance"; 112 for "Access to Emergency Services"; and 123 for "Access to the Speaking Clock". These codes can be used throughout the UK by all communications providers but only for the designated service.

4.16 Access Codes can only begin with the digit '1'. This is because the digit '0' signifies national or international dialling and the digits '2' to '9' are used for local dialling of geographic subscriber numbers within the same geographic area code. Within the digit '1' numbering space, codes have been divided into three categories:

- Type A: used by consumers to reach commonly used services;
- Type B: provide indirect access and directory enquiry services; and
- Type C: allow independent use by communications providers either to provide services exclusively to their directly connected subscribers or for internal network operator services dependent on the provider.

It is clear that a Type A Access Code is the appropriate type of access code for the proposed non-emergency healthcare service.

4.17 Type A Access Codes available for service designation are codes beginning with the digits '10X' and '11X'. Some of these codes have already been designated for services, such as 100, 101 and 112. Codes still available for service designation are:

102	103	104	105	106	107	108	109
110	111	113	114	115	117	119	

4.18 In order to designate a Type A Access Code for a service, we are required to consult on adding it to the list of such numbers in the Annex to the Numbering Condition.

Option C: Numbers from ranges designated in the Numbering Plan

4.19 The Numbering Plan lists public telephone network numbers available for allocation uniquely to communications providers. Three-digit telephone numbers are not allocated to individual communications providers and therefore are not listed in the Numbering Plan. If a number from a range designated in the Numbering Plan were to be used for the proposed service it would need to be allocated directly to a

particular communications provider. That communications provider would then sub-allocate the number to the service providers (if a different entity).

4.20 There are number ranges designated in the Numbering Plan that could be suitable for the proposed service. For instance, non-geographic numbers such as 03 "UK-Wide numbers at a geographic rate", 080 "Special services no charge", 0844 "Special service basic rate" and 0871 "Special services higher rate" are possible options. Numbers in the "030" range have been specifically reserved by Ofcom for use by public bodies and not-for-profit services and could therefore be suitable for the proposed service.

Option D: Harmonised European Numbers for Services of Social Value

4.21 The European Commission (the "Commission") published a decision on 15 February 2007[17] (the "Decision") requiring all National Regulatory Authorities ("NRAs") to reserve the 116 six-digit range of national telephone numbers for harmonised European services of social value. According to the Decision, these are services that answer a specific social need and are potentially of value to visitors from other countries. The first three 116 numbers reserved by the Commission are: the 116000 hotline for missing children; 116111 for child helplines; and 116123 for emotional support helplines. Services using 116 numbers are harmonised across Europe and are 'freephone' (see paragraph 4.49).

4.22 The Commission decides which services should be reserved 116 numbers and attaches conditions relating to the use of the numbers. Any party may make an application to the Commission for a 116 number to be reserved for a specific service of social value at any time. The Commission will consider requests for new 116 number reservations periodically and has indicated that this is likely to be every six to twelve months depending on demand.

4.23 The Commission will reserve only one 116XXX number for each type of service. In order for the most suitable provider to receive the allocation, Ofcom uses a comparative selection process described in our statement published on 20 February 2009.[18] We launched the comparative selection process for the initial three 116 numbers in that statement.

4.24 The Commission is already considering the reservation of 116117 for a 'medical on call' service. The original request for the service was submitted by two German Associations of health insurance physicians in response to the Commission's June 2007 consultation on proposals for services to be reserved 116 numbers.[19] The proposal was for a service that would connect callers directly to the nearest doctor on duty and so give access to medical assistance in the event of a non life-threatening emergency, outside normal office hours, over the weekend and on public holidays.[20]

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[17] Commission Decision of 15 February 2007, available at: http://eur-lex.europa.eu/LexUriServ/site/en/oj/2007/l_049/l_04920070217en00300033.pdf

[18] Ofcom, *Harmonised European Numbers for Services of Social Value; Allocation and charging arrangements for 116 numbers in the UK*, 20 February 2009 available at: http://www.ofcom.org.uk/consult/condocs/116/116statement/116statement.pdf

[19] See: http://circa.europa.eu/Public/irc/infso/cocom1/library?l=/public_documents_2007/cocom07-31_consultationp/_EN_1.0_&a=d

[20] Application for the reservation of the short code 116115 for medical stand-by emergency services, submitted to the Commission by the Association of Statutory Health Insurance Physicians of Brandenburg and the National Association of Health Insurance Physicians, 23 May 2007 (the application has since changed to a request for reservation of the 116117 number). See:

4.25 The application for reservation of 116117 is currently progressing through the Commission's Communications Committee ("COCOM") procedure for assessing applications and reserving 116 numbers for services of social value.[21] As part of this process, Member States can propose amendments to the draft service description. Therefore the UK has an opportunity to suggest wording to broaden the draft service description for 116117 to potentially cover the DH's proposed non-emergency healthcare service in England.

4.26 The process for reserving the 116117 number for the 'medical on call' service is likely to conclude by autumn this year. Once the Commission has reserved the number, we will be required to consult on making it available for allocation in the UK by adding it to the Numbering Plan. We would be likely to issue this consultation towards the end of this year or early next year and the number would potentially be available for allocation from early 2010.

4.27 Alternatively, if the service description for 116117 was not broadened to cover the DH's proposed service, the DH could also have the option of applying to the Commission to designate a different 116XXX number for the proposed non-emergency healthcare service, although the service description would need to be sufficiently different to the existing 116117 service for the Commission to designate a new number. The DH's proposed service would be likely to fall under the Commission's definition of a service of social value.

Analysis of the different options

4.28 We have set out in the following paragraphs our analysis of the options outlined above. In analysing the options, we have considered the potential benefits, costs and risks of each option specifically in relation to their impact on consumers and communications providers. In this case, as stated in paragraph 4.6 above, we consider that the following two criteria (which are based on our statutory duties) are specifically relevant to assessing the impact of the options and have therefore taken these into account in our analysis:

- the promotion of citizen and consumer interests; and
- best use of telephone numbers.

4.29 In assessing the second criterion, we have taken into account the service eligibility criteria for designation of a three-digit number established in our final statement on the designation of 101 (see paragraph 4.9 above).

Promotion of citizen and consumer interests

4.30 Numbering arrangements can further the success of communications services, and thereby promote consumer interests. The aim of the non-emergency healthcare service is to improve people's experience of accessing the most appropriate

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http://ec.europa.eu/information_society/policy/ecomm/doc/library/public_consult/116/comments/kvbb_en.pdf

[21] COCOM consists of officials from Member State authorities responsible for electronic communications and assists the Commission in carrying out its executive powers under the Framework Directive. A report of the December 2008 ad hoc COCOM meeting on proposals for new 116 numbers including 116117 is available at: http://circa.europa.eu/Public/irc/infso/cocom1/library?l=/public_documents_2007/cocom07-31_consultationp/_EN_1.0_&a=d

healthcare for their needs, by providing a single point of contact using a memorable telephone number. Memorability of the number is particularly important in situations where the caller may be feeling unwell, anxious or vulnerable. Therefore citizen and consumer interests would be promoted by the selection of the most memorable number, increasing the likelihood that when required, it can be easily recalled (and dialled).

4.31 It is reasonable to assume that, other things being equal, the fewer digits in a number, the easier it is for consumers to recall that number correctly when required. Option A, the NHS Direct number, is eight digits in length. Option B, with three-digits, is the shortest number. Option D is six digits in length, while Option C is eleven digits in length.

Assessment of potential citizen and consumer benefits under each option

4.32 Option A has the benefit of already enjoying some awareness amongst the public, although it may be unclear to consumers that the same number would be offering a different, improved service. The reduced digit length and number pattern should mean it is more memorable for the public than a new number from the Numbering Plan. However, the existing NHS Direct short-digit number has not proven to be memorable to date, even amongst health professionals.[22] Therefore, if the DH were to use the existing NHS Direct number for the proposed new service, it may result in a lower take up of the service than would be the case for a new three-digit number. In addition, there are also issues around the use of 084 numbers for public services (see paragraphs 5.14 to 5.17 below), and the Government's position on this may require a change to the NHS Direct number. This would mean that any benefits of retaining the existing number (in that some consumers are already familiar with the number) could in any case be lost.

4.33 Option B would be the most memorable number option and would in that sense offer the most benefit to consumers. By being memorable, it would also help the service deliver its key aim of ensuring consumers know what to do when faced with an urgent, non-emergency healthcare need. It could, in addition, potentially help by diverting non-emergency calls from 999/112.

4.34 Research conducted prior to our consultation on the designation of the number "101" found a large number of consumers agreed that a three-digit number was likely to be particularly memorable: 93% of consumers agreed strongly with the statement that the number was easy to remember because it only had three-digits. 86% also claimed that they would be likely to recall the number at the point they might need to call the service.[23] DH consumer research found that consumers were very positive about the concept of a three-digit number.[24] The idea of a 999 style memorable number was particularly appealing, especially given the low recall of the NHS Direct number in the sample. Participants said they would be significantly more likely to remember a three-digit number than any of the existing NHS numbers.

4.35 The DH research into the specific number found that the most memorable numbers were those that contained the fewest different digits, digits that were lower in value

[22] Diagnostics Social and Market Research, *Three Digit Number For Urgent Care Concept Research Qualitative Research Report,* November 2008. See Annex 6.
[23] Ofcom, *National Single Non-Emergency Number*, October 2005, Annex 6 Non-Emergency Number research report August 2005, p. 44.
[24] Diagnostics Social and Market Research *Three Digit Number For Urgent Care Concept Research Qualitative Research Report,* November 2008. See Annex 6.

closer together in value, arranged chronologically and either all odd or all even. For those reasons, the number 111 was preferred by 85% of consumers. The research also found that 111 was strongly associated by the public with 999, which also contributes to its memorability.

4.36 Option C would provide greater tariff transparency since consumers already associate the number ranges with call tariffs (although they do not necessarily recall the actual tariffs). However, it is likely that this would be the least memorable option because it would be eleven digits in length. Although longer telephone numbers could potentially be as memorable if the digit structure had a noteworthy pattern, there is a risk that numbers with a particularly memorable pattern would already be in use and would be unavailable for this service. The DH's choice of number would be limited by availability. It is therefore likely that the number will not be memorable and would not provide any benefit over the multitude of full length telephone numbers that are currently available to contact local health services and GP surgeries or the short digit NHS Direct number. There is therefore also a risk that Option C would not lead to as many people being aware of the service as might have been the case with a three-digit number.

4.37 Option D has more digits and could therefore prove less memorable than Option B. In addition, it could be less memorable than a three-digit number because of the availability of several other 116 numbers for different services.

4.38 Option D could eventually provide the benefit of a harmonised number for non-emergency healthcare services across Europe. However, there are uncertainties about whether the Commission would reserve a 116XXX number for access to non-emergency healthcare services and when that might happen.

4.39 There is potential for the draft service description of the 116117 medical on call service to be broadened to cover connection of the caller to a call-handler and to extend the hours when the service is available so that the proposed DH service would fall under that description.[25] If this happens, or if a new 116 number was reserved with a service description that covered the DH's proposed service, there would be an opportunity for the 116 number to be implemented in parallel with the chosen DH number in much the same way as 112 is the single European emergency call number and 999 is the national emergency call number providing access in the UK to the same emergency services.[26]

Best use of telephone numbers

Assessment of best use of telephone numbers under Option B

4.40 It is our duty with regard to telephone numbering functions to secure the best use of telephone numbers. This is particularly relevant where the type of numbering resource is especially scarce, as with three-digit Type A Access Codes. Therefore, under Option B, we must be satisfied that the proposed non-emergency healthcare service would make appropriate use of this limited resource. As outlined in paragraph

[25] However, there may be difficulties around finding a definition that would also be suitable for services in other EU member states and there is no certainty that any suggested changes would be incorporated in the final definition.

[26] If the number were implemented in parallel there is an argument that in the interests of avoiding potential consumer confusion, the three-digit number 117 would be more appropriate. However, the DH consumer research found that 117 held no resonance with consumers and was ranked very low in terms of memorability. The potential for confusion with 118XXX numbers, which provide access to Directory Enquiry facilities, was also highlighted (see Annex 6 for a summary of this research).

4.9 above, in our final statement on the allocation of the 101 number to the Home Office's non-emergency service we concluded that four criteria in particular were useful in considering designation of a three-digit number. To assess whether the three-digit number would make best use of telephone numbers, we have assessed Option B against these criteria.

4.41 Under the first criterion for this option, we consider that the proposed service would be in the public interest and would provide a significant public benefit. It would give the public a memorable number to call when they do not know what to do about their particular healthcare need, especially in urgent, non-life threatening circumstances. It would reduce the confusion around the existing options and help navigate patients around the healthcare services available. It could also potentially provide the additional benefit of reducing unnecessary calls to 999/112 or visits to A&E.

4.42 With regards to the second and fourth criteria, anyone would be eligible to call up and use the service to get access to, and advice on, available local healthcare and it would therefore benefit all sections of society. As indicated in Section 3, the DH is committed to launching the service across England and the Scottish Government is likely to use the number for its NHS 24 service. The DHSS in Wales will consider the issue further once the DH pilots have been evaluated. The DHSSPS in Northern Ireland has indicated its support for the DH proposal and will consider whether to implement the three-digit number at a later stage. Therefore there is a strong possibility that the number will be available across the majority of the UK in the future and there is the potential for it to be available nationwide.

4.43 As regards the third criterion, NHS Direct already receives around 5m calls a year and NHS 24 in Scotland receives 1.5m calls a year. In addition, GP out-of-hours services are estimated to receive around 9m calls a year. The DH has estimated that there could be between 14.4m and 30m calls per annum to the three-digit number in England alone.

4.44 We therefore consider that the proposed service would meet all of the four criteria and that the DH request for a three-digit number for the service represents a justified use of one of the available three-digit Type A Access Codes.

Assessment of best use of telephone numbers under the other options

4.45 Option A would mean the existing NHS Direct number would continue to be used and would therefore not require any action from Ofcom. This would be an efficient use of the existing short digit number. However, there are issues around the use of an 084 number for access to public services and therefore if the DH were to use this existing number they may, nevertheless, need to consider changing the number to 0345 4647 or another 03 number in the light of its recent consultation (see further paragraphs 5.14 to 5.17).[27]

4.46 Option C would not require any action from Ofcom in order to provide a number for the service and it would be a suitable use of telephone numbers provided that the characteristics of the number range meets those of the proposed service. One issue with this option is our position that the use of chargeable 084 and 087 numbers by public bodies is inappropriate as the sole means of access to essential services (see paragraph 5.15). Nevertheless, other numbering ranges from the Numbering Plan

[27] DH, *The use of 084 telephone numbers in the NHS*, 16 December 2008, available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091923

such as 030 numbers are available and are likely to be acceptable for the proposed service. Although, as indicated above, the DH choice of number within these ranges will be restricted to those available, which are unlikely to be as memorable as other options. The main drawback of this option, however, is that a number from these ranges would not provide any benefit over the other full length numbers currently used for NHS services. Therefore Option C is unlikely to represent the best use of the UK's numbering resource to provide socially valuable services.

4.47 The extent to which Option D might represent the best use of the UK's available numbering resource is difficult to assess at this stage, given that it is not clear whether the Commission would allocate a 116 number specifically for this type of service or whether the definition of 116117 will be expanded beyond the current service description relating to doctors on duty outside of normal office hours. If the DH were to apply to the Commission for a 116XXX number at this stage it is very unlikely that the number would be reserved in time to meet the launch timescales for the DH service in England. Therefore this option has the risk of delaying implementation of the service until the reservation of a 116XXX number for a service that provides access to non-emergency health services has been made. There is also a risk that the Commission may not reserve a 116XXX number for this type of service or expand the service definition for 116117 to include the proposed service. The risk that best use would not be made of numbers if the Commission reserved a 116 number that covered the DH's proposed service is alleviated by the fact that the 116 number could be used in parallel with the DH's chosen number.

Costs of the options

Consumers

4.48 Looking at Option A, calls to 0845 numbers are currently set at BT's standard local call retail price for calls from BT landlines (currently between 1p and 4p depending on time of day and included in the BT Together call package). Calls from other providers may vary and from mobiles may cost considerably more. The cost to consumers to call Option B would depend on the associated tariff, which has yet to be decided, although the DH has outlined some potential tariff options, ranging from free to caller to ten pence per call (see Section 5 below). The tariff for calling a number from Option C would depend on the number range selected.

4.49 Under Option D, the Commission has applied a "freephone" tariff to 116XXX numbers. In the UK, callers may be charged for calling a freephone number provided that the caller is notified by an announcement at the start of the call. It is common practice for mobile providers to charge for calls to freephone numbers. Ofcom has taken the view that the extreme social value of some services on 116 numbers means that those numbers should, subject to consultation, always be free, including from mobiles. Such services are known as 'free to caller'. We will consult on a case-by-case basis to determine whether each 116 number reserved by the Commission is 'freephone' or 'free to caller'.

Communication providers

4.50 Option A would involve no additional costs to communications providers. Option C would also represent no additional costs to communications providers beyond "business as usual" costs of data amendments and call routing.

4.51 Options B and D are likely to result in higher costs and inconvenience for communications providers who would need to set up charging and routing processes

for new individual numbers (and possibly a new tariff for Option B). We understand these costs are mainly likely to be incurred by the larger providers, while costs for small landline providers will be relatively small. Mobile providers will also face some costs. However, for all providers the level of costs incurred will depend on the tariff option selected by the DH. Under Option B, if the selected tariff is already included in communications providers charging engines (e.g. local or national geographic tariff; ten pence per call as per the 101 number) they will not face significant costs in introducing the new number.

4.52 A further cost under Options B and D may include modifying payphones to accept the new code and charge the chosen tariff accordingly. However, we understand that when introducing the 101 number, providers were able for the most part to make modifications to payphones remotely and the majority of these costs were avoided. Again the tariff option selected will also determine the overall level of costs incurred for modifying payphones.

4.53 Communications providers will have additional costs in providing the routing necessary for Option B and other options that involve routing across the boundaries of England, Scotland, Wales and Northern Ireland. These routing facilities would enable, as far as possible, calls to be routed to the correct SHA or devolved administration. Under Option B, the DH is currently proposing for mobile and other providers to use the same process as was used for 101. This should reduce the costs of implementing the number as much as possible as it should be a case of following the process already used to set up 101. Furthermore, additional routing facilities will be implemented to help deal with “boundary conditions” where callers are close to an SHA or national boundary. These additional routing facilities will not incur additional costs to mobile providers.

4.54 Under Option D, other 116 numbers are likely to have been introduced before the DH pilots and therefore communications providers are likely to have already incurred the initial costs of making 116 numbers available. In addition, the tariff arrangement of freephone or free to caller would already be included in communications providers charging engines. However, the initial three 116 numbers would not have arrangements for routing calls based on geographic location of call origination. The routing technique used for 101 to achieve that is not necessarily available for Option D, because the technique used to route calls under Option B is based on routing a telephone number that is three digits long. Therefore a method of routing calls based on geographic location of the caller for 116 numbers would need to be developed for Option D, potentially creating higher costs for communications providers.

4.55 One potential additional cost for Option B is the fact that three-digit numbers can attract calls accidentally caused by pulses created through faulty wiring. Some providers have introduced a “four second gap” before routing the call to minimise such accidental calls on the 112 emergency number. The 999 emergency number is largely immune to such affects as a pulsed ‘9’ is hard to generate. The number 111 would attract such accidental calls but it is expected that a "four second gap" will be centrally implemented which will avoid any work needing to be done by landline providers. Therefore to the extent that providers already have functionality in place, it should be the case that the costs of extending this to another three-digit number would be relatively minor.

Summary of the costs of the options

4.56 We have not been able to put a figure on the exact costs that communications providers would face but it is likely that Option B would result in relatively higher

costs for communications providers, particularly compared to Options A and C. However, although these costs are not insignificant, they will be dependent on the DH's selection of tariff. The costs to consumers for Option B will also depend on the tariff option chosen by the DH but it is likely to be less than Option A and similar to Option C. The cost for consumers is likely to be least with Option D because of its freephone or free-to-caller tariff, however, it could also potentially carry the highest costs for communications providers because of the need to develop method of routing calls based on geographic location of the caller.

Additional risks and unintended consequences

4.57 We have already outlined some risks in relation to Options A, C and D in the paragraphs above. Option B has the additional risk that communications providers may not open access to the new code, particularly as tariff and interconnection arrangements have yet to be agreed. Consumers may therefore find that access provision is dependent on the network used to make the call and whether that network has chosen to provide access. In addition, there may be delays in implementing modifications to payphones, which will mean consumers will not be able to access the service from a payphone. However, during the development of the 101 service, virtually all providers in the relevant areas provided access to the service and virtually all payphones were set up to provide access to the number. There were therefore no significant issues in this respect. Nevertheless, during the pilots and thereafter we will assess the need to consider further issues of access to the service and interconnection arrangements. We are also mindful of the need to ensure that tariff arrangements under Option B are transparent to consumers.

4.58 Because three-digit numbers are a scarce resource, there is also a potential opportunity cost with Option B. It carries the risk that it will exclude an alternative use of that particular three-digit number in future. However, if a preferred use of the number arose in future, the Government would have the option to apply to request a new use for the number (although that may cause difficulties if the number had already been in use for a particular service). In addition, although these numbers are scarce, there will still be 14 other three-digit numbers available for other services that meet the required eligibility criteria. Therefore, although Option B carries some risks and potential unintended consequences, we consider that these are not significant and could be addressed if necessary.

Competition effects

4.59 We consider that the allocation of a number for a public healthcare service is unlikely to create any significant competition effects in telecommunications markets. Competition for supply of the three-digit number is likely to be fairly healthy. Although communications providers that already act as service providers supplying existing three-digit numbers could have some advantages in terms of having already incurred set-up costs, we consider that the level of costs involved is unlikely to represent a particular barrier to entry such that competition to supply the number would not be effective.

Distributional and equality impacts

4.60 We have considered the distributional impacts in two key areas. First, we have assessed the possible impacts by geography. Second, in line with our obligations to conduct equality impact assessments, we have assessed the possible impact in terms of equality.

Geographic impacts

4.61 Under all four options the number should be the same in all geographic areas and there should therefore be no differing impacts by geographic area. Numbers from the Numbering Plan are allocated uniquely to communication providers and non-geographic national numbers are specifically designed to be used nationwide under Option C.

4.62 Under Option D the Commission attach conditions to the right of use for 116 numbers and for the first three 116 numbers that have been reserved, one of these conditions has been that the number is available nationwide (or where that is not the case, information about availability is made publicly available). It is therefore likely that a condition of nationwide availability would also be required for any 116 numbers reserved in future.

4.63 Under Option A, however, because the health administrations are devolved, different services are offered on different numbers in Wales, Scotland and Northern Ireland. For example, the NHS Direct number 0845 46 47 is only available in England and Wales (although the services are operated separately), Scotland has the NHS 24 service, which is available on the eleven digit number 08454 242424. There is currently no equivalent NHS Direct service in Northern Ireland. Therefore under Option A, a new number may need to be allocated in order to roll-out the service to Northern Ireland, and there would continue to be different numbers for the services in England and Wales compared to Scotland.

4.64 Under Option B, the DH is committed to rolling out the service across England, subject to the positive evaluation of the initial three pilots. The Scottish Government intends for the three-digit number to be used for its NHS 24 service. The DHSS in Wales will consider the issue further once the results of the DH pilots have been evaluated. The DHSSPS in Northern Ireland has not yet taken a decision on whether it will use the three-digit number in the future. Therefore, there is potential for different geographic impacts if the service is not fully rolled-out across all the devolved administrations. This would, however, be the case under all options.

Equality impacts

4.65 We considered whether we were required to undertake a full Equality Impact Assessment for this consultation. On the basis of our Initial Equality Impact Assessment Screening we have determined that this is not required. Under all four options the number should be equally accessible to all and we would therefore not expect any differing impacts dependent on race or gender groups.

4.66 For those consumers that have disabilities, General Condition 15 ("GC15") covers special measures required. It states that:

> "the Communications Provider shall ensure that such of its Subscribers who, because of their disabilities, need to make calls in which some or all of the call is made or received in text format, are able to access a Relay Service".

As set out in paragraph 15.10 of GC15, a Relay Service:

> "(i) provides facilities for the receipt and translation of voice messages into text and the conveyance of that text to the terminal of customers of any provider of Publicly Available Telephone Services

> and vice versa; and (ii) has been approved by the Director to be a text relay service for the purposes of this condition".[28]

BT is designated to guarantee the provision of a Relay Service in the UK, and that approved Relay Service is BT TextDirect.[29]

4.67 BT TextDirect enables text to voice and voice to text calls using a RNID Typetalk operator ('Typetalk') to relay the call, converting text to voice and vice versa. All calls relayed through Typetalk are private and confidential and Typetalk operators are highly trained and experienced in relaying calls containing personal, sensitive and confidential information.

4.68 Calls made using BT TextDirect require the dialling of an access code (18001 for text to voice and 18002 for voice to text) ahead of dialling the telephone number. For example, NHS 24 in Scotland has a textphone service available on 18001 08454 242424. Therefore, if a consumer wanted to make a call using their textphone to a service on a three-digit number such as 111 (where that call would terminate on a telephone as opposed to a textphone), they would dial 18001 111.

4.69 Text to text calls are made directly between parties using textphones. Textphones often have an individual telephone number assigned to them, however, it is possible for the same telephone number to be used to call both textphones and telephones. A consumer with a textphone would need to dial the access code 180015 before dialling the 111 number. NHS Direct currently has a textphone service available on the number 0845 606 46 47.

4.70 All service providers would therefore be expected to make reasonable adjustments to address disability issues under Options B, C and D. As above, under Option A, NHS Direct and NHS 24 already have textphone services in place.

Monitoring requirements

4.71 There may be monitoring requirements under some of the options. For example, under Option D Ofcom has a duty to report periodically to the Commission on the use of 116 numbers in the UK. In order to meet the obligation and to ensure that allocated 116 numbers are actually in service and being used in accordance with the Service Eligibility Criteria, we will audit those to whom allocations have been made in accordance with the Commission's monitoring timetable.

4.72 Under Option B, Ofcom would want to ensure that the number was being used in accordance with its service designation and would therefore keep up to date on any developments on changes with the number. For example, we continue to be involved in the '101 Liaison Committee' run by the Home Office to ensure that the 101 number is still in use and being used for the service for which it was designated.

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[28] http://www.ofcom.org.uk/telecoms/ioi/g_a_regime/gce/cvogc150807.pdf

[29] Under Article 8 of the Universal Service Directive ('the USD'), Member States may designate one or more undertakings to guarantee the provision of universal service as identified in certain articles of the USD, including Article 7, which covers special measures for disabled users. Article 7 of the USD states that "Member States shall, where appropriate, take specific measures for disabled end-users in order to ensure access to and affordability of publicly available telephone services..." Directive 2002/21/EC of the European Parliament and of the Council of 7 March 2002 on universal service and users' rights relating to electronic communications networks and services (Universal Service Directive).

4.73 Under Options A and C, we carry out regular audits of number allocations to ensure that communications providers continue to use numbers effectively and efficiently, as required by the Numbering Condition.

The preferred option

4.74 We have considered the options for the number for the DH service and assessed these in line with our statutory duties to make the best use of the UK's numbering resource and furthering the interests of citizens and consumers. Our preferred option would be to make available a three-digit number for the proposed DH service. We believe this would make the best use of the UK's numbering resource and would best promote the interests of consumers and citizens.

4.75 The table below summarises our assessment of the relative benefits and costs of each option. We have not been able to quantify the exact costs to communications providers, but our assessment indicates that Option B has relatively higher costs for communications providers (although the costs are potentially even higher for Option D). Nevertheless, Option B provides the most benefits to consumers.

Table 1: Assessment of the relative benefits and costs of each option

Option	Benefits	Costs
A: existing NHS Direct number	**none**	**none**
B: three-digit number	✓✓✓	××
C: number from the Numbering Plan	**none**	×
D: 116 European number	✓✓	××

4.76 On balance, we therefore consider that the benefits of Option B (in terms of meeting the statutory criteria) outweigh the associated costs and there are factors that suggest any risks are low and potentially manageable.

Question 1: 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.

Choice of appropriate three-digit number

4.77 Given our view that the proposed non-emergency healthcare service represents a justified use of a three-digit number, there is a further question over the choice of three-digit number. The choice of number rests with the DH and we have set out the rationale for its choice below. The three-digit numbers available for designation for the proposed service were listed in paragraph 4.17 above.

4.78 The DH has focussed on three main criteria for evaluating which number would be the most suitable for the proposed service including memorability, reduced risk of mis-dials, and ease of keyboard navigation.

4.79 The DH conducted research to explore whether there were significant differences between the 15 available three-digit numbers in terms of their ease of use, memorability and association with any existing three-digit numbers (see Annex 6).[30]

4.80 In its research, the DH paid particular attention to the needs of blind or partially sighted users, and those with restricted mobility, to ensure that no number was chosen which they would find difficult to use. In addition to exploring the views of these particular users, the DH sought advice from academic experts in the fields of neuroscience, clinical psychology and dyslexia. Their unanimous view was that the most effective numbers were those that contained the fewest different digits, digits that were lower in value, closer together in value, arranged chronologically and all odd or all even.

4.81 The research indicated that the easiest numbers to use on the keypad were those with minimum movement required between the keys and, for mobile phones in particular, keys that were at the top and left of the keypad. These physical characteristics were important for all, but found to be particularly significant for the elderly, those with movement restrictions in their hands and for the blind and partially sighted.

4.82 These same characteristics also contributed towards the memorability of the number, partly because they conformed to the principles outlined by the experts, but also because people reported that the action of dialling them would help to cement them in the memory – the easier a number is to dial, the easier it is to remember.

4.83 For all these reasons, the DH research found that 111 emerged as the overwhelmingly preferred option as the number for the proposed non-emergency healthcare service. Only three alternatives (119, 115 and 105) found support, albeit small. While 85% of the research sample chose 111, 7.5% chose 119, 5% chose 115 and only 2.5% chose 105. The researchers also found that each of the identified user groups, in particular the blind and partially sighted, those with movement restrictions, people over the age of seventy-five and those with long-term conditions, separately identified 111 as the best option. This view was further endorsed by health professionals, wardens and carers.

4.84 In addition to this overwhelming preference for 111 for its ease of use and memorability, the research also revealed that it was strongly associated in the public mind with 999. Without exception, people associated the new 111 service with the vital public service characteristics of 999.

4.85 A small minority of respondents identified the possibility of mis-dials as a potential shortcoming for 111, and the particular challenge around ensuring that three digits had been dialled was seen as a risk. This potential for mis-dials was identified in Ofcom's consultation on the designation of 101, where ergonomic advisers indicated that the same digit should not be repeated consecutively in order to avoid mis-dials.[31] However, those who expressed this view in the DH research also suggested that it was a small price to pay for a number with many other advantages.

4.86 There is a potential further issue around mis-dials with the number 111. The number 101 has attracted mis-dials and this may have been mainly generated by a pulsed '1'

[30] Cragg Ross Dawson, *Three Digit Number for Urgent Care. Qualitative Research to help identify the most appropriate number*, April 2009.
[31] Ofcom, *National Single Non-Emergency Number; Designating number "101"*, 8 March 2006, page 13. Available at: http://www.ofcom.org.uk/consult/condocs/snen/snen_statement.pdf.

preceding a customer dialling a number that started "01" which would generate a number that started 101. The number 112 is also known to generate mis-dials through accidental pulses. It is therefore likely that 111 would also generate mis-dials. However, mis-dials to 101 and 112 have been almost eliminated by the use of a four second gap (see paragraph 4.55 above) and therefore the same system on 111 would also prevent this type of misdial on this number.

4.87 As noted in the footnote to paragraph 4.39, if 111 were implemented in parallel with the European Harmonised Number 116117 there is an argument that, in the interests of avoiding potential consumer confusion, the three-digit number 117 would be more appropriate. However, the DH consumer research found that 117 held no resonance with consumers and was ranked very low in terms of memorability. The potential for confusion with 118XXX numbers, which are used to access Directory Enquiry facilities, was also highlighted.

Question 2: Do you agree with the DH's 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.

Summary

4.88 Our evaluation of the different numbering options suggests that Option B, a three-digit number, would be the most appropriate by providing the most benefits to citizens and consumers. Based on the results of its consumer research, the DH has selected 111 for the proposed service. We are therefore consulting on the proposed notification of modification to the Numbering Condition (at Annex 8) on the basis of the DH's preference for a three-digit number, specifically 111. Stakeholders are invited to comment on this proposal.

Section 5

The Tariff

Introduction

5.1 Our principal duty is to further the interests of citizens and consumers in relation to communications matters. This duty includes, as set out in Article 8.4(d) of the Framework Directive, promotion of the provision of clear information, in particular requiring transparency of tariffs and conditions for using communications service. As already stated, the DH's preference for the service is for a three-digit Type A Access Code and in particular for the number 111. However, Access Codes give no information on tariff and/or service in their digit structure. It is therefore important that consumers gain information from other sources on the charges (if any) of calling the service.

5.2 The tariff for calling the service in England will be the result of negotiations between the DH and communications providers. This may mean that tariffs for calling the service could vary considerably depending on the provider. Similar negotiations prior to the introduction of 101 resulted in all providers charging the same tariff[32], although more recently one provider has implemented a higher tariff. Nevertheless, because the call charge is a commercial decision by the provider, there is no guarantee that all providers will offer the same tariff.

5.3 To supplement its discussions with providers, the DH has asked us to seek stakeholders' views on appropriate call charges as part of this consultation, and the tariff options in this section are set out on behalf of the DH. These options relate to the proposed service in England only. The devolved administrations will need to consider appropriate call charges for the three-digit number should they decide to launch it in Scotland, Wales or Northern Ireland respectively.

Introduction

5.4 A number of factors need to be taken into account when determining the appropriate charge to call the proposed service. These include:

- the cost and funding of call handling;
- the estimated call volumes and length of calls;
- the best way of achieving the policy aims of the service; and
- how best to provide tariff transparency.

5.5 These elements are discussed in the following paragraphs.

Cost and funding of call handling

5.6 The DH plans to invite tenders for the provision of the call handling element of the proposed service in the coming months. Until the service provider has been selected and work on establishing the cost of provision has been progressed, it is not possible to accurately calculate the cost of providing the communications element of the

[32] The tariff selected by the Home Office for calling "101" is a fixed rate of ten pence per call.

service. The DH has nevertheless estimated that the initial cost of providing the call routing infrastructure is likely to be between £1m and £5m.

5.7 Details of the budget and funding for the service in England are in the process of being agreed by the DH. The DH currently invests some £10bn per annum in the urgent and emergency care system, including funding for urgent care clinical triage of around £180m (including NHS Direct and GP out-of-hours). It has provisionally estimated that the costs involved with providing the service could range between an annual saving of £14m (compared to the existing costs of providing urgent care services and NHS Direct) and additional annual costs of up to £74m per annum, depending on which method of providing the service they decide to implement and the call volumes. The DH assumption is that, for their preferred option, the costs of delivering the assessment, referral and advice elements of the service will be met from existing resources and from better integration and consequent reduction in overlap and duplication of urgent and emergency care services. The initial pilots will be used to assess the costs of call handling using different models of service provision. This may include use of NHS Direct, Ambulance Trusts and out-of-hours providers in different ways in different pilots.

5.8 The DH's initial assumption is that callers should contribute to the cost of the telecommunications element of calling the proposed service and it therefore considers that a tariff that includes a charge would be preferable. The DH proposed tariff options are outlined below (paragraph 5.21).

Estimated call volumes and length of calls

5.9 NHS Direct receives around 5m calls a year. In addition, GP out-of-hours services receive around 9m calls a year. Based on this current level of calls, as well as calls to other urgent care services, the DH has estimated that there could be between 14.4m and 30m calls per annum to the three-digit number in England.

5.10 The DH has, however, highlighted the difficulty in estimating the exact number of calls the service is likely to receive. Reasons for this include:

- people do not always know how to access urgent healthcare services and consequently some patients may currently either contact 999/112 or go to A&E, or may not contact any service at all;
- many people are aware of the NHS Direct service but do not know the telephone number. The availability of a memorable three-digit number is likely to lead to an increase in this type of call; and
- uncertainty about how many people who meet an engaged tone when they call their GP will call the three-digit number instead.

5.11 The DH has also estimated that the average length of a call to the service will be between seven and ten minutes. This will include an assessment of the caller's medical needs, the provision of health advice and information to support self-care and, where required, a transfer to other services. This estimate is based on the average length of calls to NHS Direct and other urgent care services currently. Again the first three pilots will help predict the likely call volumes and length of calls when the service is launched across England.

Policy aims of the DH service with respect to tariff arrangements

5.12 The DH's objective in negotiating an appropriate tariff with communications providers is to try and ensure that, at the least, the public will not have to pay more to access non-emergency healthcare services than they currently do. NHS Direct uses an 0845 number, which currently costs between one and four pence per minute (depending on time of day) from BT landlines and calls from other lines vary depending on the provider. GPs surgeries are generally available on geographic numbers, although some have an 084 number.

Tariff transparency

5.13 Tariff transparency is an important component in ensuring that consumers are adequately protected and can make informed choices. An overriding point, which applies to all the tariff options, is that despite the service providers' intended charge for calling their service, the retail charge to consumers may vary between networks, because the cost for calling from all providers would be a commercial decision by the provider. It is consequently essential that tariff transparency is provided through publicity and other relevant means.

Ofcom tariff guidance and Central Office of Information's best practice guidelines

5.14 The cost to consumers of making telephone calls to public sector services is an important and sensitive issue. We noted that this was an issue of concern for many consumers during our review of Numbering Translation Services ("NTS") in 2006.[33] Consumers expressed concerns about the use of NTS numbers for public services, because call charges were generally higher than those calls to ordinary geographic numbers and because the organisation using the number might receive a share of the call charge. In 2007 Ofcom introduced a new range of numbers – beginning with 03 – in order to address some of these concerns.[34] The 03 numbers are charged at the same rate as geographic numbers and revenue-sharing schemes are forbidden on this range. In order to encourage public bodies to use these numbers, we reserved a specific part of the 03 range. All numbers beginning with 030 are for use only by public bodies and not-for-profit services.[35] We also expected this to be a number range that public services in particular would feel appropriate to use in preference to certain 08 numbers.

5.15 Our position is that it is inappropriate for public bodies to rely on chargeable 08 numbers exclusively (i.e. without, at a minimum, giving equal prominence to a geographic number alternative) for access to essential services, particularly when dealing with people on low incomes or other vulnerable groups.[36] This is because the price of these calls is generally higher than calls to geographic numbers. However, with new changes designed to facilitate the restoration of the link between the pricing of 0870 calls and calls to geographic numbers (see paragraph 5.19 below), consumer concerns could be likely to ease. Nevertheless, we consider that the

[33] Ofcom, *NTS: A Way Forward*, 19 April 2006, available at: http://www.ofcom.org.uk/consult/condocs/nts_forward/statement/statement.pdf
[34] Ofcom, *Raising Confidence in Telephone Numbers; including new 'UK-wide' 03 numbers and a consultation to amend General Condition 17*, 13 February 2007, available at: http://www.ofcom.org.uk/consult/condocs/numbering03/03.pdf
[35] We publish guidance on what bodies would be eligible for this number range: http://www.ofcom.org.uk/telecoms/ioi/numbers/030_guidance/030_v3/
[36] See http://www.ofcom.org.uk/consult/condocs/nts_forward/

choice of number and hence call tariff is a matter for the organisations concerned. During our review of NTS numbers we stated that restricting the availability of NTS numbers for public sector services would be potentially discriminatory. We considered that there was insufficient evidence of consumer detriment in relation to the use of NTS numbers in the 08 range to justify applying a complete prohibition on its use by public bodies.

5.16 The DH is, however, already considering prohibiting the use of 084 numbers in the NHS. This is because patients who use 084 numbers are often, on average, paying more than the equivalent cost of a local rate call to access services provided by the NHS. It recently issued a consultation to gather views on how valuable the extra functions provided by 084 numbers are and how they might otherwise be provided without patients having to pay more than the cost of a local call rate for them, for example by using 03 numbers instead.[37]

5.17 The Central Office of Information (COI) provides advice and support to public sector organisations on all aspects of communications. Amongst other things it publishes *Better practice guidance for Government contact centres*.[38] A section of this guidance deals with the selection of telephone numbers and the cost of calling Government services. The guidance states that the use of chargeable 08 numbers for consumer-facing services – particularly those used by vulnerable groups and those on low incomes – should be approached with caution. The guidance goes on to state that "free services would be appropriate if you are targeting those who may be deterred by the cost of a call (for example, the elderly, young people, or those in low incomes or where the nature of the call is confidential) and is particularly applicable if your objective is to encourage as many people as possible to call".

Consumer research on possible tariff options

5.18 The DH commissioned consumer research in order to understand consumer attitudes toward possible tariff options for calling a three-digit number to access the proposed service (see Annex 6).[39] As part of the research a number of tariff options were suggested which included geographic number call rates; up to three pence per minute; ten pence per call or 'free to caller'. Three different scenarios were tested: at home, at home but out of hours and away from home. The research found that 54% of respondents expected to have to pay at least the cost of a local call to contact the service. It also found that the majority of people (between 74% and 89% depending on the scenario) claimed to be at least fairly likely to use the service regardless of what they might have to pay for it. The level of respondents who claimed they would use the number did not vary significantly between the options with a charge (i.e. excluding free to caller). The levels of respondents claiming they would use the service only increased by 6% to 11% for the 'free to caller' tariff.

Tariff options

5.19 Type A Access Codes have no inherent tariff structure or interconnection arrangements. There are a wide range of possible tariff options for the service which could offer various advantages and disadvantages for consumers, communications

[37] DH, *The use of 084 telephone numbers in the NHS*, 16 December 2008 available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091923.
[38] Available at: http://www.coi.gov.uk/documents/gcc-third-edition.pdf.
[39] Jigsaw Research, *3DN Tariff Research,* May 2009.

providers, and the parties funding and providing the service. This range of options is set out below, including indicative commentary on their possible impact:

- **Freephone:** calls would generally be free from fixed lines but may be chargeable from mobile phones provided a pre-call announcement advises callers that a charge applies. This option has the benefit for consumers of tariff transparency and reduced expense (although not to the extent of the "free to caller" option – see below). It also has a benefit for emergency services by reducing the likelihood of inappropriate calls to 999/112 as calls to the DH service would also be free (at least from landlines). On the other hand, this may increase the risk of hoax/nuisance calls. The service provider would need to fund the cost of receiving calls.

- **Free to caller:** all calls would be free, including calls made from mobiles. In addition to the comments on the "freephone" option above, this would offer complete tariff transparency and would benefit all consumers including those whose only access to the service would be via mobile. This option would be more expensive for the service provider to fund than the freephone option. This option offers the greatest benefit to disadvantaged groups and is the most likely to reduce the number of 999/112 calls.

- **Special Service Basic Rate and Special Service Higher Rate as provided on 0845 and 0870 numbers (formerly known as Local Rate and National Rate):** a non-geographic rate that may differ from the distance based local/national rate associated with making a local or national call to a geographic number. We do not recommend this option for the DH service for reasons outlined in paragraphs 5.14 to 5.17 above. In April this year Ofcom issued a final statement on the cost of calling 0870 numbers, which implemented a number of changes designed to improve pricing transparency and facilitate the restoration of the linkage between charges for 0870 numbers and national calls to geographic numbers.[40] From 1 August 2009 communications providers that wish to charge more than the national rate for 0870 calls will be subject to new requirements to display their 0870 charges prominently on price lists and advertising materials.

- **Genuine Local Rate or Genuine National Rate:** the cost of the call would be the same as the cost of making a local or national geographic call regardless of the network that the caller was using. This would not mean that all callers pay the same charge but simply that the call would cost the same as a local or national geographic call from the same communications provider. This option provides clear tariff transparency.

- **Fixed rate pence-per-minute:** the tariff would be indicated by quoting a fixed pence-per-minute call cost. This would offer clear tariff transparency and equality of treatment regardless of the type of telephone used. However, it might be harder for some communications providers to implement.

- **Fixed pence-per-call / single drop charge:** the tariff would be a set charge for the call regardless of call length. This is the option was chosen for the 101 number with a fixed charge of ten pence per call.

[40] Ofcom, *Changes to 0870; Confirmation of changes to 0870 calls and modifications to the supporting regulations,* 23 April 2009, available at: http://www.ofcom.org.uk/consult/condocs/0870calls/0870statement/

- **Variable pence-per-minute according to day/time:** this tariff arrangement allows for calls to be cheaper at non-peak times, i.e. evening and weekends. This option is unlikely to provide clear tariff transparency.

- **Pence per minute with a maximum tariff ceiling:** rather than set the pence per-minute tariff for the call, a maximum tariff ceiling would be stated, for example, "up to and including five pence-per-minute". Call costs could vary between networks up to and including the tariff ceiling rate. Again this option is likely to lack tariff transparency to consumers.

- **Pence per minute / maximum tariff ceiling with maximum cost of call:** similar to the pence-per-minute and pence-per-minute with a maximum tariff ceiling, but with the addition of a limit on total call cost. This option may be difficult for consumers to understand and could potentially be difficult for providers to implement.

5.20 The above provides a comprehensive list of tariff options. However, for the purposes of focussing stakeholders' comments, the DH has selected its preferred options (see below). We are seeking stakeholders' views on appropriate call costs, and in particular the options set out below, taking into account the factors discussed in this section.

DH preferred tariff options

5.21 The DH has considered the possible tariff arrangements and has selected the following potential options for specific consideration by stakeholders:

- **Option 1**: free to caller;

- **Option 2**: 10 pence per call;

- **Option 3**: 3 pence per minute; or

- **Option 4**: genuine local or national rate (i.e. charged the same as a landline call or a call to an 03 number).

5.22 As outlined above, the DH wants the tariff to be implemented, at least initially, following negotiation between the DH, the service provider and communications providers. This was the approach taken by the Home Office when it launched the single non-emergency service on 101, with successful results.

5.23 If, at any stage, it becomes necessary to consider the question of regulatory intervention on the tariff, we would need to consult specifically on that issue. Therefore, although we are seeking stakeholder views on the tariff options, we are not making a proposal on the appropriate tariff for the service. We have consequently not conducted an impact assessment on the tariff options.

Question 3: What are your views on the tariff options selected by the DH?

Annex 1

Responding to this consultation

How to respond

A1.1 Ofcom invites written views and comments on the issues raised in this document, to be made by **5pm on 20 August 2009**.

A1.2 Ofcom strongly prefers to receive responses using the online web form at http://www.ofcom.org.uk/consult/condocs/three_number_non_emergency/ , as this helps us to process the responses quickly and efficiently. We would also be grateful if you could assist us by completing a response cover sheet (see Annex 3), to indicate whether or not there are confidentiality issues. This response coversheet is incorporated into the online web form questionnaire.

A1.3 For larger consultation responses - particularly those with supporting charts, tables or other data – please email elizabeth.gannon@ofcom.org.uk attaching your response in Microsoft Word format, together with a consultation response coversheet.

A1.4 Responses may alternatively be posted or faxed to the address below, marked with the title of the consultation.

Elizabeth Gannon
Floor 4
Competition Group
Riverside House
2A Southwark Bridge Road
London SE1 9HA

Fax: 020 7783 3574

A1.5 Note that we do not need a hard copy in addition to an electronic version. Ofcom will acknowledge receipt of responses if they are submitted using the online web form but not otherwise.

A1.6 It would be helpful if your response could include direct answers to the questions asked in this document, which are listed together at Annex 4. It would also help if you can explain why you hold your views and how Ofcom's proposals would impact on you.

Further information

A1.7 If you want to discuss the issues and questions raised in this consultation, or need advice on the appropriate form of response, please contact Elizabeth Gannon on 020 7981 3501.

Confidentiality

A1.8 We believe it is important for everyone interested in an issue to see the views expressed by consultation respondents. We will therefore usually publish all responses on our website, www.ofcom.org.uk, ideally on receipt. If you think your response should be kept confidential, can you please specify what part or whether

all of your response should be kept confidential, and specify why. Please also place such parts in a separate annex.

A1.9 If someone asks us to keep part or all of a response confidential, we will treat this request seriously and will try to respect this. But sometimes we will need to publish all responses, including those that are marked as confidential, in order to meet legal obligations.

A1.10 Please also note that copyright and all other intellectual property in responses will be assumed to be licensed to Ofcom to use. Ofcom's approach on intellectual property rights is explained further on its website at http://www.ofcom.org.uk/about/accoun/disclaimer/

Next steps

A1.11 Following the end of the consultation period, Ofcom intends to publish a statement later in 2009.

A1.12 Please note that you can register to receive free mail Updates alerting you to the publications of relevant Ofcom documents. For more details please see: http://www.ofcom.org.uk/static/subscribe/select_list.htm

Ofcom's consultation processes

A1.13 Ofcom seeks to ensure that responding to a consultation is easy as possible. For more information please see our consultation principles in Annex 2.

A1.14 If you have any comments or suggestions on how Ofcom conducts its consultations, please call our consultation helpdesk on 020 7981 3003 or e-mail us at consult@ofcom.org.uk . We would particularly welcome thoughts on how Ofcom could more effectively seek the views of those groups or individuals, such as small businesses or particular types of residential consumers, who are less likely to give their opinions through a formal consultation.

A1.15 If you would like to discuss these issues or Ofcom's consultation processes more generally you can alternatively contact Vicki Nash, Director Scotland, who is Ofcom's consultation champion:

Vicki Nash
Ofcom
Sutherland House
149 St. Vincent Street
Glasgow G2 5NW
Tel: 0141 229 7401
Fax: 0141 229 7433

Email vicki.nash@ofcom.org.uk

Annex 2

Ofcom's consultation principles

A2.1 Ofcom has published the following seven principles that it will follow for each public written consultation:

Before the consultation

A2.2 Where possible, we will hold informal talks with people and organisations before announcing a big consultation to find out whether we are thinking in the right direction. If we do not have enough time to do this, we will hold an open meeting to explain our proposals shortly after announcing the consultation.

During the consultation

A2.3 We will be clear about who we are consulting, why, on what questions and for how long.

A2.4 We will make the consultation document as short and simple as possible with a summary of no more than two pages. We will try to make it as easy as possible to give us a written response. If the consultation is complicated, we may provide a shortened Plain English Guide for smaller organisations or individuals who would otherwise not be able to spare the time to share their views.

A2.5 We will consult for up to 10 weeks depending on the potential impact of our proposals.

A2.6 A person within Ofcom will be in charge of making sure we follow our own guidelines and reach out to the largest number of people and organisations interested in the outcome of our decisions. Ofcom's 'Consultation Champion' will also be the main person to contact with views on the way we run our consultations.

A2.7 If we are not able to follow one of these principles, we will explain why.

After the consultation

A2.8 We think it is important for everyone interested in an issue to see the views of others during a consultation. We would usually publish all the responses we have received on our website. In our statement, we will give reasons for our decisions and will give an account of how the views of those concerned helped shape those decisions.

Annex 3

Consultation response cover sheet

A3.1 In the interests of transparency and good regulatory practice, we will publish all consultation responses in full on our website, www.ofcom.org.uk.

A3.2 We have produced a coversheet for responses (see below) and would be very grateful if you could send one with your response (this is incorporated into the online web form if you respond in this way). This will speed up our processing of responses, and help to maintain confidentiality where appropriate.

A3.3 The quality of consultation can be enhanced by publishing responses before the consultation period closes. In particular, this can help those individuals and organisations with limited resources or familiarity with the issues to respond in a more informed way. Therefore Ofcom would encourage respondents to complete their coversheet in a way that allows Ofcom to publish their responses upon receipt, rather than waiting until the consultation period has ended.

A3.4 We strongly prefer to receive responses via the online web form which incorporates the coversheet. If you are responding via email, post or fax you can download an electronic copy of this coversheet in Word or RTF format from the 'Consultations' section of our website at www.ofcom.org.uk/consult/.

A3.5 Please put any parts of your response you consider should be kept confidential in a separate annex to your response and include your reasons why this part of your response should not be published. This can include information such as your personal background and experience. If you want your name, address, other contact details, or job title to remain confidential, please provide them in your cover sheet only, so that we don't have to edit your response.

Cover sheet for response to an Ofcom consultation

BASIC DETAILS

Consultation title:

To (Ofcom contact):

Name of respondent:

Representing (self or organisation/s):

Address (if not received by email):

CONFIDENTIALITY

Please tick below what part of your response you consider is confidential, giving your reasons why

Nothing ☐

Whole response ☐

Part of the response ☐

Name/contact details/job title ☐

Organisation ☐

If there is no separate annex, which parts?

If you want part of your response, your name or your organisation not to be published, can Ofcom still publish a reference to the contents of your response (including, for any confidential parts, a general summary that does not disclose the specific information or enable you to be identified)?

DECLARATION

I confirm that the correspondence supplied with this cover sheet is a formal consultation response that Ofcom can publish. However, in supplying this response, I understand that Ofcom may need to publish all responses, including those which are marked as confidential, in order to meet legal obligations. If I have sent my response by email, Ofcom can disregard any standard e-mail text about not disclosing email contents and attachments.

Ofcom seeks to publish responses on receipt. If your response is non-confidential (in whole or in part), and you would prefer us to publish your response only once the consultation has ended, please tick here. ☐

Name

Signed (if hard copy)

Annex 4

Consultation questions

A4.1 Here is a list of our consultation questions:

Question 1: 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.

Question 2: 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.

Question 3: What are your views on the tariff options selected by the DH?

Question 4: Do you have any comments on the proposed notification of modification to the Numbering Condition in Annex 8 of this document?

Annex 5

Department of Health paper on the introduction of a three-digit number for access to NHS non-emergency healthcare services in England

The need for a three-digit number

A5.1 It has been clear for some time that the public have found it difficult to access NHS services when they develop unplanned, unexpected healthcare needs, especially outside normal working hours when GP practices are closed or when they are away from home. In part, this is because patients are often unclear about how serious their healthcare needs are, but it is also because they may not know what services are available and how they should be accessed.

A5.2 In 2000, the Carson Review of GP Out-of-Hours Services emphasised the need to simplify people's access to NHS services, and it recommended that "*A new model of integrated out-of-hours provision should be accessed by patients via a single telephone call*".[41]

A5.3 In addition, changes in the way in which services are delivered, in particular the introduction of new services like NHS Walk-in Centres or Urgent Care Centres, has added to the complexity of the (urgent) healthcare system. The result is that many people are unclear which services are available to meet their urgent, unplanned needs. For example, they are unsure when services are open, how they should be accessed and what kinds of needs they are actually equipped to meet.

A5.4 In the light of this, a major public consultation in 2005 revealed clear support for "*Being able to get advice in one place from a health or community services professional*".[42] Early work in 2006[43] with service users and carers also confirmed that simplifying access to urgent, non-emergency (i.e. non life-threatening) care was a major priority for the public, and the development of a new three-digit number ("3DN") providing quick, easy access to such care was identified as one of the most important steps that could be taken to improve the current position.

A5.5 Around the same time, the consumer organisation Which? carried out an investigation into out-of-hours healthcare services, and it too drew attention to public confusion about how to access such services, emphasising in particular that nearly three quarters of people surveyed did not know the NHS Direct telephone

[41] Department of Health, *Raising Standards for Patients; New Partnerships in Out-of-Hours Care*, London 2000.
[42] Department of Health, *Our health, our care, our say: a new direction for community services*, London, 2006, Figure 3.4 p. 71.
[43] The Department of Health held some workshops with service users and carers, but the findings were not published.

number. It concluded that the NHS Direct number should be changed to a 3DN.[44] In its response to the Department of Health's consultation about urgent and emergency care, Which? drew particular attention to the importance of "*A single three-digit national number providing 24/7 access to information about available local services or an assessment of the urgency of need*".[45]

A5.6 Additional professional support for the need to simplify access to urgent care came in a position statement from the Royal College of General Practitioners in 2007, which stated that: "*Patients find the current system for accessing out of hours care confusing. Access to urgent care must therefore be made as simple as possible for patients. Patients should expect a consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need*."[46]

A5.7 A major review of NHS services was then undertaken in 2007-8 by Lord Darzi to coincide with the sixtieth anniversary of the founding of the NHS. At the heart of that Review was the detailed work led by each of the ten English Strategic Health Authorities, which gave local NHS clinicians, and the communities they serve, an opportunity to identify their own visions for the way in which the NHS should develop in the coming decade. Eight out of the ten recommended the introduction of a new easy-to-remember, 3DN to provide quick, easy access to urgent care,[47] and Lord Darzi's Final Report, *High Quality Care for All,* committed the Department to ongoing work to explore the costs and benefits of introducing such a number.[48]

A5.8 At the same time, the Healthcare Commission carried out a service review of urgent and emergency care, and it concluded that there was real merit in the introduction of a new telephone number and considered that the successful implementation of the new service would require the full engagement of local health and social care services.[49]

Public support for a 3DN

A5.9 In 2008 the Department commissioned a research agency, "Diagnostics Social & Market Research", to conduct qualitative research to explore whether there would be public support for the idea of a new 3DN as a way of accessing healthcare services, which would sit alongside the 999/112 emergency number. The research found that there was widespread support for the concept, with the idea of a 999 style, memorable number being particularly appealing:

> *"It would be embedded in your mind, you wouldn't have to look it up in a book, and you wouldn't be panicking and dialling 999 so it would ease up on emergency services."* (Female)

[44] Which?, *Which Way – Negotiating the Out of Hours Maze*, London, 2006.
[45] *Which? Response to Department of Health discussion document 'Direction of travel for urgent care'*, London, 2007.
[46] Professor Mayur Lakhani, Dr Agnelo Fernandes and Dr Graham Archard, *Urgent Care. A position statement from the Royal College of General Practitioners*, London, 2007, paragraph 4.2, p.6
[47] Since the publication of their Vision documents, one further SHA (South East Coast) now supports the introduction of the new number.
[48] Department of Health, *High Quality Care for All. NHS Next Stage Review Final Report* London, 2008, p. 40.
[49] Commission for Healthcare Audit and Inspection, *Not just a matter of time. A review of urgent and emergency care services in England,* London, 2008, p. 8.

A5.10 Respondents also liked the fact that a 3DN could help them to find the right service for their particular needs if they were unsure about whom to call or how serious their health need was:

> *"That's a very good idea. I like the fact that if you don't know which category you fall into – whether you need a doctor or an ambulance – you just ring up and they tell you."* (Female, Unpaid Carer)

> *It's very hard to tell if a child is really ill or not – you need reassurance as to what to do next."* (Young Family)

A5.11 Some respondents indicated that they would find the service most useful either when they were away from home or when they needed to access healthcare services outside normal opening times. Others could also see the benefit of using the service when they were at home – these included people that had not had much experience of using urgent healthcare services, like inexperienced fathers. It would also be especially empowering for older people who are often reluctant to "trouble" the service. For this group, the research indicated that a 3DN could be empowering, because it would give them "permission" to use the NHS. Carers saw the introduction of the number as potentially life-changing, because it would give them straightforward access to support, advice and help 24 hours a day, seven days a week, enabling them to share responsibility for difficult medical decisions.

A5.12 The research concluded that "*the new three-digit number service idea should indeed achieve its objectives of helping the general public towards the most suitable medical response for their particular situation and thereby lessen the demand on existing front-line services such as 999*".

Benefits of a 3DN

A5.13 As indicated, introducing a new 3DN for healthcare – alongside 999/112 – will give the public a memorable number to call when they do not know what to do about their particular healthcare need, especially in urgent, non-emergency (i.e. non-life threatening) circumstances. It will reduce the confusion around the existing options and help patients access the healthcare services they need.

A5.14 For callers with urgent, non-emergency needs, such a number would provide a clear direct route to appropriate care services or advice and information to support them in self-care. For the purposes of the research, Diagnostics defined urgent care as "*the range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis*". Inevitably, as respondents to the Diagnostics research identified, the distinction between what is an urgent healthcare need and an emergency need is not always clear, which is why it is envisaged that the 3DN service and the emergency services will have consistency in how they assess calls and mechanisms for routing calls between services. Based on current calls to NHS Direct and the demand for GP Out of Hours and other urgent care services, the Department estimates that there could be between 14.4m and 30m calls per annum to the 3DN.

A5.15 Because of low awareness of local services or the NHS Direct number, people sometimes default to A&E or 999 although there are likely to be services available locally that are more appropriate or convenient. Currently, approximately 37%[50] of

[50] DH Reference Cost Data – 2006/07.

visits to A&E are "minor attendances" (i.e. non-emergency). Similarly, the ambulance service handles 7.5m[51] calls per year of which 2.2m (29%) are categorised as being in their lowest category of response required, Category C. This means that the ambulance service is not required to dispatch an ambulance and may choose to resolve the call by referral to an urgent care service. The Diagnostics research showed that people thought that the introduction of a 3DN for access to non-emergency care would alleviate the pressure on 999/112.

A5.16 A new 3DN will therefore simplify access to the NHS when people experience unexpected, urgent needs at a time when they are, aside from life-threatening situations, at their most vulnerable. It would give the public, for the first time, a clear, simple choice, namely: "*If the situation is an emergency, call 999/112; for all other urgent health needs, call 111 and we will work out with you what is the best way of meeting those needs*."

A5.17 In summary, the benefits of a 3DN would be (i) to bring knowledge, reassurance and clarity into potentially confusing and frightening situations; (ii) give permission to access the NHS and feel less guilty about doing so; (iii) offer alternatives to calling 999/112 or going to A&E.

The 3DN service

A5.18 The 3DN service will provide information and advice to support self-care as the NHS Direct service currently does. It will also assess a caller's individual needs, identify which part of the NHS is best placed to meet those needs and explain how the caller can access that service. Just like NHS Direct and 999 it will be available 24 hours a day, 365 days a year. What will be new is better integration of the services that sit behind the number, helping to ensure that patients are referred to the right service the first time, thus eliminating the need for people to keep repeating the same information. Wherever possible, assessment of need and referral to an appropriate service will take place within the initial call, avoiding the need for call-backs which we know the public find frustrating.

A5.19 The method of delivering the 3DN service and the way in which calls are handled will be tailored to meet the availability of services across the different administrations and regions. However, it is envisaged that across all areas the service would fulfil three core functions:

i) identify immediate life-threatening emergencies and transfer to 999;

ii) respond to requests for health or service information (similar to NHS Direct); and

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

A5.20 Importantly, the new 3DN is not designed to replace access to services that are already familiar, i.e. patient choice in accessing (local) health services will not be removed. For example, it is expected that people will continue to telephone their GP practice for 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.

[51] NHS Information Centre for Health and Social Care, *Ambulance Services England 2008-09*.

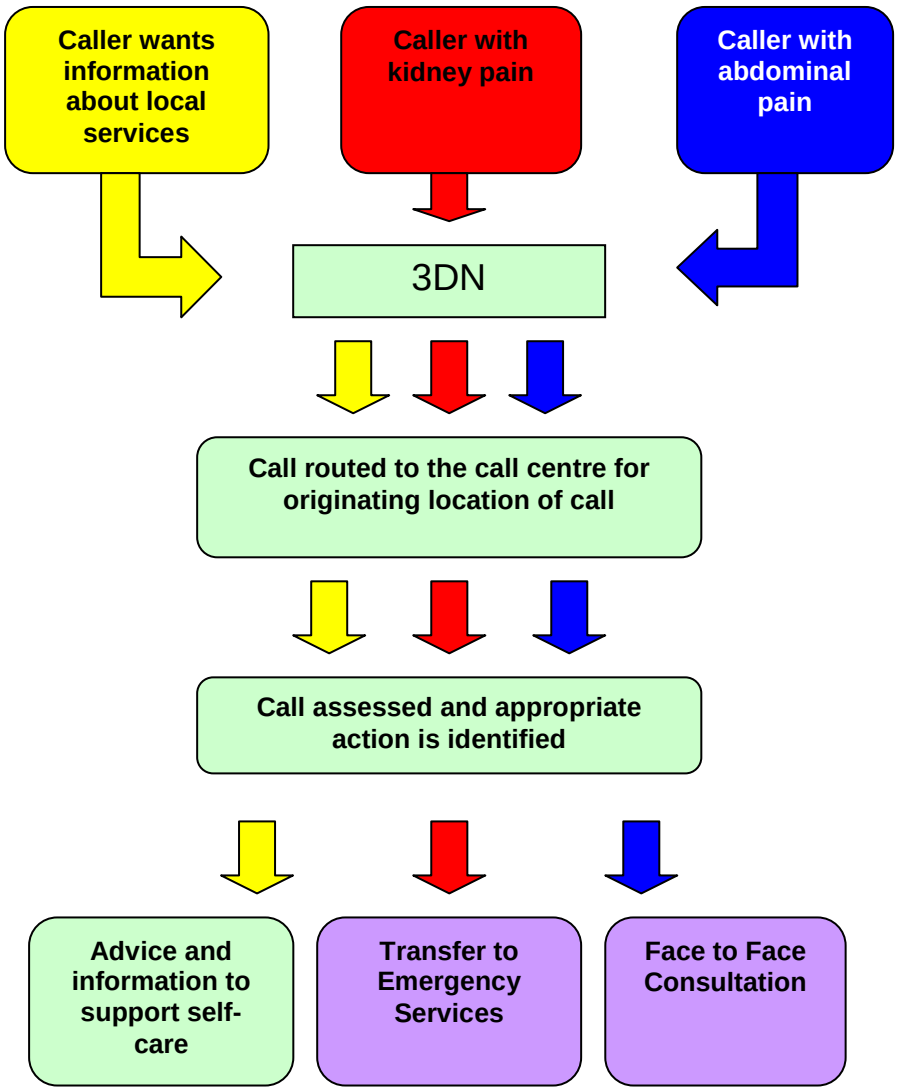
A5.21 In time we envisage that 111 will become the single number to access urgent care services including NHS Direct. During the piloting phase (see further below), access to the 3DN will be restricted to participating geographic areas, and calls made to the 3DN from non-participating areas will be routed to NHS Direct. Eventually, it is envisaged that the NHS Direct number 0845 46 47 would be switched off. Online health advice and information would continue to be available on the NHS Choices website at www.nhs.uk.

A5.22 Our high level vision of how calls to the 3DN service would be handled is as follows (also see Figure 1 below):

- 999 will continue to be the number to call in an emergency situation.
- The technical architecture and method of routing calls has yet to be decided, although there are various options that the Department is considering. Depending on the location of the 3DN caller, it is envisaged that calls in England will be routed to one of ten regional call centres, based on the NHS Strategic Health Authority areas. There will be a mechanism for handling calls, which is likely to be similar to the solution adopted for the 101 service (the 24-hour number provided by the police and local authorities to deal with community safety issues, including non-emergency crime, policing and anti-social behaviour) for handling calls where the geographical location of the caller is not known.
- The service will undertake an immediate clinical assessment of the caller's needs (including screening for emergencies): call-handlers[52] will assess and determine the most appropriate course of action, from self-care advice through to transfer to emergency services. Wherever possible, this will be achieved within the first telephone call, without the patient having to wait for a call-back.
- The service will have access to an accurate, up-to-date directory of the full range of locally available services that exist to meet callers' needs (including GPs). Information about services can therefore be tailored to the location of the caller.
- Where necessary/more appropriate, callers will be transferred directly to local services, and the details of the initial clinical assessment will also be passed directly to that service. This will avoid callers having to repeat their contact details or undergoing further clinical assessments. Our long-term ambition for the service is that, in time, it should be possible for callers to be booked directly into appointments with face-to-face services
- Wherever possible, the patient's needs will be met by the service to which they are referred. There should be a high completion rate, with callers clear as to what they should do next.

[52] As for the NHS Direct service model, there will be a mix of highly trained call-handlers and clinicians operating the service.

Figure 1 - Flow diagram showing high-level view of call handling and referral to other services



Timetable for Implementation

A5.23 We intend to pilot the 3DN service in a number of Strategic Health Authority Areas in England from spring 2010. The pilots will inform the development of the service for wider roll-out across England, which will take place once the results of the pilots have been evaluated.

A5.24 During the piloting phase, access to 3DN will be restricted to the participating geographic areas; calls made to the 3DN from non-participating areas will be routed to NHS Direct.

The number

A5.25 A wide variety of different services exist to meet people's urgent, unplanned healthcare needs – most of these are local, but since 2000 they have been supplemented by one national service, NHS Direct. Each of these services has its own telephone number. A number of GP practices currently use an 084 number. Those practices which do not use an 084 number tend to use an 01 or 02 (i.e. normal geographic) number. Only a small number have adopted one of the new 03 numbers.

A5.26 Even where people are clear which service is best suited to meeting their particular needs, the Diagnostics research has shown that they struggle to remember the telephone number. This is also true for NHS Direct, with its single number for England and Wales, where even regular users and carers find it difficult to recall its eight digits. Therefore, the Department is taking the initiative to introduce a 3DN which is as memorable as 999 and which the public will understand offers an efficient, effective method to access urgent, non-emergency healthcare services.

A5.27 In order to understand issues around the number better, the Department has commissioned three separate pieces of detailed research with the public. Research by Diagnostics explored the public's attitudes towards accessing NHS services by telephone and the extent to which a new 3DN would improve the current position.[53] In the second piece of research Cragg Ross Dawson looked more directly at the range of possible numbers, with a view to identifying which would prove most memorable and effective.[54] In the third piece of work Jigsaw Research explored the public's attitudes to various tariff options.[55]

A5.28 One of the key findings of the initial research was that the times when people are most likely to look to the NHS for help with an unplanned, unexpected need for healthcare are, by definition, times of anxiety and stress. In those circumstances, the only number that comes immediately to mind is 999. The people consulted in this initial research concluded that a new 3DN would be incomparably more memorable than any of the existing NHS numbers and also that there was a strong likelihood that many of those who currently default to 999 would use the new number instead, when they recognised that they were not facing a life-threatening situation.

A5.29 Ofcom has advised that only numbers in the 10X and 11X can be made available, and there are 15 three-digit numbers in this range remaining. The second research project was designed to explore whether there were significant differences between these 15 available three-digit numbers in terms of their ease of use, memorability and association with any existing three-digit numbers.

A5.30 Particular attention was paid to the needs of blind or partially sighted users, and those with restricted mobility, to ensure that no number was chosen which they would find difficult to use. In addition to exploring the views of these particular users, advice was sought from academic experts in the fields of neuroscience, clinical psychology and dyslexia. Their unanimous view was that the most effective numbers were those that contained the fewest different digits, digits that were lower in value, closer together in value, arranged chronologically and all odd or all even.

A5.31 '111' emerged as the overwhelmingly preferred option. Only three alternatives (119, 115 and 105) found support, albeit small. While 85% of the research sample chose 111, 7.5% chose 119, 5% chose 115 and only 2.5% chose 105.

A5.32 In addition to an overwhelming preference for "111" because of its ease of use and memorability, it also became clear that it was strongly associated in the public mind with 999. Without exception, people associated the new "111" service with the vital public service characteristics of 999 suggesting that a new NHS service that was

[53] Diagnostics Social and Market Research, *Three Digit Number For Urgent Care. Concept Research. Qualitative Research Report,* November 2008.
[54] Cragg Ross Dawson, *Three Digit Number for Urgent Care. Qualitative Research to help identify the most appropriate number*, April 2009.
[55] Jigsaw Research, *3DN Tariff Research, Report of Findings,* May 2009.

accessed through 111 would enjoy high levels of trust and confidence from the outset.

A5.33 A small minority of respondents identified the possibility of mis-dials as a potential shortcoming for 111, and the particular challenge around ensuring that three digits had been dialled (as opposed to four) was seen as a risk. On the other hand, even those who articulated this view argued that it was a small price to pay for a number with many other advantages.

A5.34 For the above reasons, the Department proposes that the new 3DN to access non-emergency healthcare should be 111.

The tariff

A5.35 The third piece of research, undertaken by Jigsaw Research was commissioned to help the Department have a better understanding of public attitudes to the different choices of tariff. The research surveyed over 5,000 members of the public including people from vulnerable groups and some carers.

A5.36 The research considered four possible tariff options:

- Option 1 - free to caller, including payphones and mobiles
- Option 2 - 10 pence per call, regardless of call length
- Option 3 - 3 pence per minute
- Option 4 - charged as a landline call (this would vary in respect of different kinds of telephone provider).

A5.37 The research found that most people (54%) expected to have to pay at least the cost of a local call to contact the 3DN service. It also found that the vast majority of people (between 74% and 89%) claimed to be *at least fairly likely* to use the service regardless of which one of the charged tariff options (options 2, 3 or 4) was adopted. Vulnerable groups tended to be less likely to use the new number, regardless of whether they would have to pay for the cost of call or not. That being said, the majority (at least 64%) of all these groups were at least fairly interested in using the service, even if they would have to pay for it. The differences in people claiming they would use the number for the various price options (i.e. options 2-4) is marginal, suggesting that any of the three charged tariffs would be viable. Even looking at those most likely to use the number (extremely and very likely to use), the variation in claimed uptake at the different tariffs is relatively small.

A5.38 We will not know what options are most affordable until the vendor selection exercise is complete and we know what the cost to the public purse would be of the different options. We are however interested in the views of the public and telecoms providers on this issue.

Annex 6

Department of Health research into the three-digit number concept, the specific number and the tariff

Introduction

A6.1 In developing its proposal for the three-digit number and the service behind it, the DH commissioned three separate pieces of research with the public. The first set of research explored the public's attitudes towards accessing NHS service by telephone and the extent to which a new three-digit number would improve the current position. The second looked specifically at the range of possible numbers available, with a view to identifying which would prove most memorable and effective, and the third explored public attitudes towards various tariff options.

A6.2 A summary of each of these pieces of research is provided below. Each report is available in full at http://www.dh.gov.uk/en/Healthcare/Urgentcare/index.htm.

Research into the concept of a three-digit number

Diagnostics, *Three-digit number for urgent care, concept research*

Background and objectives

A6.3 Department of Health (DH) wished to establish "proof of concept" amongst the public for the establishment of a three-digit number for urgent care and to test the public's views on the value of a 3DN concept sitting alongside the 999 emergency care number.

A6.4 Specific research objectives required the exploration of the following:

i) awareness and experience of current sources of help from the NHS when people have an urgent need;

ii) views on the concept of a new national 3DN available 24/7 (ensuring that the service proposition is made clear and that it would not be introduced in addition to NHS Direct nor would it replace the 999 service, nor existing, well-known telephone numbers like the GP practice number);

iii) extent to which it is felt it would make a significant difference to accessing urgent care help for a variety of situations/scenarios; and

iv) whether there any barriers/concerns around the service and its offering.

Methodology and sample

A6.5 The study was conducted via a series of discussion groups and depth interviews. 7, 2 hour discussion groups comprising 8 respondents were held with members of the public across the UK in London, Banbury and Oldham and were segmented by age/life stage and socio-economic grade. There was a mix of men and women in each group. In addition, one, 2 hour mini discussion group (4 respondents) took place with 70-80 year olds. All respondents took responsibility for their health, at least to the extent of being prepared to attempt to organise their own urgent care. Users of private healthcare for urgent / emergency medical situations were excluded. There was a representation of individuals with long term health conditions within each group, together with users of urgent / emergency care in the last 12 months. 10, 1 hour depth interviews were undertaken with 'hard to reach audiences' – namely, carers (both professional and unpaid), older people living in warden-controlled accommodation and people with mild hearing impairments.

Summary of findings

A6.6 A key element of this research was to ensure the process of evaluation of 3DN was rooted in as near real life situations as possible. To this end, respondents were exposed to a number of urgent need and emergency scenarios both before the introduction of the 3DN concept and afterwards. These scenarios covered both in-home and out-of-home situations as well as in hours and out of hours needs. The result was an assessment of 3DN which was grounded in relevant situations and one, moreover, where respondents' individual and spontaneous thoughts were captured, prior to opening up discussion on the matter for group consideration.

A6.7 While 'emergency' need proved relatively easy to define, as a potentially life threatening situation, and was linked to 999 and a need for immediate face to face medical attention, the need for 'urgent care' proved more difficult. Importantly, 'urgent' needs did, however, require respondents to make a judgement, often difficult at a time of concern and perhaps panic, and resulted in a much less clear action profile. However, it must be said that, for many, taking oneself to A&E was an appropriate response to an 'urgent' situation. Feelings of guilt resulted more from using the ambulance service, not from the visit to A&E.

A6.8 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.

A6.9 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.

A6.10 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.

A6.11 Less positive responses were in the minority. A few felt that calling the 3DN would keep them away from 'proper' medical help, some voiced concerns relating to unqualified staff / call handlers, and a few saw the concept as wasteful, perhaps

encouraging time wasters or offering no more than an expensive rebranding exercise for NHS Direct.

A6.12 In terms of 3DN details, there was reluctant acceptance of a call handler taking the call and most understood the need for basic details to be provided. '999 screening' was both expected and reassuring and thus this stage met with approval, on the whole. Although the idea of a 'call back' was frustrating, with respondents feeling they would be left waiting and unsupported, most reluctantly accepted the situation. Call back time expectations were highly variable and often situation and past experience dependent. Few expected the call handler to have access to the caller's past 3DN usage or records.

A6.13 Once the stage of Doctor / Nurse call back was reached, relief was expressed at having arrived at this point and obtaining solid medical information. Most respondents did not specify a level of training that was necessary as long as he / she was a medical professional and they could talk over the situation details with them. However, some concern was voiced over expected lack of access to personal medical records and thus a questioning of the ability of the medical professional to give informed advice.

A6.14 In terms of the final stage of the process, 'medicines advice' was both expected and accepted by all, although again there were some minority concerns over 'unsuitable' medical advice given in the absence of medical records. As for 'health advice', this was understood conceptually but felt to run counter to the core 'Urgent Care' focus. There was fear that the 3DN could be seen as an invitation to hypochondriacs and time wasters. The main take-out from this element of the service was that health advice needed careful positioning via clear explanation of the concept; how it fitted into 3DN with its focus on urgent care; and what it would deliver. The Doctor / Nurse response / Action was viewed as the ideal, all-encompassing response, which many had originally envisaged as the first level of response on calling the 3DN. The level of appreciation of the quality of the offer depended on the standard of each respondent's current services, but overall there was a consensus of approval.

A6.15 Confusion over the current NHS Direct offer made direct comparisons hard for some, but nonetheless for the majority the 3DN offer was seen as providing an even better NHS Direct. For NHS Direct users, the hope was for a crisper, sharper, more authoritative and more decisive service.

A6.16 Spontaneous suggestions for improvements and extra services to 3DN largely related to providing additional reassurance for callers, specifically around the call back, with a ring back service if the returned call from the medical professional was going to be delayed, or swifter, guaranteed call back times or indeed prioritisation of call backs. Some also wanted the 3DN service to be able to access their personal medical records.

A6.17 Maximum benefit from 3DN was thought to derive from being away from home, out of hours, closely followed by being away from home, but in hours. However, some benefit was also expected from 3DN when respondents were at home, whether in or out of hours.

A6.18 Whilst 3DN was reckoned to be "life changing" only for a few (principally amongst the carer segment), the majority would position it as more than a 'nice to have'. The scenario exercises were however vital in demonstrating the potential utility of 3DN, both in urgent and emergency situations and also when general advice was

needed. It would bring knowledge, reassurance and clarity into confusing and frightening situations and cut down on knee-jerk reactions involving calling 999 or going direct to A&E. It would also give permission to access the NHS and thus ensure respondents felt less guilty in doing so.

A6.19 Overall, the least relevance for 3DN was amongst those in warden accommodation, who were mostly or wholly reliant on the warden to make decisions and were less comfortable using the telephone for medical situations.

A6.20 To ensure the 3DN achieves its potential, it will be necessary to offer an easily recalled 3DN, to promote this number and to clarify its services as being broader and more responsive than those of NHS Direct i.e. from information to advice through to active medical assistance.

A6.21 Some sort of positioning for the new service will be essential. The current suggestion of *"if you don't know what to do"* works well to endorse known options and to avoid seeming to block access to medical help.

Research into the number

Cragg Ross Dawson, *Qualitative research to help identify the most appropriate three-digit number*

A6.22 The DH commissioned qualitative research to establish which of the available 3DNs is most appropriate for the new service. The aim of this research was to help DH identify a 3DN which:

- can be remembered effortlessly, or very easily
- is found simple and easy to use from an ergonomic perspective
- is easy to navigate for those who are blind or partially sighted
- feels appropriate and relevant for an urgent health number

Methodology

A6.23 Fieldwork was conducted in three phases, with some of the candidate 3DNs eliminated after each phase.

A6.24 In Phase 1, all 15 candidate numbers were explored in….

- individual interviews with experts in dyslexia, dyscalculia, psychology and other fields – to establish general rules about which types of number sequence are most easily used and remembered, and to gather their opinions on all 15 candidate 3DNs
- short individual interviews (SQIs) with people who are blind or partially sighted, and those with restricted movement in their hands – to explore the usability and memorability of all 15 candidate 3DNs, and eliminate those which were least suitable for this audience
- group discussions with members of the public – to gather initial views on all 15 candidate 3DNs, and response to the service in general

A6.25 Following this, 8 numbers were eliminated, and in Phase 2, the remaining 7 were explored further in…

- individual interviews with carers, wardens and health professionals – to explore their opinions of the 3DNs from their own point of view and that of their wards or patients
- individual interviews with people aged 75 and over, and those with long-term conditions – to explore their particular needs with regard to a telephone service and 3DN
- SQIs with members of the public – to gauge preferences and memorability
- 'pyramid' interviews in which some SQI respondents asked friends and family what they thought – to extend the fieldwork and explore the effect of 'word of mouth'

A6.26 Following this, 4 numbers were eliminated, and in Phase 3, the 3 remaining were explored further in…

- SQIs with members of the public, in which respondents were shown a series of four mocked-up poster ads for various products (a car, a holiday, a cleaning product), including one of the 3DNs
- SQIs with members of the public, in which respondents were shown a longer series of mocked-up ads, including all three of the 3DNs

A6.27 Respondents in Phase 3 were shown the ads at the beginning of the interview, then distracted by discussion of current affairs or their plans for the week, then asked what they remembered from the ads and in particular whether they remembered the number(s) they saw. They were also telephoned a few days later to check longer-term recall of the three 3DNs.

Summary and conclusions

A6.28 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.

A6.29 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.

A6.30 One or two respondents thought that 111 may be misdialled, either by mistake as a 'bum call', or with too many 1s by people who become confused over how many digits they have dialled. But this was rarely expected to be a problem by these respondents, or indeed by others to whom these points were put. If there are disadvantages entailed by the possibility that 111 will sometimes be called by mistake, these need to be weighed against the benefits noted above. In any case, we believe that landline telephone services at least will ignore any digits after the third, so 1111 would still work (although of course this would need to be checked), and we expect that mobiles will not allow 111 to be dialled without unlocking the

keypad, as they currently do for 999, so 'bum calls' will be less frequent for 111 than 999.

A6.31 For all these reasons, we feel that 111 will be the most successful and effective number to represent an information service for use in urgent situations, in terms of both migrating inappropriate calls from 999 and attracting calls which would not otherwise have been made.

A6.32 113 and 114 were distant second preferences, with some support from most sample sectors. Of the two, 114 seems marginally preferable. It was strongly preferred by BPS respondents, and there is arguably less chance of it being misdialled, as there is no key between 1 and 4 – 113 may be dialled as 112, which is a valid 3DN in itself. There is also less danger of 114 being confused with 118 when displayed visually – 3 and 8 may look similar to some.

A6.33 Ultimately, few thought that 114 is a 'bad' number, and given sufficient publicity it is likely to be perfectly adequate. However, it is likely to require more publicity than 111 to reach the same level of awareness, and to achieve the same positive association with 999 since the number itself is more likely to be related to a 118-type 'useful private-sector' service. Overall, we feel there is a danger that 114 would be less easily recalled in urgent situations than 111, and it may inspire less confidence in the service, and thus be less widely used.

Tariff research

Jigsaw Research, *3DN Tariff research*

A6.34 The purpose of this piece of research was to examine the potential for introducing the new 3DN service at different tariffs, exploring and identifying:

- Likelihood of calling the number for each of the tariff options:
  - How willing are people to pay for a telephone call to access the service?
  - How does this vary across different segments of the population and in particular among more vulnerable people who potentially have greater need for the service?
- The variety of scenarios in which people may use the number, and whether this has any impact on the claimed take up of each tariff option
  - To what extent are people less price sensitive in situations where they have less service choice? For example: at home during the day vs. at home out of hours (when the GP is closed) vs. out and about/away from home.
- The barriers to claimed uptake of the service as a result of particular tariff options:
  - Crucially, to what extent do these barriers impact negatively on claimed take up amongst more vulnerable people with potentially greater need for the service?

A6.35 Whilst the target audience for the new 3DN service (and hence for the research) is all adults in England aged 16+, it is anticipated that the service will be of particular potential value to more vulnerable or hard to reach groups. The research was

therefore designed to ensure sufficiently robust samples for independent analysis of each of the following subgroups:

- older people aged 75+, living independently;
- people with poor heath: this was defined for the purposes of the research as being those with long term health condition that cannot at present be cured, but can be controlled by medication and other therapies (e.g. Chronic kidney disease, Dementia, Schizophrenia, Depression, Diabetes, Asthma, Multiple sclerosis, Parkinson's disease), living independently;
- BMEs: this group was defined for the purposes of the research as those who would describe their ethnic group (i.e. cultural background) as mixed, Asian or Asian British, Black or Black British, Chinese or another non-white ethnic group;
- carers (non-professional): this group was defined for the purposes of the research as those who are currently looking after a friend, relative or neighbour who needs support because of their sickness, age or disability?; and
- less affluent / low income groups: defined for the purposes of the research as those falling within socio-economic groups D and E.

Summary of findings

Use of current health services

A6.36 Usage of NHS Direct is relatively low and a lack of clarity surrounds the cost of calling this service.

- Most respondents (76%) have called their GP in the past year. However usage of NHS Direct is relatively low, almost as low as usage of 999 (25% have called NHS Direct in the past year compared to 13% having called 999).
- Most respondents know that calling 999 is free of charge (78%) and that a call to their GP is the cost of a local call (71%). However one in three have no idea how much it costs to call NHS Direct, and this rises to 38% among people who have not called the service in the past year. Among those who were able to comment, most (48%) thought they had to pay for such a call but a not inconsiderable proportion (18%) thought the service was free.

A6.37 Older people tend to have close ties to their GP, weak ties to NHS Direct and are much less price aware than average.

- If they were presented with a non-life threatening health issue while they were at home and needed NHS advice, those aged 75yrs or older would be more likely than average to call their GP – whether the issue emerged during the day (63%) or out of hours (21%). However senior citizens are less sure than other groups what they would do if they were out and about: 21% wouldn’t know what to do in this situation compared to an average of 14%.
- Those aged 75yrs or above are less likely than average to have called NHS Direct in the past year (11% compared to an average of 25%). It follows that in any of the three scenarios described above, they are less likely than average to consider calling NHS Direct for information or advice (8%, 16% and 10% respectively).

- Older age groups are also much less price aware than other groups: 31% don't know that calling 999 is free, 62% don't know what it costs to call NHS Direct and 21% don't know what a call to their GP costs.

A6.38 Those with long term health conditions have more frequent contact with their GP and also have weak ties to NHS Direct.

- The vast majority of those with a long term health condition have called their GP in the past year (85% compared to an average of 76%). They also tend to be in more frequent contact with their GP than other groups (34% had called their GP at least once a month in the past year, compared to an average of 19%).

- It follows that the GP is the first port of call for this group if they were at home during the day and needed help or advice from the NHS about a non-life threatening health issue (65% say they would call their GP in this situation compared to an average of 59%). Those with long term health conditions are less likely than average to call NHS Direct in any of the three scenarios described above (9%, 28% and 17% respectively).

A6.39 BMEs are more inclined to turn to the emergency services than other groups and have weak links with their GP.

- BMEs are significantly more likely than average to have called 999 (19%) and NHS Direct (30%) in the past year.

- Furthermore, if they found themselves with a non-life threatening health issue and needed NHS advice they would be more likely to turn to the emergency services than average: 11% would dial 999 if they were at home during the day (compared to 4% on average), 10% would dial 999 if they were at home out of hours (compared to 5% on average) and 18% would dial 999 if they were out and about (compared to 9% on average).

A6.40 Carers tend to be more engaged with health services than other groups, as is consistent with the demands of their role.

- Non-professional carers are more likely than average to have called 999 (19%), NHS Direct (31%) and their GP (85%) in the past year.

- The GP is more likely to be their first port of call if they were to find themselves in a non-life threatening health issue out of hours while they were at home (19% compared to 14% on average). This could be related to higher awareness of GP out-of-hours services among this group as a result of their role – although this research cannot provide evidence for this hypothesis.

A6.41 Less affluent groups are unusual in so far as they are consistently less price aware than average.

- Those in socio-economic groups D and E are less likely than average to know how much it costs to call any of the health services tested: 18% don't know the price of calling 999 (compared to 14% on average), 41% don't know the cost of a call to NHS Direct (compared to 33% on average) and 18% don't know the price of a call to their GP (compared to 14% on average).

Use of new 3DN service

A6.42 Most people would expect to pay to call the 3DN service described.

- Around one in three (38%) expect the 3DN service to be free. Expectations of a free service increases among the minority of people who believe calls to existing services are free: rising to 56% among those who believe calls to their GP are free, and to 59% among those who believe calls to NHS Direct are free.

- However, most people (54%) expect to have to pay at least the cost of a local call.

- Young singles and BMEs are more likely than average to expect a free service whereas middle aged, middle class groups are more likely than average to anticipate call charges.

A6.43 High levels of claimed uptake across all groups suggests the service will have broad appeal, even in a paid for scenario.

- The vast majority of people (between 74% and 83%) claim to be *at least fairly likely* to use the service regardless in a paid for scenario. The proportion of people who are *extremely or very likely* to use the service varies between 43% and 57% in a paid for scenario.

- The vulnerable groups tend to display a lower than average claimed uptake across the different scenarios, regardless of whether they have to pay for the service or not. This is particularly the case for those aged 75yrs or above, who most consistently display under-average levels of claimed uptake across the different tariff options (including the free of charge option).

- That being said, the majority (at least 64%) of all these groups remain at least fairly interested in using the service, even if they would have to pay for it.

A6.44 The difference in claimed uptake between the tariffs is marginal, suggesting that at these relatively low price differentials, any of the tariffs are viable.

- Even looking at the two most receptive answer categories (extremely and very likely to use), the variation in claimed uptake at the different tariffs is relatively small: 52-56% at 10p per call depending on the scenario, 48-57% at 3p per minute, 43-53% at local call rates. In other words, although the 10p per call tariff attracts slightly higher levels of uptake, either of the other two tariffs remain viable options for the new service.

A6.45 Claimed uptake increases significantly if the service is free. However, the impact is relatively small given the high baseline level of interest in a paid for scenario.

- Claimed uptake increases significantly if the 3DN is free to call: the proportion claiming to be at least fairly interested rises by 6-11% (to 85-89%) depending on the scenario. (It is worth noting that the proportion claiming to be extremely or very interested rises by a more substantial amount if the service is free, to between 68% and 71% depending on the scenario.)

- However, given that there is already a high baseline level of interest (at least three in four) even in a paid for scenario, the impact is relatively small.

- Of all the vulnerable groups, BMEs are the most likely to respond positively to a free service (90% are at least fairly likely to use the new service in this scenario, compared to an average of 85%) suggesting that they are a more price sensitive group. Whereas those aged 75yrs or over are the least likely to respond positively to a free service (78% respectively) suggesting that they are a less price sensitive group.

A6.46 It follows that while cost is off putting to some, preference to speak directly to a health professional is a greater barrier to using the 3DN service.

- Among those who are unlikely, or only fairly likely, to use the new 3DN service, cost is a barrier to one in four (24%) people. This represents 14% of all respondents. Cost is a higher barrier among young families, students, DEs, those who only carry mobile phones and BMEs.

- However, a significantly greater barrier is the desire to speak directly to a health professional (in particular a GP), which is a problem for more than one in three (39%) people. This represents 22% of all respondents.

A6.47 The new 3DN service is least likely to be used from home during the day, although claimed uptake remains high even in this scenario.

- There is a small but significant uplift in claimed uptake when at home out of hours (4-9%) or if away from home (4-6%). In other words there is a slightly lower claimed uptake in a scenario where a health issue arises while the person is at home during the day. That being said, most people (74-85%) are still at least fairly likely to use the service in this scenario, depending on how much they might have to pay for the call.

A6.48 The new 3DN service is most appealing to those who would currently call NHS Direct if a non-life threatening health issue arises.

- Claimed uptake among those who would currently call NHS Direct in the three scenarios is consistently higher than average at all tariffs (by between 6% and 13%).

- At the very least, this provides evidence that the 3DN service as described in this research is not off putting – respondents appear to have got the message that they will still be able to access NHS Direct services via the new number. At best, the data suggests that the new 3DN is a viable and potentially improved alternative to the NHS Direct number as a way to access these services.

A6.49 The new 3DN service provides some guidance to those who wouldn't currently know who to call if a non-life threatening health issue arises.

A6.50 Claimed uptake of the new 3DN service ranges between 57% and 79% among those who currently don't know who they would call in any of the three scenarios. Despite the fact that these levels of interest are lower than the average, this suggests that the new service could provide genuine assistance to at least a proportion of a key target audience.

Annex 7

Legal Framework and Tests

The legal framework

A7.1 Ofcom regulates the communications sector under the framework established by the Act. The Act provides, amongst other things in relation to numbering, for the setting of General Conditions of Entitlement relating to telephone numbers, which is General Condition 17 (Allocation, Adoption and Use of Telephone Numbers - the "Numbering Condition") and procedures for making modifications to such Conditions. These procedures include the requirement to ensure that proposals are consistent with our general duties as set out in section 3 of the Act and Community obligations as set out in section 4 of the Act.

A7.2 We are consulting on the proposal to designate the number 111 for "Access to NHS Non-Emergency Healthcare Services (Type A Access Code)" in accordance with the DH's request. If the proposal is accepted, we will need to modify the Annex to the Numbering Condition so that the number 111 and its service designation can be added to the list of telephone numbers for use or adoption by communications providers in accordance with their designation (as provided by Numbering Condition 17.3).

The Numbering Condition

A7.3 Section 45 of the Act gives Ofcom the power to set conditions:

"(1) Ofcom shall have the power to set conditions under this section binding the persons to whom they are applied in accordance with section 46.

(2) A condition set by Ofcom under this section must be either –

(a) a general condition…"

A7.4 Section 58 states that general conditions may include conditions about the allocation and adoption of telephone numbers, including conditions which impose restrictions on and requirements in connection with the adoption of telephone numbers by a communications provider.

A7.5 Section 47 of the Act sets out the test for setting and modifying conditions.

A7.6 The test set out in section 47(2) is that the condition or modification is:

"(a) objectively justifiable in relation to the matters to which it relates;

(b) not such as to discriminate unduly against particular persons or against a particular description of persons;

(c) proportionate to what the modification is intended to achieve; and

(d) in relation to what it is intended to achieve, transparent".

A7.7 Section 48 of the Act sets out the procedure for setting, modifying and revoking conditions which includes the publication of a notification setting out the modifications.

A7.8 Section 48(2) states that:

"Before setting conditions under section 45, or modifying or revoking a condition so set, Ofcom must publish a notification-

(a) stating that they are proposing to set, modify or revoke the conditions that are specified in the notification;

(b) setting out the effect of those conditions, modifications or revocations;

(c) giving their reasons for making the proposal; and

(d) specifying the period within which representations may be made to OFCOM about their proposal.

Subsection (3) states that such period must end no less than one month after the day of the publication of the notification.

A7.9 Under section 50(1)(a), a copy of every notification published under section 48(2) must be sent to the Secretary of State. This includes notifications of modifications to the Numbering Condition.

Ofcom's general duty as to telephone numbering functions

A7.10 Ofcom has a general duty under section 63(1) of the Act in carrying out its numbering functions:

"a) to secure that what appears to them to be the best use is made of the numbers that are appropriate for use as telephone numbers; and

b) to encourage efficiency and innovation for that purpose."

General duties of Ofcom

A7.11 The principal duty of Ofcom to be observed in the carrying out of its functions is set out in section 3(1) of the Act as the duty:

"a) to further the interests of citizens in relation to communications matters; and

b) to further the interests of consumers in relevant markets, where appropriate by promoting competition."

A7.12 This consultation fulfils Ofcom's duties in proposing a modification to the Numbering Condition by containing the notification in Annex 8 and by providing the reasoning behind the proposals in the main body of this document. The various legal tests and duties, and how Ofcom has complied with them in consulting on the modifications to the Numbering Conditions, are set out below.

Legal Tests

A7.13 As indicated above, it is Ofcom's duty, when proposing modifications to the Numbering Conditions, to show how it considers that its proposals comply with the legal tests set out in section 47(2) of the Act. In this case, the proposed modification would be to designate the number 111 for "Access to NHS Non-Emergency Healthcare Services (Type A Access Code)" in the Annex to the Numbering Condition. Ofcom is satisfied that the proposal meets the tests set out in section 47(2) of the Act being:

- **objectively justifiable**, in that it relates to Ofcom's general duty to secure that the best use is made of the UK's telephone number resource (see further paragraph A7.14 below). It could also help to ensure that calls to the emergency services are handled more efficiently by making available a more suitable number to access non-emergency healthcare services. The designation of the number 111 to the proposed service would therefore further the interests of citizens in relation to communications matters.

- **not unduly discriminatory**, in that all communications providers may provide subscriber access to the non-emergency healthcare service through the use of the 111 number without application to Ofcom;

- **proportionate**, in that the proposed modification to the Numbering Condition is the minimum revision to its provisions necessary to provide access to the non-emergency healthcare service through the 111 number; and

- **transparent**, in that the notification proposing the modification to the Numbering Condition and Ofcom's reasoning is set out in this document.

A7.14 Ofcom considers that it is fulfilling its general duty as to telephone numbering functions set out in section 63 of the Act by:

- **securing the best use of appropriate numbers**, in that the non-emergency healthcare service is considered to be a service of significant public benefit which Ofcom believes would make the best and appropriate use of a three-digit number, which is a scarce and valuable numbering resource; in particular, the service has the four chief characteristics set out in the final statement on 101 (see paragraphs 4.40 to 4.44 above); and

- **encouraging efficiency and innovation**, in that provision of the 111 number aids the delivery of an innovative service that is designed to further consumers' interests by improving their experience of accessing non-emergency healthcare services and the handling of genuine emergency calls.

A7.15 We consider that our proposals are consistent with our general duties in carrying out our functions as set out in sections 3 and 4 of the Act. In particular, we consider that the proposals further the interests of citizens in relation to communications matters by providing an easy and convenient way for the public to access non-emergency healthcare services.

Question 4: Do you have any comments on the proposed notification of modification to the Numbering Condition in Annex 8 of this document?

Annex 8

Notification of proposals for a modification to the Numbering Condition

Notification of proposals for a modification to the provisions of General Condition 17 of the General Conditions of Entitlement under section 48(2) of the Act

1. Ofcom, in accordance with section 48 of the Act, hereby makes the following proposal for a modification to the provisions of General Condition 17 (the Numbering Condition).

2. The draft modification to General Condition 17 is set out in the Schedule to this notification.

3. The reasons for making the proposal and the effect of the modification are set out in the main body of the accompanying consultation document.

4. Ofcom considers that the proposed modification complies with the requirements in section 47(2) of the Act.

5. In making the proposals referred to above, Ofcom has performed its general duties under section 3 of the Act and its duty as to telephone numbering functions under section 63 of the Act and acted in accordance with the six Community requirements in section 4 of the Act.

6. Representation may be made to Ofcom about the proposal by **5pm on 20 August 2009**.

7. A copy of this Notification has been made available to the Secretary of State.

8. In this Notification:

    - "Act" means the Communications Act 2003;
    - "General Condition 17" means General Condition 17 of the General Conditions of Entitlement set by the Director by way of publication of a Notification on 22 July 2003;
    - "Director" means the Director-General of Telecommunications as appointed under section 1 of the Telecommunications Act 1994; and
    - "Ofcom" means the Office of Communications.

Signed by

A person authorised by Ofcom under paragraph 18 of the Schedule to the Office of Communications Act 2002

Schedule

The following shall be inserted for “111” (which will appear after “101”) in Table 1 in the Annex to General Condition 17 of the General Conditions of Entitlement. Note: the asterisk denotes a number beginning or in entirety that is designated for access to the service as set out in the adjacent column:

111*	Access to NHS Non-Emergency Healthcare Services (Type A Access Code)